For those patients that require transitional support to either help them achieve independence or plan for appropriate long term and/or complex care needs, community services will extend its approach to reablement and rehabilitation services to support the local integrated model through its urgent and complex long term care function.

These services are provided by multi-disciplinary neighbourhood teams that include expertise from reablement services, physiotherapy, occupational therapy, social care assessors, social care outreach and intermediate care practitioners. Care will be provided either in the patient's own home or from a bed-based unit for those patients who can be safely managed in the community, with clinical and or therapy interventions. This model limits the need for transition between services as it operates under the one service umbrella as a means of overcoming restrictive referral processes and organisational and professional boundaries and ensures a seamless continuum of care. This service plays a pivotal role in managing pressures for acute beds across the health economy. Referrals for the service will be managed via a single point of contact within a Care Coordination Centre supported by a process of clinical triage.

The development of primary and community services and in particular the INTs, will be one of two key priority areas for development in 2014/15

5.4 High quality urgent and emergency care

NHS England, in a publication about the future of urgent care services[xxxiii], describes five key elements which must be taken forward to ensure success as follows:

1. Provide better support for people to self- care.

2. Help people with urgent care needs to get the right advice in the right place, first time. To achieve this, to achieve this the Department of Health plans to greatly enhance the NHS 111 service so that it becomes the smart call to make, creating a 24 hour, personalised priority contact service.

3. Provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E. This will mean providing faster and consistent same-day, every-day access to GPs, primary care and community services.

4. Ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.

5. Connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts. NHS England has signaled intent to develop broader emergency care networks.

5.4.1 Transfer of Care Service

Discharge coordinators are part of the support provided to improve the patient's experience of their transfer of care from an acute to a primary or community care setting. Discharge coordination is a complex process and requires skilled professionals with knowledge of health and social care provision in both acute and community settings. This service will impact on the number of patients admitted to general or specialist wards, reduce length of stay, reduce the numbers of delayed transfers of care, improve the care planning processes and improve the quality of discharge information.

The discharge co-ordinators currently support the discharge process for patients in hospital. They assess patients using 'LACE' (a risk stratification tool) and refer patients to the appropriate services. They monitor each patient's discharge liaising with the discharge planning team, social services and therapy teams, removing barriers to patients discharge and ensuring the process is completed in a timely manner and on a seven day a week basis.

Consideration will be given to establishing a multi-disciplinary hospital transfer of care team to include expertise from community matrons, district nurse liaison, social care screeners, occupational therapy, physiotherapy, social workers and palliative practitioners. This team will also consider when an admission can be avoided by having a presence on accident and emergency and medical assessment units, and they will take steps to co-ordinate a timely community response.

We will expect to see transfer of care planned at the point of admission and the principle of "expected date of discharge", embedded, audited and managed within the provider organisation, taking into account the need for collective accountability of all organisations involved to make the system work. In order to facilitate safe transfer of care, appropriate communication systems need be in place by working towards a single point of access.

5.4.2 Skelmersdale Walk-in Centre & West Lancashire Health Centre

Skelmersdale Walk-in Centre is based in the shopping centre in Skelmersdale and offers both resident and visitors of the town an ability to see a registered nurse without an appointment for a variety of minor injuries and illnesses.

West Lancashire Health Centre is situated at Ormskirk District General Hospital and is run by GPs and registered nurses providing advice and treatment for members of the local community presenting with a range of minor illnesses and injuries.

Both of these centres operate seven days a week and offer a viable alternative to an attendance at the A&E department for minor and moderate urgent care needs. West Lancashire CCG will continuously work to ensure that the services offered through these centres are optimised in context the urgent care agenda.

5.4.3 Integrated Observation Ward

Southport and Ormskirk Hospital NHS Trust has already implemented an Integrated Observation Ward at the Southport &Formby District General Hospital, which links closely with the A&E Department on the site. The ward aims to provide the setting for patients to receive continued assessment and care from a number of providers with the aim of reducing unnecessary hospital admissions. The impact of this facility will be monitored by the Urgent Care Network.

5.4.4 *Mental Health Assessment*

Merseycare currently offers 24/7 provision for assessment of patients from age 16 years onwards, that serve the population of North Sefton and West Lancashire presenting with acute or complex mental health need in the A&E Department. Merseycare also provide a single point of access for mental health assessment and liaison to individuals who are in-patients from age 16 years onwards, including the medical assessment units and other derivatives of assessment units within Southport & Ormskirk Hospital NHS Trust. These patients are individuals who are identified as being potentially in need of mental health assessment, advice and support.

The current provision is Monday-Friday during the hours of 9.00 am – 5.00 pm (excluding bank holidays). Service provision will be reviewed to ensure response times prevent any unnecessary delays and unnecessary stays in an acute hospital bed.

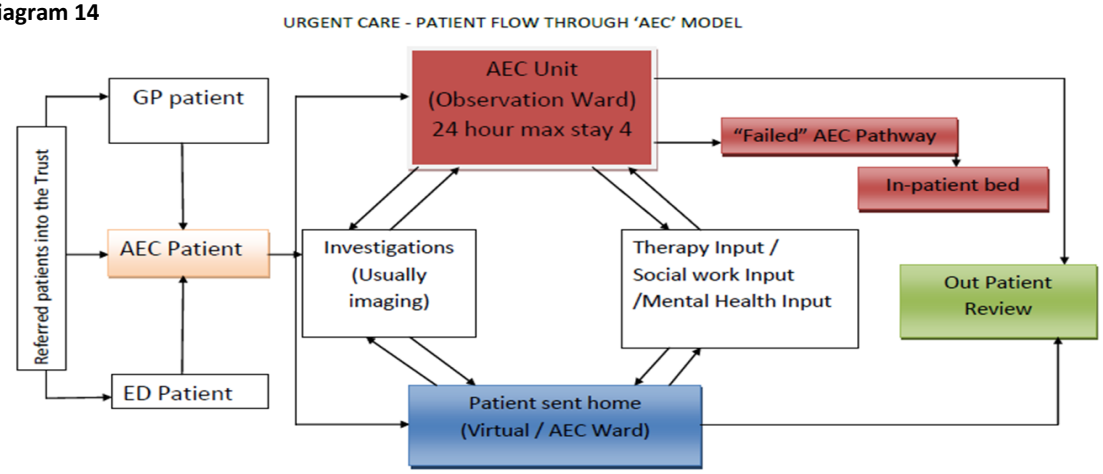
5.4.5 *Ambulatory Emergency Care*

Ambulatory Emergency Care (AEC) has been operational within the Southport District Hospital emergency department since the 4th November 2013 and is a service designed to diagnose and treat patients quickly and effectively, without the need for hospital admission. It is medically led by the Accident and Emergency Department Consultants and supported by nursing staff.

Ambulatory Care offers emergency care to patients at the hospital, where patients are assessed, diagnosed and have treatment started on the same day. They are not admitted to hospital. For some specialist investigations patients may need to return the next day but again they are not admitted to hospital. This benefits patients as they get diagnostics sooner and therefore start treatment earlier.

The Ambulatory Emergency Care Service runs 7 days a week (not at night). It is based in the Accident and Emergency departments Observation ward. The service is delivered by Advanced Nurse Practitioners (Band 8a) and medically led by the A&E Consultants.

Diagram 14



5.4.6 Connecting the urgent care system

An Urgent Care Operational resilience group, reporting to the System Resilience Group (aka CCtH Programme Board) will be developed as a:

"Network to support getting patients to right place, right time for urgent care services"

This will enable the Urgent Care services to work more effectively as a networked system and provide opportunities for workforce engagement in service improvement across Southport, Formby and West Lancashire. The network will be expected to debate operational needs, share and plan activities to improve performance in an integrated approach.

This is to be focused on "keeping patients out of hospital unnecessarily, and enable the public to make the most appropriate choice for accessing urgent care facilities" and lever the following benefits:

- Will allow proactive engagement of teams across the population to deliver best possible coordinated care for patients.
- Relationship building and improved communication for proactive working across care teams
- Focused regular, and organised, mechanism to review and progress urgent care planning discussions
- Reduce duplication of multiple meetings to address same issues
- Proactive mechanism to engage people to respond to variations; issues/problems innovatively
- To facilitate joint development of an integrated approach and culture for urgent care planning.

5.5 Frail older people

Our local population is aging and as people live longer, we can expect more frail older people will be using health and social care services. Frail older people need specialist high quality services in both community and hospital settings, which is why we have prioritized the development of integrated care pathways for this group. Southport & Ormskirk Trust identified that a high number of people over 80 year of age, were admitted to hospital consequent to relatively minor health problems, such as, delirium, urinary tract infections and falls, but that these health problems often have a profound effect on peoples mobility and outcomes. The average length of stay in hospital was around ten days, but some people were in for much longer.

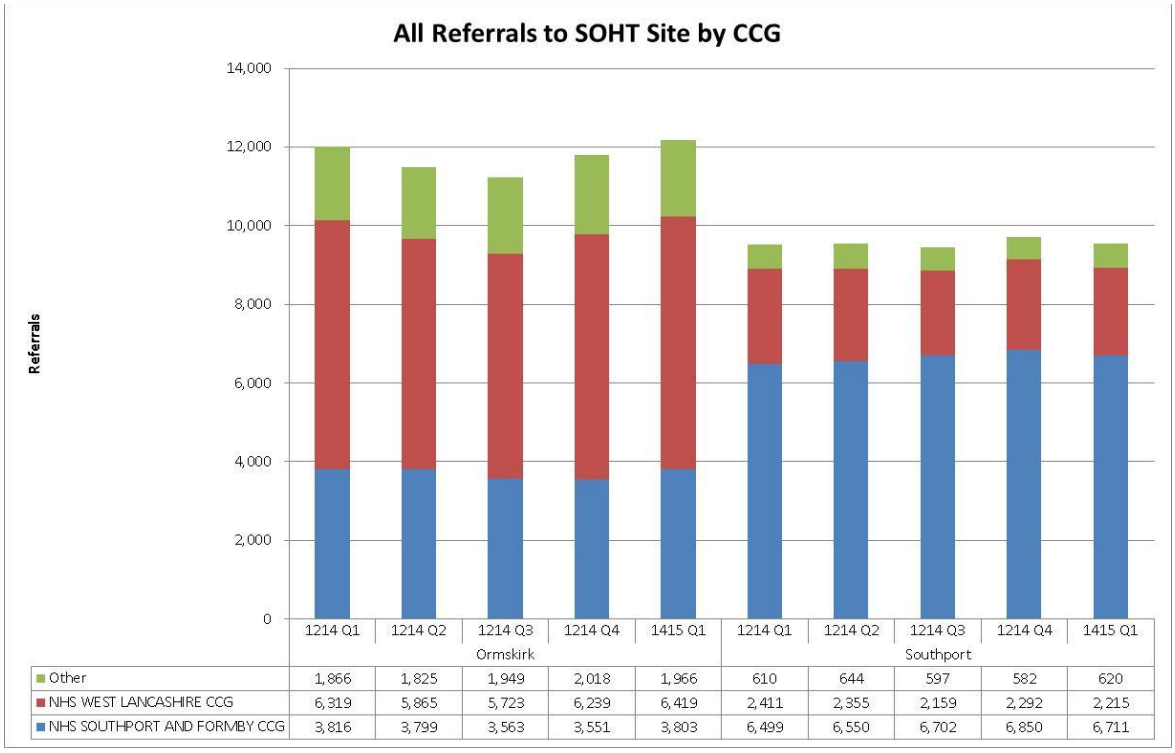
In November 2013, a 28 bedded Frail Elderly Short Stay Unit (FESSU) was established, through the award of additional winter pressures monies in September 2013.The premise of the FESSU was that by having an early multi-disciplinary assessment and treatment with early morning daily multi-disciplinary team meetings including senior medical staff, nursing, pharmacy, mental health, and the Community Emergency Response Team (CERT), the mean length of stay in hospital could be reduce to five days. The Community Emergency Response Team is also responsible for intermediate care beds, which provide step up/step down beds in the community and, linked to social care and the third sector, can quickly access re-ablement services and community assets to enable better patient experience and improved health outcomes.

Combined, these services offer a more effective response to the urgent health needs of frail older people than standard care.

5.6 Increased elective productivity

During 2013/14 Southport and Ormskirk NHS Trust received a total of 84,604 referrals into elective care services from GPs, 33,183 of these were from GPs in West Lancashire CCG and 41,330 of these were from GPs in Southport and Formby CCG. The table bellows shows the pattern of referrals, which appears to be relatively consistent.

Graph 6

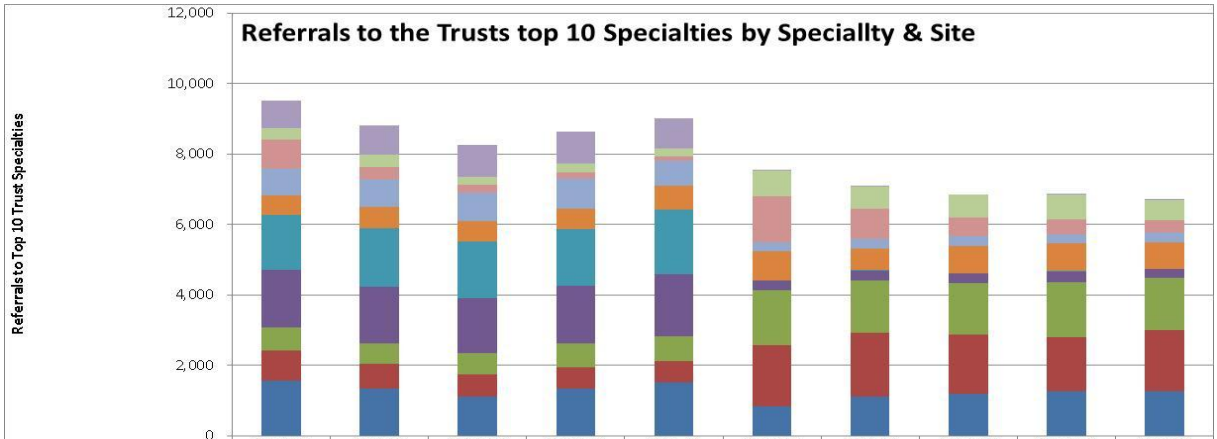


	1214 Q1	1214 Q2	1214 Q3	1214 Q4	1415 Q1	1214 Q1	1214 Q2	1214 Q3	1214 Q4	1415 Q1
	Ormskirk					Southport				
Other	1,866	1,825	1,949	2,018	1,966	610	644	597	582	620
NHS WEST LANCASHIRE CCG	6,319	5,865	5,723	6,239	6,419	2,411	2,355	2,159	2,292	2,215
NHS SOUTHPORT AND FORMBY CCG	3,816	3,799	3,563	3,551	3,803	6,499	6,550	6,702	6,850	6,711

If our local referral patterns reflect the rest of the country, we can expect that there will be variations in rates between GPs and late referrals for some cases, which may lead to poorer survival rates for cancer[xxxiv]. Active referral reviews by CCGs and GPs in the local neighbourhood configurations, with access to systematic comparative information, will reduce variation, as will support the redesign of elective care pathways.

The table below shows the top 10 GP referrals made by speciality, which reflect the location configuration of specialist services across the two hospital sites at Ormskirk and Southport.

Graph 7



	Ormskirk					Southport				
	1214 Q1	1214 Q2	1214 Q3	1214 Q4	1415 Q1	1214 Q1	1214 Q2	1214 Q3	1214 Q4	1415 Q1
ORAL SURGERY	789	849	914	915	863	1	2		1	1
GENERAL SURGERY	339	333	233	264	217	708	639	663	693	584
GENERAL MEDICINE	826	372	212	163	130	1,310	840	521	431	350
MIDWIFERY	741	774	819	846	712	267	297	292	263	258
EAR, NOSE AND THROAT	564	590	569	581	689	820	595	760	781	768
DERMATOLOGY	1,552	1,678	1,601	1,620	1,833	10	15	5	10	6
GYNAECOLOGY	1,636	1,594	1,571	1,642	1,755	268	289	278	307	244
OPHTHALMOLOGY	659	595	615	682	689	1,574	1,492	1,455	1,567	1,494
TRAUMA & ORTHOPAEDICS	854	704	627	601	613	1,734	1,806	1,689	1,522	1,722
MCAS PHYSIOTHERAPY	1,565	1,333	1,103	1,330	1,518	826	1,107	1,193	1,272	1,266

For people who need episodic, elective care, access to services must be designed and managed from start to finish to remove error, maximise quality, and achieve a major step – change in productivity. We expect to see centres that can deliver high quality treatment, treating adequate numbers to be expert, and with the most modern equipment available. If we are going to transform out of hospital care and look to concentrate specialised services in fewer sites then we need to review how we deliver routine planned admissions for patients for less complex treatments.

5.7 Specialised services concentrated in centres of excellence

For those who need them, specialised services for less common disorders need to be concentrated in centres of excellence where we know that the highest quality can be delivered. Maximising quality, effectiveness and efficiency means working at volume and connecting actively to research and teaching. NHS England plans to reduce significantly the number of centres providing NHS specialised services and will require standards of care to be applied consistently. Early indications suggest a concentration of expertise in some 15 to 30 centres for most aspects of specialised care. The Spinal Unit on the Southport Hospital site is less likely to be impacted by these changes as it is a highly specialised national centre.

5.8 Key service model enablers

There are a number of potential risks to the transformation of our health and social care services that must be addressed to enable the transformation of services, specifically:

- Future workforce capacity and ability to deliver effective multi-disciplinary working
- Separate IT systems with associated barriers to effective multi-disciplinary communication
- Provision of facilities to support multi-disciplinary working in the community
- Effective communication and engagement of patients, staff, stakeholders and the public to redesign services and introduce new ways of working

5.8.1 Workforce planning and development

There is growing concern about the numbers of experienced clinicians who are coming up to retirement, particularly GPs and Community Nurses. It is also becoming increasingly difficult to recruit to social work posts. In the future primary and community services will be managing greater need in the community as care is shifted closer to home and changing demographics and it is likely that will be fewer people available in the workforce. In addition, there are significant vacancies nationally in some specialist areas, e.g., medical consultants in emergency and urgent care and geriatricians, which is putting more pressure on senior clinicians.

Southport and Formby CCG hosted a workforce symposium on 7th July 2014, which concluded that:

Workforce planning needs to happen across the system as we are all fishing from the same pond and encourage younger people into the health and social care workforce by using initiatives such as the apprenticeship schemes

Integrating assessment processes will be challenging as it relies on inter-professional trust and professional accountability requirements (NMC, GMC, etc) but we need to use professional governance as an enabler, rather than a barrier to integrated working.

Workforce planning challenges Issues/challenges in the system:

- Voluntary sector – have a small workforce with increasing pressures, short term funding (usually year on year) makes it harder to recruit and retain staff and increasing future need will create a greater reliance on the Voluntary Sector.

- NHS and Local Authorities –national recruitment issues, e.g. newly qualified doctors not wanting to become GPs and lots of duplicated roles e.g. Occupational Therapists and Physiotherapists are often asked to do the same things

- Training and Education - Not enough joint work with key training providers to develop bespoke courses to meet the needs of the population

To address we need to:

- Map out the demographic needs of our local population and determine the skills we need address this need
- Work closer with the voluntary sector and develop longer term contracts and relationships (invest in the voluntary sector)
- Develop more value based recruitment across health and social care to attract the right people

- Develop a workforce strategic plan across the health and social care sector and stop workforce planning in silos
- Work more closely with local training providers to support up-skilling workforce
- Develop more incentives to attract the right workers to the area
- Need to develop more hybrid shared roles
- NHS and Local Authorities to offer training to volunteers and voluntary organisations
- Start thinking differently, eg, skills required to operate an effective respiratory pathway

Some of the future workforce issues will be addressed in the development of the integrated neighbourhood teams and the emergent model of care, as part of the 'Facing the Future Together' programme.

5.8.2 *Interoperable IT systems*

We recognise that to ensure true integrated care across the health and social care economy; we need to have good IM&T systems that are accessible to all staff. Our aim is to have systems that support mobile working for peripatetic staff and are interoperable with other existing information systems across the local health economy.

During 2014/15 we are implementing a pilot of EMIS community across the whole of community services, taking a phased approach:

Phase 1 – Community Matrons and Chronic Care Co-ordinators

Phase 2 – Podiatry, Diabetes and Community Emergency Response Team

Agreed 'success criteria' against which the outcome can be measured will be drawn up by the participants at the commencement of the project. The pilot will inform the roll-out of IM&T across community based services.

5.8.3 *Fit for purpose estate facilities*

Developing a collaborative estates solution to support integrated neighbourhood teams, presents a number of challenges and barriers listed below:

- Partner organisations categorise facilities differently and use different software formats
- Changes to NHS organisations and how such property is funded (or rented) by occupiers and commissioners has resulted in confusion
- Each organisation has information about their own property, but the information is not shared and may be in different software formats
- It is difficult to identify who is authorised to make decisions about the use of the estate available
- It is likely that there are a number of community assets that are 'hidden' and should be considered in the work

West Lancashire CCG has been approached by West Lancashire Borough Council to support consideration of the health infrastructure requirements resulting from the future planning (residential) requirements as laid out in the Local Plan. Southport & Formby CCG have a Strategic Estates Legacy Plan, developed by NHS PropCo in April 2013, which considered clinical space in terms of capacity and demand over the next ten years and recommended that a Hub and Spoke estate model is implement it across each of the four localities.

NHS PropCo, which now manages health centres in the community, no longer undertakes reviews of community facilities as part of its core. Their remit includes managing proposed health centre developments and the closure and decommissioning of any identified sites.

A group of individuals nominated by the CCtH Programme Board in June 2014, met on 21st July 2014 to scope out what needs to be done to ensure that future facilities are fit for purpose and enable multi-agency working and multi-disciplinary team meetings at locality level. The meeting involved representatives from CCGs, the Trust and Lancashire County Council. The delivery of our integrated model of care (described in the Service Model above) requires the involvement of multiple stakeholders, such as:

a) Southport and Ormskirk Hospital NHS Trust – Community Services
b) Southport and Formby CCG
c) West Lancashire CCG
d) Liverpool Community Health – Heart Failure Team
e) Lancashire Care Foundation Trust – Mental Health Services
f) Merseycare
g) NHS PropCo
h) Owls
i) Lancashire County Council
j) West Lancashire Council
k) Sefton Council

5.8.4 *Engagement and communication*

We believe that we cannot successfully develop CCtH without the views of those involved in the delivery of care, or those who use our health services. Therefore meaningful engagement, consultation and involvement with our key partners and publics in the development of CCtH is critical to our success.

As public organisations, we also have a duty to involve through legislation and guidance. The most important of these is the Health and Social Care Act, which puts into law the involvement of service users in the planning, development and decision making process of service change, design or redesign.

NHS organisations also have a duty to consult Overview and Scrutiny Committees in the substantial development of health services in the area of the local authority, or a substantial variation in the provision of services.

To this end, the CCtH Programme Board approved a communication and engagement strategy for the programme, to encourage and enforce an appropriate level of transparency and consultation with relevant people.

For information, Department of Health Guidance Real Involvement (page 22) states:

"Users must be involved not only in the consideration of proposals to change services, but also in the development of any proposal that will change the manner in which a health service is provided or the range of services offered. For example, users must be involved in the development of a range of options for the way community services could be provided within a PCT area, not just asked for their opinion on a model that has been developed behind closed doors by health professionals and managers".

Importantly, the courts are clear that public bodies are entitled to have identified their "preferred option" before consulting. This is as long as the consultation is carried out with a genuinely open mind and the commissioner takes

everything it learns from that exercise into account before making its final decision. Again, the issue is honestly and clarity about what is being said.

The guidance from the Department of Health (Real Involvement) and case law show that there is no set format which every consultation should take. It is for the NHS body undertaking the consultation to decide what form it will adopt. What matters is that clear information is given to the public; that they are able to respond; and that their responses are taken into account when making the final decision. The greater the impact of proposed changes, and the more people likely to be affected, the more detailed and comprehensive the public involvement should be."

West Lancashire CCG host bimonthly listening events in different areas of West Lancashire operate a 'My View' membership scheme with a dedicated email address: myview@westlancashireccg.nhs.uk . West Lancashire CCG gathers patient feedback and stories are gathered from a number of sources and using different methods, such as, online surveys, focus groups and through general community involvement activities and partner organisations. Patient insight reports are prepared for the CCG Quality Committee, identifying emerging themes and issues.

Southport and Formby CCG have established the Engagement and Patient Experience Group (EPEG), which is a subgroup of the CCG Quality Committee. EPEG is designed to ensure local peoples voices are heard, that patient experiences shape commissioning priorities and effective communication channels and networks are in place to enable the CCG to engage with local people. Under the direction of EPEG, the CCG convenes 'Big Chat' events and supports proactive public and patient engagement in line with the NHS Constitution and statutory requirements.

Southport and Ormskirk NHS Hospital Trust convene a Patient Experience Group, which is focused on improving patient experience, monitors internal Trust improving patient experience projects and responds to national surveys. The group involves Trust membership (drawn from our communities) and shadow governors, HealthWatch, staff representatives and is chaired by the Director of Nursing. The Trust engages the membership in 'Effectiveness Events', which focus on quality, risk and patient experience; and also involves staff, who volunteer to conduct one to one sessions with patients called, 'In Your Shoes', where staff listen to patients accounts of their experiences using Trust services (using a themed approach, e.g., Cancer services). The Trust utilises patient bedside TV systems, Hospedia, to ask patients to complete feedback questionnaires at the point of discharge, the results of which are collated and published monthly on each ward notice board.

"I want the right to clear and accurate information that I can use to make decisions about health and care treatment. I want the right to education about how to take care of myself and about what I am entitled to in the health and social care system".

6. What have we achieved so far?

In May 2012, Southport & Formby and West Lancashire health economies established an Urgent Care Network and held a visioning workshop to begin the process of reviewing the existing menu of urgent care provision and planning the future requirements for the area. This work is important to ensure that the health and social care services deliver urgent care services in the future that will meet the needs of the local population and improve the performance across the urgent care system.

The Urgent Care Network recognised that improvement in urgent care performance required whole-system change and commissioned the development of Care Closer to Home Strategy, which was approved in June 2013. The Urgent Care Network was renamed the Care Closer to Home Programme Board and the remit of the group extended to oversee implementation of this strategy, providing assurance to the Strategic Partnership Board of delivery.

The current Care Closer to Home (CCtH) Strategy was approved in June 2013 and the Programme Sponsor, a joint post with CCGs, was in place from August 2013 to support delivery of the strategy.

To date the programme has addressed a number of milestones as follows:

2012/13 CCGs invest additional £1.7m to fund Active Case Management approach and other posts in September 2012 and recruitment to the following posts commenced

- Discharge Coordinators
- Chronic Care Coordinators
- Additional community staff to form Rapid Response Team

March 2013 Some key projects are initiated:

- Integrated Clinical Pathway Groups established
- Discharge planning project
- Development of Urgent Care strategy commenced
- Enhanced Community Service phase 1 – resulting in analysis of Southport & Ormskirk NHS Trust community workforce mapped against population need

June 2013

- Quality Improvement Event takes place
- CCtH (Urgent Care) Strategy approved
- Southport & Ormskirk NHS Trust Telehealth (1 year research) Pilot commences

August 2013

- CCtH Programme Sponsor commences in post

September 2013

- CCtH programme governance is reviewed and strengthened
- CCtH primary care development projects identified
- Commencement of clinical governance approval process to authorise the new Integrated Care Pathways for implementation

- Ambulatory Emergency Care project commences

November 2013

- Additional 'winter funding' from central government enabled the development of services to reduce length of hospital stay for frail older people and reduce hospital admissions:
  - Frail Elderly Short Stay Unit
  - Rapid Response Team expanded to become Community Emergency Response Team (CERT) to provide domiciliary support in response to urgent care needs
  - Additional step up/step down beds contracted by CCGs in local nursing homes, supported and access co-ordinated by CERT

Key projects initiated:

- GP Acute Visiting Scheme in West Lancashire in collaboration with North West Ambulance Service
- Risk Stratification in Southport & Formby
- CCtH Communication and Engagement Strategy approved

December 2013

- CCtH Self Care Group project commences
- CCtH dashboard reporting commences

January 2014

- CCtH Organisational & Workforce Development Strategy approved
- CCtH vision statement revised (by stakeholders) and approved
- CCtH Financial Advisory & Planning Group established

February 2014

- Better Care Fund(BCF) action planning process indicates CCtH programme is seen as vehicle to support delivery vehicle for BCF action plan

March 2014

- The 'National Voices' person-centred principles are agreed for use across the CCtH programme and approval given for the development of patient experience measures
- A set of whole-system urgent care performance measures agreed to form Urgent Care Dashboard
- Integrated Clinical Pathway developments now focused on implementation
- Frail Elderly Integrated Clinical Pathway phase 2 focuses on:
  - Implementation into nursing and residential homes
  - Development of a single care plan

April 2014

- CCGs fund additional £2.226m
- West Lancashire specialist heart nurses commence in post to support integrated clinical pathway implementation

June 2014

- Strategic Partnership Board approves plans to explore and develop a culture that supports innovation and service improvement at system level
- CCGs submit 5 year strategies
- Southport & Ormskirk NHS Trust submits Integrated Business Plan

- Telehealth & assistive Technology project commences

July 2014

- Estates review project initiated
- Self-Care Group develop research proposal with CLARHC to support the Self-Care model
- CCtH Programme Board agrees draft illustration of Integrated Neighbourhood Team to consistently explain model

August 2014

- Health Economic Analysis Group established to undertake a cost benefit analysis of additional CCG funded investment (£1.7m and £2.226m see above) under the direction of the CCtH Financial Advisory & Planning Group

The new integrated clinical pathways have been developed and are listed as follows:-

- Cardiology – Heart Failure & Atrial Fibrillation.
- End of Life – Advanced Care Planning.
- Dementia – Diagnosis.
- Frail Elderly – Nursing Home; Crisis & Community.
- Respiratory – COPD Diagnosis; COPD Exacerbation & Management of Established COPD.
- Diabetes – Foot Attack; Prevention; Primary Care & Acute.

A number of outstanding gaps and issues, that currently prevent the implementation of some integrated clinical pathways, are being addressed. These largely relate to:

- Workforce development and training in primary care
- Development of business cases and commissioning of gaps by CCGs
- Workforce development and capacity gaps in Southport & Ormskirk NHS Trust

7. What do we need to do next?

It is clear that the potential gains in terms of health outcomes, patient experience and cost savings are considerable. Many of the suggested interventions would also have an impact on health inequalities, something that CCGs have a legal duty to consider. The 'Five Year Forward View' (NHS England, 2014) sets out a clear direction for the NHS, showing why change is needed and what it will look like. Some critical decisions will need to be reached, for example on investment, on local reconfigurations. The key challenge relates to the scale of the change management task, particularly as investing in community-based care will deliver savings only if accompanied by strategic disinvestment from hospitals to ensure a sustainable configuration of public services.

Unless the national £30 billion funding gap (NHS England 2014) is addressed, local commissioners will need to make a robust case for service disinvestment where it is clinically justified, and will need to utilise strong communication and political skills in order to defuse potential resistance to much-needed, evidence-based change.

The Care Closer to Home Programme has started to see positive results and improved collegiate working across the system. Demonstrating the direct link between the CCtH outputs and activities and the realisation of outcomes is challenging. Given the scale and scope of the task ahead, the Care Closer to Home Programme must now focus on a number of critical developments during 2014 and 2015 as priorities for action and these areas are presented below.

7.1 *Integrated Neighbourhood Teams*

Partners across the CCtH programme need to agree the capabilities and composition of the Integrated Neighbourhood Teams (INTs) and by establish the conditions for successful integration of care, which are:

- Work in an integrated system
  - Care coordination
  - Shared assessment and care records
  - Multi-disciplinary (MDT) delivery at locality level
  - Introduce case conferences
  - Shared protocols
  - Performance reviews at MDT level
  - Use disease registries
  - Use of direct payments and Personal Health budgets

- Assess patient needs according to pathways to case find and segment people according to need and risk of deterioration

- Establish key enablers and mechanisms
  - Accountability and joint decision making
  - The right clinical team leadership
  - Information sharing
  - Aligned incentives
  - Patient/Service user engagement

Initially, CCGs must decide which INT model they want to commission to meet the needs of populations at locality level and address inequalities. Contractual arrangements and incentives must be aligned to facilitate better joined up working across the system of providers and deliver better outcomes.

Providers of health and social care will need to work together in co-operation as a system of networked services, designed to optimise workforce skills and capacity and improve health outcomes and quality of life across populations.

7.2 *Self-care, self-management and the use of assistive technologies and telehealth*

The research evidence on the benefits of self-care, self-management and the use of assistive technologies and telehealth for some patients and service users provides compelling support for action. The CCtH Self-Care Group is leading on the following developments for 2014/15, which are:

- Introduce the Self-Care Model, which is underpinned by evidence – a research proposal has been submitted to a local research collaboration (CLARHC) to undertake an evidence synthesis
- A 'Train the trainers' programme is being developed to equip the workforce (public, private and third sector) to introduce new ways of working and behaving with patients and service users; to enable people to become co-producers in their own care and shift the emphasis of interactions towards solutions (empowering) rather than problems (disabling)
- A research grant bid is being prepared to start a project that will develop training packages, delivered by the third sector, which will weave together peoples experience of living with long-term health conditions, education about long-term health conditions and the use of telehealth care in supporting self-management. These 'packages' will be developed with and in the community.

7.3 *Implementation of the newly designed integrated clinical pathways*

Clinical leaders and managers from CCGs and Southport and Ormskirk Hospital trust have worked together to produce a set of clinical pathways spanning primary, secondary and specialist services in the following areas:

- Cardiology – Heart Failure & Atrial Fibrillation
- End of Life – Advanced Care Planning
- Dementia - Diagnosis
- Frail Elderly – Nursing Home; Crisis & Community
- Respiratory - COPD Diagnosis; COPD Exacerbation & Management of Established COPD
- Diabetes – Foot Attack; Prevention; Primary Care & Acute

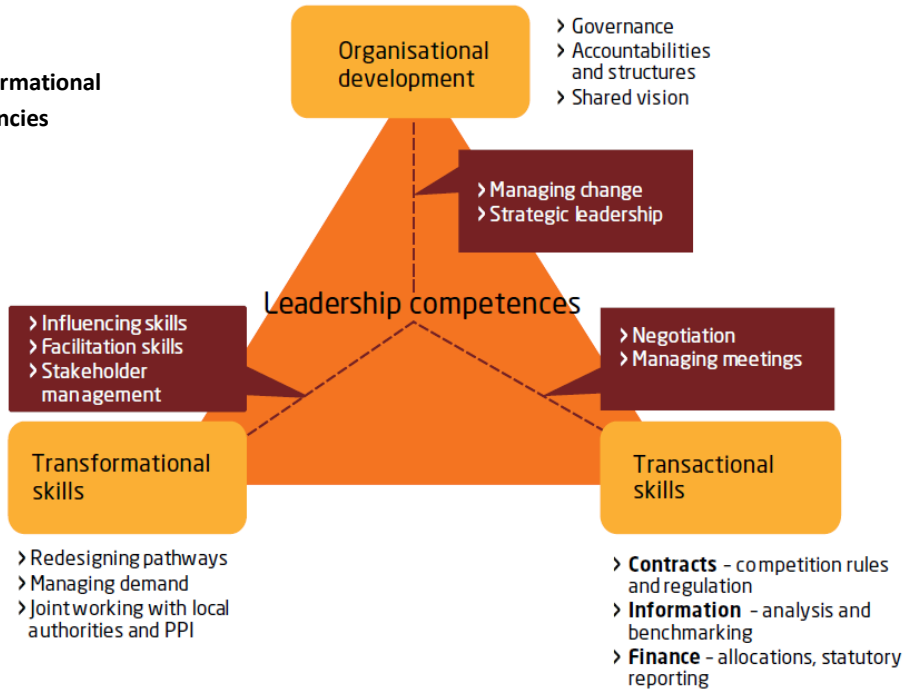
Implementation of these pathways is now focused on addressing the gaps in service provision, such as, the newly commissioned specialist respiratory service in West Lancashire, and the training and education required to introduce the pathways across community and primary care services.

7.4 *Governance and leadership*

It is not just a question of 'doing the right thing' but 'making the right things happen'. Much of what we describe has been known for some time, yet it is not applied in practice. Largely because, while it is relatively straightforward to

impart knowledge about what to change, it is much harder to create the culture and enthusiasm required to deliver change, particularly when working across organisational boundaries. The potential strength of GPs' engagement in commissioning is that their clinical foundation is a step towards creating the necessary culture, but they will need to invest heavily in developing strong commissioning organisations and good working relationships across the health system if they are to exploit this advantage. There are three important areas that require developing – organisational development, transactional skills and transformational skills (see figure below).

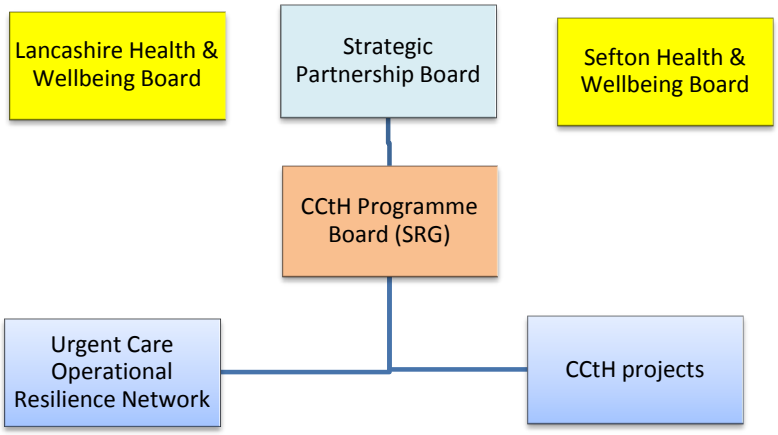
Diagram 15: Transformational leadership competencies



The CCtH Programme Board has continued to undertake the responsibilities of the Urgent Care Network, ensuring that urgent care services continue to provide safe and timely patient care. In June 2014, NHS England published guidance which requires Urgent Care Networks to build upon their existing roles, and expand their remit to include elective as well as urgent care; to become the forum where capacity planning and operational delivery across the health and social care system is coordinated. The new forum is known as the **'System Resilience Group' (SRG)**, to underline the importance of whole system capacity planning and building resilience throughout the full calendar year. This role is fulfilled by the CCtH Programme Board and the terms of reference have been revised to reflect the changing nature of these responsibilities (see Appendix 2).

The introduction of the Better Care Fund brings additional opportunities to further strengthen working across health and social care. The presence of all health providers and commissioners, as well as local authorities and social care partners, on the Care Closer to Home Programme Board, will be crucial to delivering an integrated approach. The diagram below shows the governance and reporting arrangements for the CCtH programme.

Diagram 16: Governance and reporting arrangements



7.5 *Programme delivery and monitoring*

The CCtH programme is currently supported by three different programme management functions/teams with variable resource and capabilities, which may result in different approaches to programme management being applied and different styles of reporting. The three programme functions/teams supporting the CCtH programme are as follows:

1. The Programme Management Office (PMO) Support for Southport and Formby Clinical Commissioning Group (CCG) supplied by Cheshire and Merseyside Commissioning Support Unit
2. A number of identified officers, in various roles, employed by West Lancs. CCG, who work into the CCtH programme using a matrix approach
3. The newly appointed PMO team at Southport and Ormskirk Hospital Trust (hereafter referred to as 'the Trust'), which will also be supporting the organisations service improvement agenda

The Trust and CCGs each have an identified organisational lead for the CCtH Programme with responsibility for leading the respective programme functions/teams outlined above.

Consistent PMO Approach to the Care Closer to Home Programme

The primary purpose of the Programme Management Office (PMO) is to provide assurance to the Programme Board, and thereby the Strategic Partnership Board (SPB), that the Care Closer to Home (CCtH) programme and its portfolio of projects are being managed in accordance with industry best practice, specifically MSP and PRINCE2, and the principles of each are upheld. With the anticipated revision of the programme's strategy, there exists an opportunity to formalise

the operations of the PMO functions that support the programme, given that they have evolved since the programme's inception.

In order to provide that assurance, the PMO needs to capacitate the staff appointed to the key roles defined in the PMO Review document to adhere to best practice wherever possible. This is conducted by developing and adapting the tools, processes and templates designed to plan and manage project information, and then working closely with project personnel in planning workshops, one-to-one coaching sessions and project information evaluations. The PMO officers support Project Managers (usually drawn from the service area) to set up the project and develop the project plan.

Since the CCtH programme will deliver transformational change in the delivery of health and wellbeing services for the patients and service users of three NHS organisations, each with a different approach to the PMO concept, it is imperative that these functions are intelligently aligned and able to provide the services required by both those organisations and the CCtH Programme Board.

Using the 3PMapproach to support system improvement and transformation across the CCtH partnership

Portfolio Management is a discipline by which an organisation can design and manage its entire portfolio of change programmes alongside business as usual to deliver its strategic aims. Portfolio management will ensure that CCtH programmes and projects are individually and collectively aligned and fit with the organisational strategy. It will provide the board and senior management with the right information to have a clear overview of progress enabling:

- An assessment of the overall impact of the CCtH initiatives on staff, patients and other key stakeholders.
- Strategic prioritisation
- The right mix of work carried out to maximize overall returns.
- Greater control of the risks to the organisation.
- Resources are allocated optimally across the projects.
- Performance problems are corrected before they become major issues.
- Projects remain aligned with business goals throughout their execution.
- Projects receive the support and oversight needed to be completed successfully.

Programme Management is the discipline / process of delivering strategic outcomes through managing a number of related projects to:

- Enable more effective delivery of change
- Keep the focus on the business change objectives
- Provide a framework for senior management to direct the change process
- Encourage more efficient use of resources through project prioritisation and integration
- Provide better management of risk because the wider context is understood
- Achieve business benefits during and after the programme through a formal process
- Improve control of costs, standards and quality
- Enable more effective management of the Business Case
- Provide more efficient control of a complex range of activities
- Provide clear definition of roles and responsibilities
- Deliver a smooth transition from current to future business operation

- The elimination of risk arising from interfaces between the projects
- The coherent prioritisation of resources
- Reduction in management effort

Project Management is the discipline / process of planning, organising, securing and managing resources to deliver specific objectives. A project being a temporary endeavor, having a defined beginning and end; undertaken to meet specific objectives and benefits, as defined by the business case. The benefits of this approach with the delivery of the CCtH programme are:

- A common, consistent approach
- A controlled and organised start, middle and end regular reviews of progress against plans
- Assurance that the project continues to have a business justification
- Flexible decision points
- Management control of any deviations from the plan
- The involvement of management and stakeholders at the right time and place during the project
- Good communication channels between the project, project management, and the rest of the organisation
- A means of capturing and sharing lessons learned
- Focuses on products and their quality
- Tailored to suit the particular product environment

The main tool used to provide these services is the Project Toolkit element of the West Lancs Commissioning Toolkit. It is important to be clear that this tool is intended specifically to manage and report on *project* management information and that there is only very limited functionality for recording and managing *programme* information. At a programme level it provides:

- Basic programme details (programme name, programme lead, a brief description, current RAG status aggregated from the programme's constituent projects, programme lead monthly update)
- Project Portfolio (i.e. the list of schemes contributing to the programme's objectives)
- Programme Schedule (i.e. a Gantt chart aggregated from the programme's constituent projects)
- Document Library, where programme-related documents can be stored and thus shared with programme personnel
- Risk Register, where programme-level risks may be recorded and tracked

At a strategic and programme level, then, there is not much information available to indicate how the programme is doing, particularly from a capability/outcomes/benefits perspective, and no mechanism for ensuring that the principles of programme management are being upheld. It is also important to be clear that it is not the Toolkit's purpose to provide that level of intelligence; it is intended to support the process-based methodology of project management rather than the more flexible framework approach of programme management. Further development of the toolkit is required to enable full functionality at programme level.

7.6 *Overarching delivery plan*

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NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/53	**Author of the Paper:** Melanie Wright Lead for Intermediate Care Melanie.wright@southseftonccg.nhs.uk
Report date: March 2015	

Title: Sefton Joint Intermediate Care Strategy

Summary/Key Issues:

This paper presents the Governing Body with Sefton's Joint Intermediate Care Strategy, which has been developed in partnership between both Sefton CCGs and the Local Authority.

Recommendation

The Governing Body is asked to approve the Joint Intermediate Care Strategy.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Sustain reduction in non-elective admissions in 2014/15
x	Implementation of 2014-15 phase of Care Closer to Home
	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.
x	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
Patient and Public Engagement	x			Presentation at "Big Chat", plus "Mini Chats" and other listening activities. Further, more specific engagement events planned as part of wider patient engagement process 2015/16.

Process	Yes	No	N/A	Comments/Detail
Clinical Engagement	x			
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered	x			
Locality Engagement			x	
Presented to other Committees	x			SMT, 10 March 2015.

Links to National Outcomes Framework	
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

Sefton Council

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

Sefton Joint Intermediate Care Strategy
2015-2019

Version 2
Date: March 2015

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Intermediate Care in Sefton

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

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Print date: 18 March 2015

1. Executive Summary

This strategy is the product of collaborative working with a range of professionals in both health and social care organisations during 2014. It is a combination of recommendations, values and beliefs, an understanding of what works well and what offers value for patients and these will shape the future development of an Intermediate Care Model for adults within Sefton.

This strategy sets out work undertaken to date and will lead to the delivery of a new model of service delivery, designed to rebalance hospital and community care, provide rapid response, rehabilitation, avoid unnecessary admission to hospital and accelerate discharge from hospital, while ensuring that no long-term decisions about care and independence are taken in a hospital setting.

Both health and social services are committed to making a real difference to the way services are delivered and the quality of the patient's individual experience of health and social care provision in Sefton.

Fiona Clark
Chief Officer
NHS Southport and Formby CCG
NHS South Sefton CCG

Dwayne Johnson
Director, Older People
Sefton Council

2. Introduction

2.1. *Definition of Intermediate Care*

Intermediate care was defined by the Department of Health (2001)[1] and "Halfway Home" (2009)[2] as a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

Intermediate Care services should:

- be targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care;
- be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;

[1] Intermediate Care Guidance (DH 2001)
[2] Intermediate Care – Halfway Home (DH 2009)

- have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home;

- be time-limited, normally no longer than six weeks and frequently as little as a few days;

- involve cross-professional working, with a single assessment framework, single professional records and shared protocols;

- inclusive of older people with mental health needs, either as a primary or secondary diagnosis.

Intermediate Care services may also:

- form part of the pathway for end of life care, if there are specific goals for the individual or carer that could be addressed in a limited time; or

- link with longer term plans for support.

There is also a national emphasis on delivering care away from a hospital setting, wherever safe to do so, closer to people's homes and centred around the needs of the individual.[3]

In May 2010, the Secretary of State indicated that Health and Social Care economies must be influenced by the following emerging priorities:

- patients must be at the heart of everything, not just as beneficiaries of care, but as participants, in shared decision-making. As patients, there should be no decision about them, without them;

- the focus for Health and Social Care should be to seek to achieve continuously improving outcomes. Not simply measuring inputs or constant changes to structures, but a consistent, rigorous focus on outcomes which achieve results for patients;

- professionals are empowered to deliver. This is the only way we can secure the quality, innovation, productivity and safe care, all of which are essential to achieving those outcomes;

- as a society, focus should concentrate on improving the health and well-being and of preventing ill-health more effectively, of families and communities. This will result more in the overall health outcomes being sought, not just good health services but good population-wide health outcomes, and reduce the inequalities in health, which so blight our society;

- health and social care should be more integrated. Whether provided by their families, by carers, by support workers or by health professionals, all are part of a spectrum of care for those in need. There is a need to reform social care alongside healthcare, so that we can support and empower people – not least as individuals – to be more safe and secure and, themselves, to be able to exercise greater control over their care.

Partnership working is key to successful delivery of intermediate care and work is under way in Sefton to further align services in health and social care.

This strategy was developed by Southport and Formby CCG and South Sefton CCG in partnership with Sefton Council.

[3] Putting People First – Transforming Adult Social Care (DH 2009)

2.2. *Types of Intermediate Care*

Halfway Home states that the services that might contribute to the Intermediate Care function include:

- rapid response teams to prevent avoidable admission to hospital for patients referred from Primary Care, Accident and Emergency or other sources, with short-term care and support in their own home;

- acute care at home from specialist teams, including some treatment such as administration of intravenous antibiotics;

- residential rehabilitation in a setting such as a residential care home or community hospital, for people who do not need 24-hour consultant-led medical care but need a short period of therapy and rehabilitation, ranging from one to about six weeks;

- supported discharge in a patient's own home, with nursing and/or therapeutic support, and home care support and community equipment where necessary, to allow rehabilitation and recovery at home. The arrangements may work well in specialist accommodation such as extra care housing;

- day rehabilitation for a limited period in a day hospital or day centre, possibly in conjunction with other forms of intermediate care support.

Those accessing Intermediate Care services should not be in need of 24-hour access to consultant-led medical care, however, they may have medium to long-term medical conditions that make them liable to relapse.

3. Vision

Both Southport and Formby CCG and South Sefton CCG, together with Sefton Council, envisage appropriate, co-ordinated care for patients via integrated services and responsiveness to patients' needs, while ensuring the best possible use of resources, avoiding fragmentation of services and reducing the complexity of the patient journey.

This duly aligns with the Sefton Health and Wellbeing Board's vision of delivering "personalised coordinated care, health and wellbeing services with, and around, the person" as set out in the Better Care Fund submission, of which Intermediate Care forms a key scheme.

4. Context

4.1. *Strategic Aims and Objectives*

This strategy has been informed by ongoing discussions with patients, carers, local residents and a wide range of stakeholders through the CCGs' "Big Chats", "Mini Chats" and other listening activities and is congruent with the CCGs' strategic priorities of:

4.1.1. 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;

4.1.2. 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;

4.1.3. 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.

Further, as part of the Intermediate Care and Reablement Scheme of the Better Care Fund for Sefton, the main scope of this scheme is to reduce hospital admissions and readmissions, reduce the need for ongoing care and support and to reduce the number of admissions into long term residential and nursing care.

4.2. *Care Closer to Home/Virtual Ward*

This strategy is cognisant of the Care Closer to Home Strategy and Virtual Ward Strategy, particularly in relation to Community Based Step Up and Step Down Facilities.[4]

4.3. *Current and Future Demand*

The Sefton Strategic Needs Assessment[5] identifies the following key facts.

- The population of Sefton in 2010 was 272,900. The latest 2010 based population projections suggest an increase in population year on year rising by 5% to 288,000 in 2035. The biggest percentage increase is estimated to be among residents aged 65 and over, with this age group expected to rise by more than 40% from 59,000 in 2012 to 83,000 by 2035 (from 20% of the population to almost 30% of the population). Every quinary age group above 65 is projected to have a significant increase, in particular those aged 85-89 projected to increase by 84% and those aged 90 and over by 170%.

- Sefton's 65+ population is 56,300 accounting for 21% of the total population and largely accounts for the projected future increases in the total population.

- Sefton already has a sizeable population of older people. As this grows, it will have a large impact on services and their ability to cope.

- Sefton has the highest proportion of residents aged 65+ and 75+ than all local and comparable local authorities.

- An increasingly elderly population are likely to attend A&E and be admitted to hospital as a result of falls - 28% more by 2030.

- By 2030, it is projected that 34% more people aged 65 and over will have dementia. This will impact on their wider health and their care needs.

- By 2015, over 2,300 people are forecast to be living in a care or nursing home – this will rise by over a quarter by 2030.

By way of summary, the Sefton Strategic Needs Assessment identifies Sefton as having a growing elderly population. Older people are more likely to develop complex and long term health conditions, which lead them to require increased health and social care.

Managing such increased demand will necessitate a new approach to service planning, enabling people to maximise their independence and decrease reliance upon acute and social care services.

[4] Care Closer to Home Strategy 2013-2018 (2014 refresh), Southport & Formby and West Lancashire Health Economies

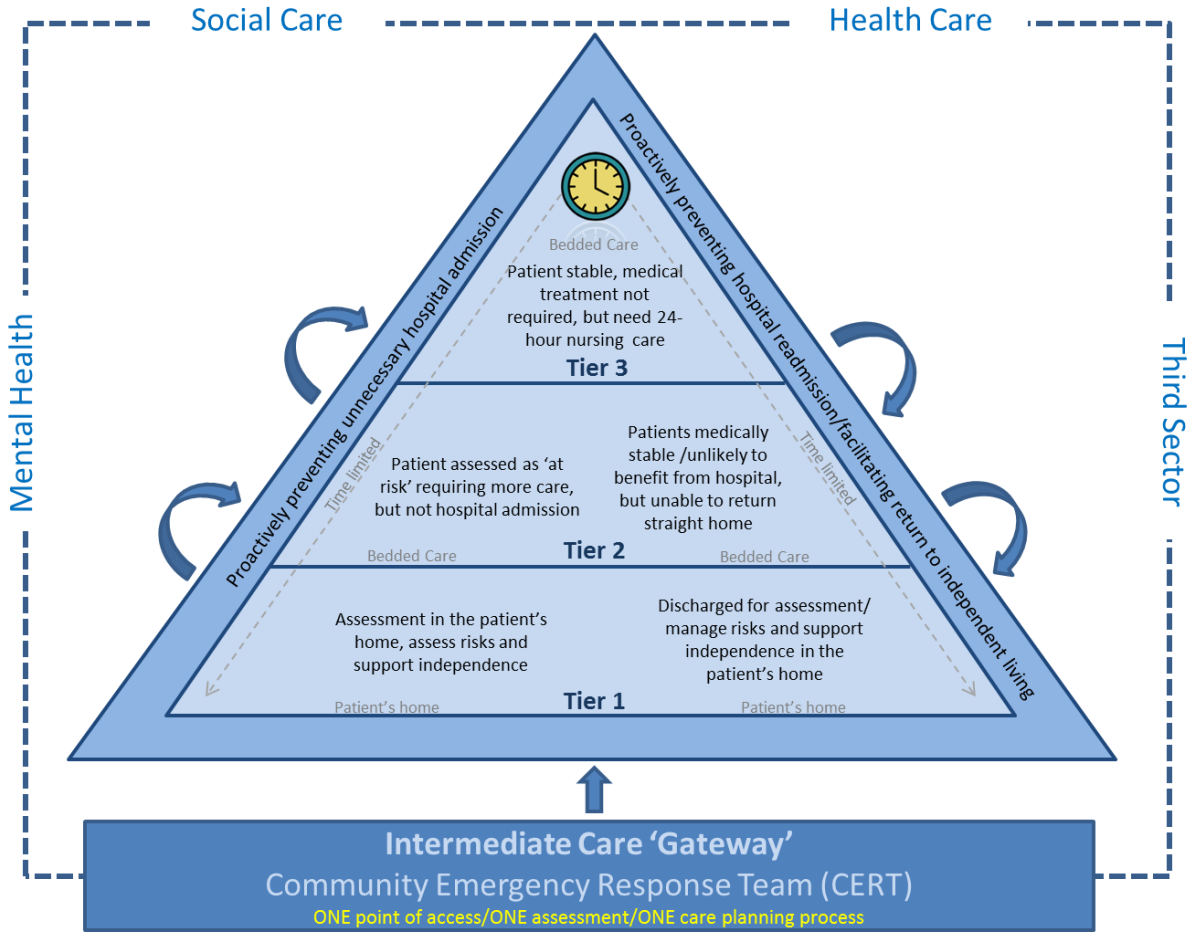
[5] Sefton Strategic Needs Assessment 2012-2013, Business Intelligence & Performance on behalf of Sefton Council in partnership with Sefton Public Health, NHS Sefton, South Sefton and Southport and Formby Clinical Commissioning Groups, Sefton CVS, Sefton Drug Action Team

5. Service Model

The local approach in Sefton is that intermediate care delivery is provided via a single point of access or "gateway", which includes a multi-disciplinary health and social care team and works cohesively with other community and third sector services, to provide a seamless intermediate care experience for Sefton patients.

Following entry via the gateway, Intermediate Care required is provided in three 'tiers', with patients being "stepped up" or "stepped down" the model as appropriate. Figure 1 describes the model of Intermediate Care for Sefton.

Figure 1: a Model of Intermediate Care for Sefton



5.1. *WHO will deliver the care?*

Key to delivery of this model is an Intermediate Care 'Gateway' who will act as the 'gatekeeper' or single point of access to the Intermediate Care Service, facilitating the "one assessment, one care planning process" approach.

The Gateway will comprise an integrated, proactive, multi-agency and multi-disciplinary team providing holistic short-term care and rehabilitation – it is not a series of standalone teams. The team will comprise:

- Nurses
- Occupational Therapists
- Physiotherapists

- a GP or Geriatrician
- Social Workers
- Mental Health Workers
- Technical Instructors
- Health Care Assistants
- Third sector representatives (ie, community, volunteer or faith services).

The Gateway will establish links with a variety of additional key health and social care community services to include, *inter alia*, stroke, falls, continence and respiratory services, together with Sefton Council's Reablement and Continuing Health Care Teams, will ensure that each individual's care is person-centred and that their journey through the Intermediate Care pathway is timely and seamless.

5.2. *WHERE care will be provided*

Intermediate care will largely be provided in the person's own home (Tier 1), but for those assessed as at risk if 24-hour care is not provided or their home is unsuitable, an intermediate care bed in a residential setting (Tier 2), or with some nursing care (Tier 3) may be the only viable option to avoid hospital admission.

5.3. *WHEN care will be provided*

Step up: the service will provide a proactive "rapid response" assessment within two hours of referral, providing an intervention in people's homes (or place of residence) with a view to avoiding admission to hospital.

Step down: the service will also 'in reach' into local acute services with a view to facilitating early discharge. Decisions relating to long term care will not be made in a hospital environment, but in the patient's home environment to promote and sustain independence and wellbeing.

5.4. *HOW LONG will care be provided for?*

Intermediate care is a time-limited service with the intention of preventing unnecessary hospital admission, reducing lengths of stay in hospital and enabling patients to return home quickly by providing support in the community for a short period while on-going packages of care are commissioned from Adult Social Care.

It is goal-focussed and provides time for assessment and invention based on specific, agreed outcomes to be achieved within days and weeks, supporting people to return to self-care.

6. The Intermediate Care Pathway

The streamlined care pathway will ensure a flow through intermediate care for the patient at a time and level as their need dictates. To be effective, the pathway relies on the interdependence and close alignment of health and community services, together with third sector services to ensure there all gaps in services are bridged and there are no delays in transfers of care.

7. Outcomes

7.1. *Ensuring individuals receive care at the right time in the right place, reducing acute hospital admission and manage the projected increase in demand*

- We will agree a model across Sefton, in partnership between health and social care and the third sector to agree a single model for intermediate care.
- We will review and develop team capacity in the community, together with community bed provision to take account of the projected increase in the elderly and frail population, while demonstrating value for money and effectiveness in reducing hospital admission.
- Organisational boundaries will not be allowed to obstruct or delay operation of the system. A cohesive team will ensure effective co-ordination and accountability for all members of the intermediate care teams.
- Develop clear and consistent referral pathways between intermediate care services, primary and secondary care and the Social Services, ensuring the single point of access is promoted widely.
- The strategy will be delivered through a patient-centred approach and implemented through working in a collaborative manner.

7.2. *Ensuring decisions about long term care are made only when individuals have had an opportunity for rehabilitation and recovery*

- We will ensure that patients are not transferred directly from a hospital ward to residential care (unless in exceptional circumstances) without being offered a period of intermediate care and reablement.
- We will ensure that individuals with complex health needs are treated fairly and offered rehabilitation prior to any decision being made about their long term needs.

7.3. *Increase patient satisfaction and maximise independent living*

- We will continue to monitor and review the pathway to ensure a fully integrated service.
- We will ensure our services are patient centred.
- We will introduce a new series of measures to performance manage the operation and delivery of the service, which will include continuous assessment of the patient experience.
- We will ensure patients do not become delayed in the system or access intermediate care services for longer than necessary.

8. Conclusion

Delivery of this Intermediate Care Strategy will be crucial in supporting the delivery of the CCGs' strategic aims and it is the aim of the Health and Wellbeing Board, in an environment where the elderly and frail population is projected to rise significantly and there are an increased number of people living longer with more complex health needs.

Our challenge is to commission a service upon which there will be growing demand, which offers a high standard of care within the current financial constraints. Integration between health and social services will be key to delivery of this strategy.

The benefits for patients will be an increased quality of care and not being admitted to hospital unless it is absolutely necessary and if admitted to hospital, ensuring patients are discharged quickly and are supported to resume independent living.

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/54	**Author of the Paper:** James Hester Programme Manager - Quality Email: james.hester@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: March 2015	

Title: Draft CCG Quality Strategy

Summary/Key Issues:

The CCG Quality Strategy sits alongside the CCG Strategic Plan and 5 year Forward View to enable the CCG to achieve its 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’’.

Recommendation:

The draft Quality Strategy is submitted to the Governing Body for approval.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
X	Improve quality of commissioned services, whilst achieving financial balance.
X	Sustain 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 (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		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

Southport and Formby
Clinical Commissioning Group

Quality Strategy
2015 - 2019

Date Approved:

Date for Review:

Chair: Lead:

Chief Officer:

Author & Lead:

Quality Strategy

Contents

Foreword

The first priority of NHS Southport and Formby Clinical Commissioning Group (CCG) is to commission services that offer quality for local people – services that are clinically effective, safe, well- led, responsive to patient's needs and offer a positive patient experience.

The drive to secure positive health outcomes for local people and continuously improve the quality of services is at the heart of the work of the CCG. It requires focused leadership by the CCG Governing Body, together with relentless individual and collective commitment across the CCG membership and its management.

Securing and improving quality cannot be achieved by the CCG in isolation. We recognise that our patients' journey cut across primary, secondary and specialist care, health and social care, with services commissioned and delivered by multiple organisations and professions both within and outside the NHS. We appreciate the commitment of our partners to work with us in improving quality. We will continue to support and collaborate with provider organisations to improve the quality of services provided, whilst holding them to account for standards of service delivery.

The appalling failures, at Mid Staffordshire NHS Foundation Trust, Morecambe Bay, the independent hospital Winterbourne View and the review into 14 hospital Trusts in England, highlight the risks if we do not have robust systems and processes to identify and act on quality issues. These examples act as a reminder that when failures in expected standards occur, the consequences are directly felt by patients, service users, their carers and families.

Systematically and continuously improving the quality of services across settings of care represents a significant challenge for the CCG and partner agencies. To ensure value for money in commissioning of care, we need to improve quality and outcomes through innovation in service design, efficiency, and a continued focus on prevention of ill-health alongside treatment and care.

The measures of quality are not static. We know that we need to set standards higher year on year to improve health outcomes and the patient experience. This is likely to require some difficult and courageous decisions by the CCG in the months and years ahead as we seek to reconfigure services and prioritise resources towards areas of greatest health gain and quality improvement for local people in line with our strategic plan and the 5 year forward view.

This Quality Strategy is central to the purpose and work of the CCG, and underpins any strategic plan. It describes our responsibilities, approach, governance and systems to enable and promote quality across the local health economy. The Quality Strategy is, above everything, about people. It describes our approach to provide everyone with the care and compassion they need and enabling their voice to be heard. It supports our commissioning of services to ensure that they are amongst the safest and most effective in the NHS, provided reliably to every patient, every time. The CCG Quality strategy is underpinned by six fundamental values: care, compassion, competence, communication, courage and commitment (6C's) - these six areas of action will help to support the CCG to commission excellent care and promote enduring values and behaviours. The 6C's put into context how delivering health and care support and services involves the CCG working with people in a new partnership, offering and engaging with people in making choices about their

health and care, and supporting ‘no decision about me without me’. Every patient and person we support can and should expect high quality

Implementation of this strategy will support the CCG to achieve 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”.

Quality Strategy

Introduction:

Commissioning high quality compassionate healthcare is at the heart of everything the CCG strives to achieve for the people across Southport & Formby.

The Health and Social Care Act 2012 changed the way the NHS in England is organised and run. Certain vital elements have not changed and are the driving force behind the changes in a challenging financial environment:

- Improving quality and healthcare outcomes for patients remains the primary purpose;
- The cultures, values and behaviours of the CCG constituents and staff is the first line of defence in safeguarding quality;
- Greater emphasis on the involvement of clinicians being at the heart of commissioning.

Commissioners' statutory duty and responsibility for:

- Meeting the needs of the local population through commissioning high quality services;
- Obtaining assurance and securing continuous improvement in the quality of commissioned services and the outcomes that are achieved.

The CCG brings together 19 GP surgeries, serving a population of 122,00 stretching from Ince Blundell in the South to Churchtown in the North.

Our population is getting older - we have many more residents aged over 65 than the national average and by 2021 there will be nearly half as many more people aged over 85 years than now.

Over the next decade we don't expect to see much change in the number of children and young people.

We have become more ethnically diverse, with around 5% of our population from different backgrounds and cultures and we have seen a small number of international workers move into the CCG area.

Whilst Sefton is more affluent than its neighbours across Merseyside, nearly one fifth of residents live in pockets of the borough that are amongst the 10% of most deprived communities in the country.

In our poorest communities, on average people can expect to live much shorter lives than their more affluent neighbours and this is unacceptable.

Levels of long term health conditions – especially heart disease, respiratory disease, kidney disease, mental health conditions and obesity - are much higher than national averages.
The number of early deaths from heart disease and cancer has reduced over the last decade as smoking rates have declined but we want to do more to close the gap between our population and the national average.

The CCG aims to commission services that improve the health and wellbeing of all patients registered with its member practices and those who are unregistered but are resident within the boundaries of the CCG.

Following the reforms outlined in the White Paper '*Liberating the NHS'*, which describes the move to clinically-led commissioning from April 2013. Southport & Formby GPs have created a Clinical Commissioning Group across the North of the Borough of Sefton with four strong localities:-

- The CCG staff work in a matrix model with colleagues from a number of areas; the Joint Commissioning Unit with Sefton Borough Council, the North West Commissioning Support Unit (NWCSU) and NHS England (NHSE) to ensure a comprehensive approach to commissioning in Southport & Formby.

- It is essential that the CCG has in place robust quality governance arrangements to ensure the commissioning of high quality services which are responsive to the needs of our population.

- The CCG as a statutory body from April 2013 commissions health services from a diverse range of provider organisations across all settings of care (primary, community, secondary and mental health).

- The CCG commissions health care from local acute hospitals, mental health providers, and community providers, independent and social care providers, and the voluntary sector.

- The CCG has demonstrated ownership of the quality agenda throughout the authorisation process, and had no conditions attached at authorisation neither for the new organisation nor since our formal establishment in April 2013.

- In developing this quality strategy, the CCG has identified how it will operate to improve and maintain quality in the context of the legislative framework and in collaboration with partner agencies.

- The CCG believes the use of contractual levers and performance management is one specific process for supporting the CCG in discharging its responsibility for improving quality and quality assurance.

- The CCG is passionate and focused on good quality of services and where necessary will use performance management to improve service quality.

- The CCG does not consider that its presence alone will have the necessary impact on health outcomes; however, based on robust evidence, the CCG has developed a vision of what it aims to deliver.

The quality strategy is integral to the CCG strategic plan and is focused on delivering high quality care and experience, ensuring no harm is done to patients and addressing areas of any concern promptly and effectively. It is underpinned by the 6C's, as outlined in the Chief Nursing Officers paper 'Compassion in Practice- Our Vision and Strategy' which sets out the shared purpose to deliver high quality, compassionate care, and to achieve excellent health and wellbeing outcomes.

The CCG has to maintain safe and effective safeguarding services and to strengthen arrangements for safeguarding adults and children across Sefton, working collaboratively with partner agencies. To do this the human rights, independence and well-being and secure assurance that the child or adult thought to be at risk, stays safe. The CCG safeguarding strategy sets out priorities for the forthcoming years 2015- 2017 and is the start of the journey

to plan and commission locally delivered services that drive up quality and ensure our population receives effective, safe and personalised care.

Definition of Quality:

Quality means different things to different people and the NHS is the only healthcare system in the world with a single definition of quality.

At its simplest, Quality is defined as care that is **safe**, **effective** and provides as positive an **experience** as possible. The definition of quality sets out three dimensions to quality:

- **Patient Safety:** commissioning high quality care which is safe, prevents all avoidable harm and risks to the individual's safety; and having systems in place to protect patients;

- **Clinical Effectiveness:** commissioning high quality care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes. Making sure care and treatments achieve their intended outcome;

- **Patient Experience:** commissioning high quality care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what the individual wants or needs, and with compassion, dignity and respect. It's about listening to the patient's own perception of their care.

This simple, yet powerful definition was first set out in *High Quality Care for All* in 2008, following the NHS Next Stage Review led by Lord Darzi. This definition now enshrined in legislation has the patient and the NHS Outcomes Framework at the heart.

The Care Quality Commission (CQC)'s new inspection approach goes further to build on the three dimensions of Quality by adding two additional dimensions:

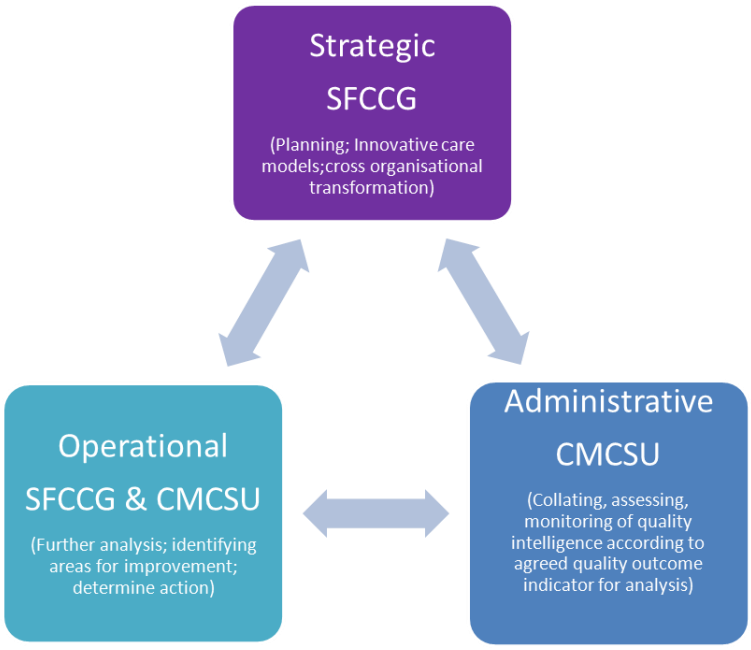
- **Organisational Culture & Leadership:** commissioning high quality care which is well-led;

- **Responsiveness:** commissioning high quality care which is responsive to the needs of patients.

Quality is not an abstract term or concept relevant only in policy debates. It must begin within our own organisation and be apparent within the organisations the CCG commissions services from. It is the measure of how we commission services and how commissioned services are treating and caring for patients in their care. In order for commissioned services to be considered as providing a high quality service, being good in one or two of the above five dimensions of quality is simply not good enough.

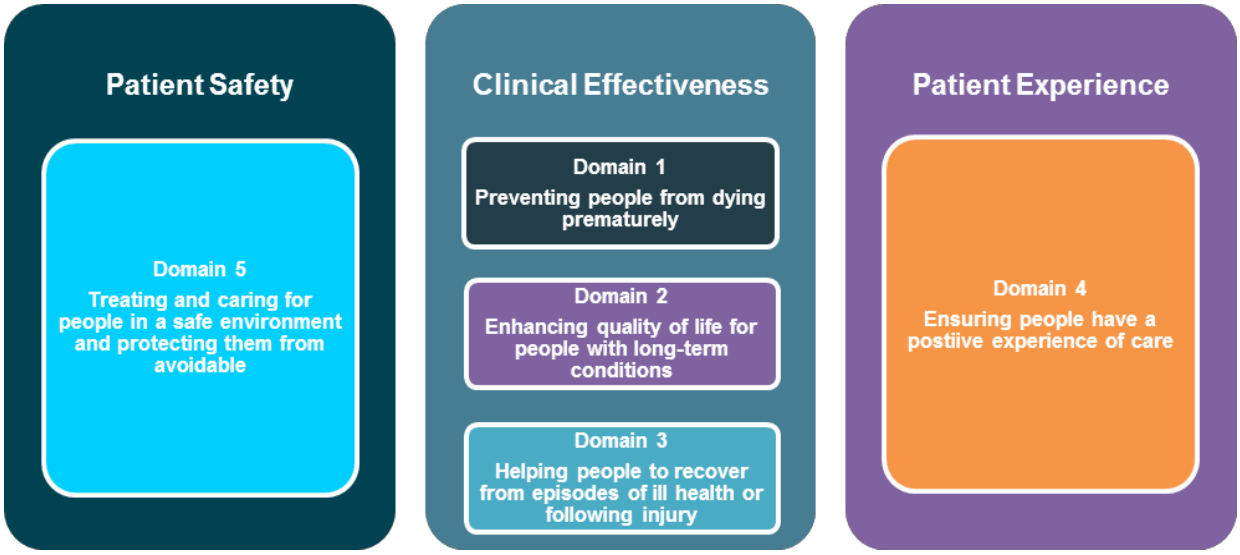

Patient Safety
(Are commissioned services safe?)
Clinical Effectiveness
(Is the care commissioned effective?)
Organisational Culture & Leadership
(Are commissioned services well-led?)
Patient Experience
(Have patients had a good experience)
Responsiveness
(Are commissioned services responsive to people's needs?)
Quality

To ensure the CCG is focused on the five dimensions of quality it needs to have an effective quality control process which is fit for purpose, proactive and reactive and applicable to every directorate within the CCG.



The NHS Outcomes Framework builds on the definition of quality through setting out five overarching outcomes or domains, which captures the breadth of what the CCG is striving to achieve for patients:

- **Domain 1** Preventing people from dying prematurely;
- **Domain 2** Enhancing quality of life for people with long-term conditions;
- **Domain 3** Helping people to recover from episodes of ill health or following injury;
- **Domain 4** Ensuring people have a positive experience of care;
- **Domain 5** Treating and caring for people in a safe environment and protecting them from avoidable harm.


Patient Safety
Domain 5
Treating and caring for people in a safe environment and protecting them from avoidable
Clinical Effectiveness
Domain 1
Preventing people from dying prematurely
Domain 2
Enhancing quality of life for people with long-term conditions
Domain 3
Helping people to recover from episodes of ill health or following injury
Patient Experience
Domain 4
Ensuring people have a postiive experience of care

The domains of the NHS Outcomes Framework are a crucial element of focus for the CCG's commissioning strategic plan, acting as driver for commissioning.

National Quality Drivers

The CCG will drive local health systems towards a sustained focus on quality, guided by several policy drivers. These policies inform the way the CCG continuously monitors, measures and improves the quality of care and experience received by its population:

- *The NHS Outcomes Framework*: sets out the improvements against which NHSE will be held to account. The NHS Outcomes Framework is intrinsically linked to the local and national quality priorities which consist of five domains set across the three dimensions of quality;

- NHS England published its up-dated planning strategy in October 2014 (Five Year Forward View). This places an increasing emphasis on the prevention of ill-health and the role of public health in tackling major causes of disease. This emphasis is consistent with the CCG Strategic Plan and is in keeping with the Better Care Fund plan that has been jointly developed with Sefton Metropolitan Borough Council.

  In addition, the Five Year Forward View places a resounding emphasis on self-care and local support for self-care. This is very much in keeping with the CCG locality model and adds strength to the major transformation schemes (Virtual Ward, Care Closer to Home) within the CCG strategic plan.

- *The Next Stage Review: High Quality Care for All* (2008): sets out a clear quality framework including the components of quality assurance mechanisms. The review placed great emphasis on being more patient centred, clinically driven, valuing people and promoting lifelong learning and improving the quality of commissioned services;

- *NHS Constitution* (2013): establishes the principles and values of the NHS in England. It sets out the pledges the NHS' commitment to operate fairly and effectively, the rights to which patients, the public and staff are entitled. The NHS Constitution is adhered to and reflected within the CCG's mission, vision and values;

- *Quality, Innovation, Productivity and Prevention (QIPP)*: is a large scale transformational programme for the NHS, involving and engaging staff, clinicians, patients and the voluntary sectors in Sefton in improving the quality of care delivered whilst making efficiency savings, leading and supporting change and addressing local quality challenges. In the CCG, QIPP is a well-established programme and the CCG works with its local health partners in developing integrated QIPP plans that address local quality challenges;

- *Commissioning for Quality and Innovation Framework (CQUIN)*: enables commissioners to reward excellence by linking a proportion of healthcare provider's income to the achievement of local quality improvement goals thus enabling providers to act as a vehicle for improving patient safety, experience and outcomes. CQUINs schemes form part of the contract between the CCG and its main providers of healthcare. These are routinely monitored by the NWCSU Contracts team with updates provided quarterly at the commissioned services Clinical Quality Performance Group (CQPG) meeting;

- *Healthwatch England*: is the independent consumer champion for health and social care in England created to ensure that the voices of the public and those who use services reach the ears of the decision makers. Healthwatch Sefton plays a key role at local level in ensuring the views of Sefton's population and people who use commissioned services are taken into account;

- *Quality Premium*: is the incentive payment used to reward CCGs for their performance in achieving specific outcomes related to a number of clinical conditions. The criteria will be developed by NHSE and come from within the overall administration costs limit set in directions for the NHS commissioning system;

- The National Quality Board (NQB) is a multi-stakeholder board established to champion quality and ensure alignment in quality throughout the NHS. The NQB is a key aspect of the work to deliver high quality care for patients.

  The aim of the NQB is to bring together all those with an interest in improving quality, to align and agree the NHS quality goals, whilst respecting the independent status of participating organisations.

- *General Practice (GP) Quality and Outcomes Framework*: is a system to remunerate GPs for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the General Medical Services contract, introduced on 1st April 2004;

- The CCG now commissions GPs to deliver a number of schemes to improve patient care.

- *Care Quality Commission (CQC):* is the independent regulator of health and social care in England. It monitors, inspects and regulates care provided by CCG's commissioned services to ensure they meet fundamental standards of quality and safety;

- *Recent National Reviews*: there is a focus on quality following recent scandals. The recommendations and lessons learned from the following reviews will be fully implemented and signal a shift in how the CCG commission services:

  - Mid Staffordshire NHS Foundation Trust (Francis Report);
  - Review into the quality of care and treatment provided by 14 hospital: Sir Bruce Keogh;
  - Winterbourne View Hospital;
  - Maidstone and Tunbridge Wells NHS Trust;
  - Basildon and Thurrock University Hospitals NHS Foundation Trust;
  - Professor Don Berwick's Review into Patient Safety;
  - Dr David Colin Thomé and Professor Sir George Alberti's Review of Commissioning Roles.
  - Morecambe Bay
  - Savile Enquiry

The CCG Vision, values and objectives as part of its 5 year Strategic Plan

The vision of the CCG is 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.

The values the CCG hold as part of its 5 year strategic plan are:

- To maintain a local focus, working in partnership
- To be transparent, open and honest
- To be approachable and to listen to our public
- To enable action and prioritise effort to optimum effect
- To act with integrity, act fairly and with respect
- To be accountable for what we do
- To be caring and compassionate

The system objectives the CCG have, aim to:

- Potential rate of years of life lost from causes considered amenable to health care. To significantly reduce hospital avoidable deaths by 14%.
- To improve the health related quality of life for people with one or more LTC by 9%.
- Reducing the amount of time people spend avoidably in hospital. Reduce emergency admissions by 21%.
- To improve in-patient experience by 12%. The proportion of people reporting poor patient experience of inpatient care.
- Improve patient experience of GP and out of hours care by 28% (% reporting poor care to reduce)

Patient Integrated Locality Care represents the locality delivery model for the CCG. These will focus on delivering enhanced primary and community care with improved access and management of individuals' needs with Long Term Conditions to prevent unnecessary admission to hospital.

The CCG will deliver its strategic plan and vision through the following governance arrangements:

- Sefton Health & Wellbeing Board
- Aintree Strategic Partnership Board
- Health & Wellbeing Board Provider Forum
- CCG Service Improvement & Re-design committee.
- Integrated approach with BCF and Sefton Council through Health & Wellbeing Board.
- Governing Body

The CCG will measure its success in the delivery of its strategic plan using the following criteria:

- All organisations within the health economy report a financial balance in 2018/2019
- Reduction in Unplanned activity by 15%
- No provider under enhanced regulatory scrutiny due to performance concerns
- Achievement of the 5 defined system objectives

The CCG is clear in this strategy that Quality is everyone's responsibility and ensuring that effective mechanisms are in place to proactively monitor, triangulate and ensure continuous improvement is crucial.

The importance of quality is reflected in the CCG's Constitution and in its values and behaviours. The CCG embraces a culture of openness, learning and honest collaboration where individuals and the organisation are transparent about the quality of care being commissioned for patients.

The CCG embraces the principles and values as set out within the NHS Constitution (2013). These act as a guide to the NHS (including CCG staff) in all it does:

Principles:

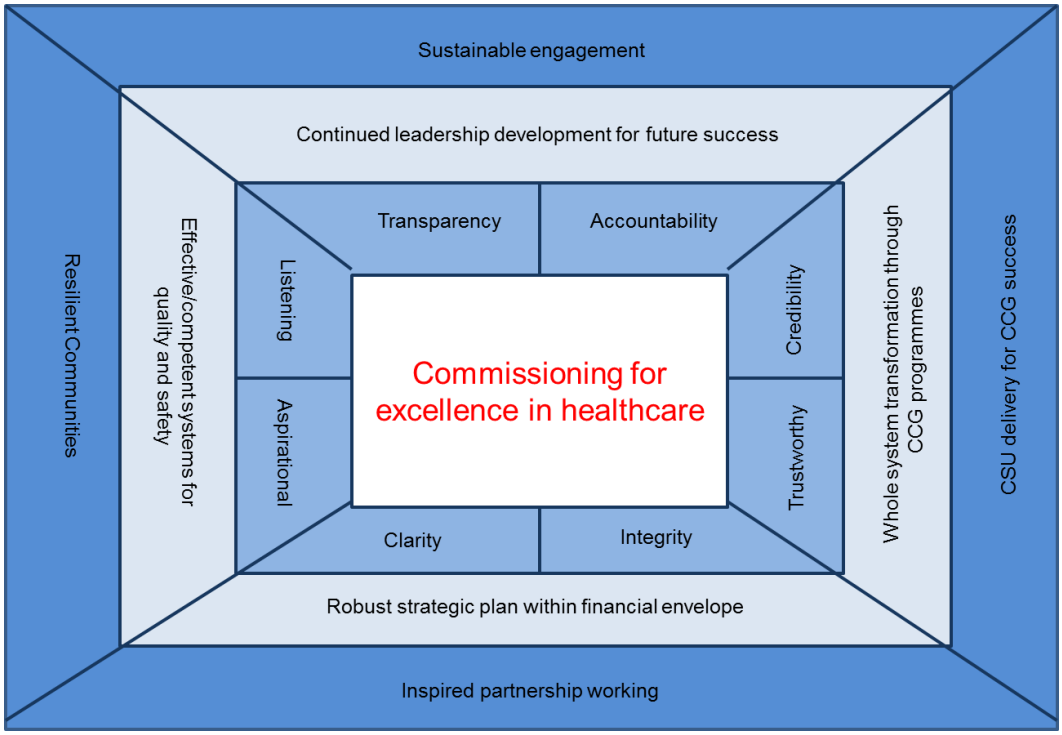
- The NHS provides a comprehensive service, available to all;
- Access to NHS services is based on clinical need, not an individual's ability to pay;
- The NHS aspires to the highest standards of excellence and professionalism;
- The NHS aspires to put patients at the heart of everything it does;
- The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients, local communities and the wider population;
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources;
- The NHS is accountable to the public, communities and patients that it serves.

Values:

- Working together for patients;
- Respect and dignity;
- Commitment to quality of care;
- Compassion;
- Improving lives;
- Everyone counts;
- The CCG has gone further in building on the NHS Constitution to describe how it will conduct itself in achieving 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''.

An adherence to Quality for the CCG



The organisation aims to demonstrate the values illustrated when commissioning care on behalf of the CCG and demonstrates 'how we do things' across the constituency.

The CCG believes in order to ensure the delivery of the quality agenda there needs to be commitment to the creation of a culture where our staff are valued and supported.

The CCG enables staff to feel valued and supported with an ethos of:

- Distributed Leadership
- Integration
- Decision making
- Head Space
- Focus
- Senior management support
- Smoother clearer governance

All of which are underpinned by a robust Organisational Plan.

Corporate Objectives

- The focus of the CCG's quality strategy is to support the achievement of the CCG's corporate objectives and vision for its residents of Southport & Formby.

- The CCG's seven corporate objectives form part of the golden thread of quality running through the CCG:

- These corporate objectives will be reviewed on an annual basis and new objectives set accordingly which support the delivery of quality services and improved outcomes for the population

e CCG's aspirations described through the corporate objectives are the key focus for quality and the CCG recognises and accept that to deliver the corporate objectives some difficult and challenging choices will be required.

- Ensuring the CCG achieves its corporate objectives and that patients receive high quality care relies on a complex set of interconnected roles, responsibilities and relationships between the CCG staff, patients and the public, our member practices, professionals, Public Health, commissioned services, other CCG commissioners, professional regulators and other national bodies.

The CCG Governing Body is accountable for driving the quality agenda. The CCG's Quality Committee is the responsible committee (under delegated responsibility from the Governing Body) for the monitoring of the agenda and has key responsibilities to:

- approve arrangements including supporting policies to minimise clinical risk, maximise patient safety and secure continuous improvement in quality and patient outcomes
- approve the arrangements for handling complaints
- approve the CCG's arrangements for engaging patients and their carers in decisions concerning their healthcare
- approve arrangements for supporting NHS England in discharging its responsibilities to secure continuous improvement in the quality of general medical services.

In order to ensure delivery of the quality agenda and corporate objectives and promote a quality focused culture throughout the CCG, the necessary leadership arrangements for commissioning high quality services has been established. The Board has delegated responsibilities to the following committees, groups and forum:

- Senior Management Team/ Senior Leadership Team;
- Finance Resources Committee;
- Audit Committee;
- Quality Committee;
- Service Improvement & Redesign Committee;
- Remuneration Committee;

The CCG itself has to demonstrate that it is operating effectively to commission safe, high quality and sustainable services within their resources.
Internally it demonstrates this in a variety of ways:

- Internally focussed Quality Committee meetings
- Risk Registers
- Governing Body Assurance Framework

In addition the CCG Assurance Framework outlines the process to be used by NHS England to monitor and gain assurance on the performance of CCGs. The CCG assurance process has been designed to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively

This framework sets out six broad 'assurance domains' under which this assessment will be made:

- Are patients receiving clinically commissioned, high quality services?
- Are patients and the public actively engaged and involved?
- Are CCG plans delivering better outcomes for patients?
- Does the CCG have robust governance arrangements?
- Are CCGs working in partnership with others?
- Does the CCG have strong and robust leadership?

A key element of the assurance process is quarterly assurance meetings with the NHS England Area Team, together with the production of a 'delivery dashboard' which provides information on performance against certain targets and metrics

- The CCG understands that effective commissioning cannot be embedded if different parts of the CCG work in isolation, therefore, the CCG have ensured there are robust quality governance arrangement and delivery and assurance structure aligned to ensure systematic reporting and performance monitoring in place. This ensures the CCG focuses on quality improvement through delivery of the corporate objectives in the best interest of patients;

- The CCG reflects the strategic objectives and quality strategy through staff objectives and training strategy in order to embed quality, make quality a reality, promote and deliver the quality agenda;

- The CCG has responsibility for identifying the learning from all newly released national and local reports (e.g. Francis, Berwick, Keogh Reports), guidance and any other relevant documents as appropriate as part of the CCG's assurance process. Such documents have been summarised to include the following and have been presented to the CCG Governing Body and Quality Committee (QC):

- Identified themes;

- Findings of the report;

- Recommendations:

    - CCG reflective review against the report findings, triangulation to support the CCG's assurance of its system and processes and gap analysis to identify areas for improvement.

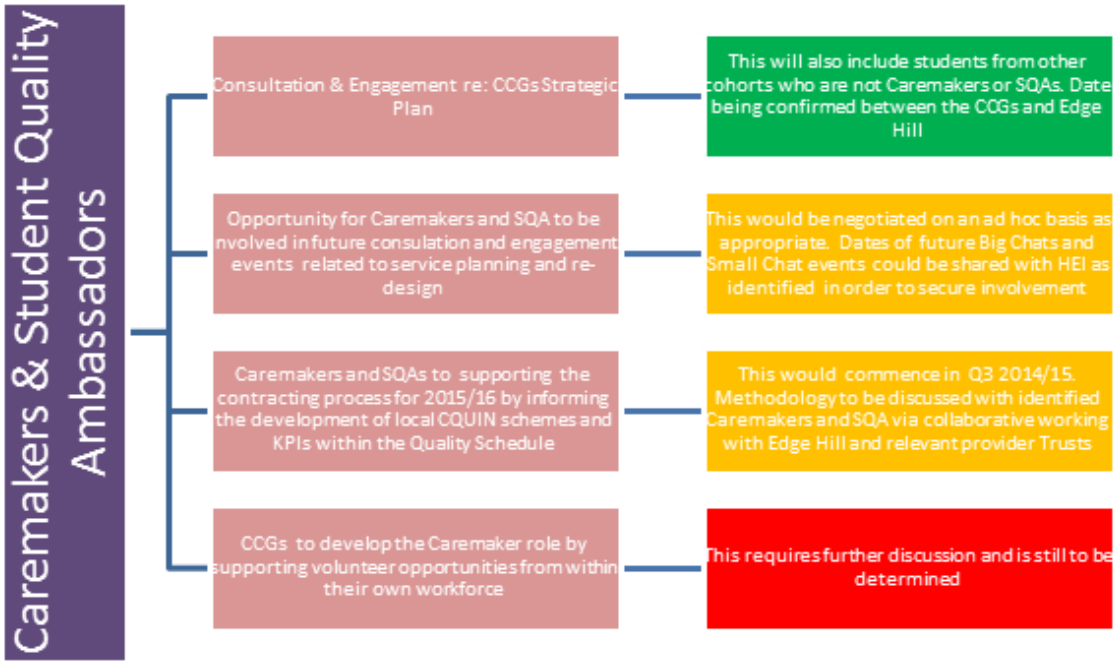
    - The CCG expects commissioned services response to all newly released national reports and inspections carried out by CQC or any other inspectorate bodies to be presented for discussion by the commissioned services' at CQPG meetings.

    - Research – The CCG have a research strategy in place in line with *The Health and Social Care Act 2012.* The CCG are working towards the promotion and enablement of research and evaluation to improve health outcomes. This will be in line with active participation and collaboration with HEIs, Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and North West Coast Academic Health Science Network (AHSN).

    - The CCG has initiated a contact with Edge Hill University and the NHS England NW lead for Care makers and SQAs to explore how both of the above programmes could be introduced within a commissioning setting in order to improve quality of care. Both the HEI and the NW lead confirmed that this hadn't been done before and wished to support the CCGs in being the first 2 known commissioning organisations in the country to develop this initiative further by taking the idea out of the provider and education environment into

that of commissioning. The CCG is an accredited hub and spoke placement for students.

Diagram 1 – Illustration of the Care maker / SQA Proposal for within the CCGs



Quality Assurance Framework

As the CCG seeks to do the best for the population it commissions services on behalf of, it recognises that there needs to be an effective framework for how quality assurance will be obtained.
An Early Warning Dashboard highlights the current position for hospital providers of interest to the CCG against a number of quality measures within the following domains:

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

The CCG has developed a quality assurance framework adopted from Sir Bruce Keogh's four stage methodology. The CCG believes this methodology is transparent, comprehensive and systematic. The four stages are as follows:

- **Stage 1** Quality Data Analysis
- **Stage 2** Triangulation
- **Stage 3** Multi-disciplinary Reviews
- **Stage 4** Support Improvement

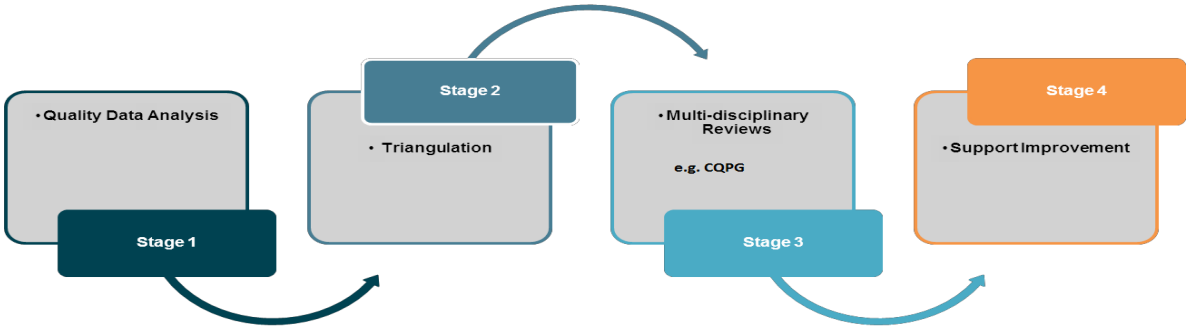
The framework offers the CCG a systematic way of:

- Obtaining quality assurance of commissioned services quality;
- Monitoring quality performance against agreed standards and outcomes and;
- Carrying out quality surveillance of safety, effectiveness, leadership and culture, responsiveness and patient experience intelligence to build a profile of a commissioned service.

Each stage is an important component, equipping the CCG with a range of methods, tools and intelligence when combined together can help commissioners determine the quality of services commissioned.

No quality assurance framework offers a definitive conclusion about the quality of care provided by commissioned services but it allows for questions to be raised, exploratory review to be undertaken and for improvement to be supported.

The CCG's quality assurance framework is designed to encourage clear and effective communication, avoid duplication through collaborative working and focusing on what adds value. Transparency is key to these stages and based on support and improvement rather than blame.



Stage 1: Quality Data Analysis

Quality cannot be improved until there is clear understanding of how to identify and measure if care is of a high standard in the first place. The CCG is aware that poor standards of care do not necessarily show up on quality outcome indicators and across the CCG and externally, there is a wealth of intelligence, gathered formally and informally, about the CCG's commissioned services.

The CCG has gathered, identified and conducted detailed analysis of a vast array of meaningful hard and soft quality intelligence. This includes but not limited to standards from national standard contracts, CQC essential standards, etc.

This quality intelligence in isolation will not draw definitive conclusions or judge the quality of care and is only as good as what you do with it. Instead, the CCG uses them as an 'early warning system' which will start to sound if commissioned services are outside the expected range of standards.

It allows for key lines of enquiry to be analysed and turned into knowledge which can then be triangulated with other information (stage 2). It paves the way for penetrating questions to be asked during relevant multi-disciplinary reviews (stage 3). The intelligence is then used to judge a commissioned service's performance, determine effectiveness and drive quality improvement (stage 4) in a consistent way.

Hard and soft intelligence required are identified within the quality schedule that is agreed with each commissioned services through the contracting process. Nationally, the NHS Standard Contract and national drivers provides the CCG with a mechanism for setting consistent quality requirements.

Stage 2: Triangulation:

Quality cannot be seen in isolation but as a part of a broader concern about cost, performance and contracting. Stage 2 allows for continuous monitoring, linking the data gathered (stage 1) from our commissioned services against standards sets in the contracts/national standards, identifying where data link with each other to enable us to dive deeper to identify potential areas for improvement to be delivered.

Often the information that one directorate alone has, will not cause concern, however, when systematically combined and triangulated, with intelligence that another part the CCG system and/or external source may have, might point to a potential problem that should be investigated further.

For e.g., the quality committee would analyse and discuss quality alert concerns around discharge. Combined and triangulated with the discharge information held by the Experience and Patient Engagement Group (EPEG) via patient feedback and the Strategy & Outcomes directorate via performance meeting can identify improvement areas and they can be presented to providers.

For stage 2 to work, all the different directorates within the CCG and external colleagues NHS Trust Development Authority (NTDA), NHSE, Healthwatch Sefton, CQC Inspections, routinely and methodically together to align and share intelligence to identify good practice and any potential or actual quality failure without undermining or overriding individual accountabilities.

Reports produced by external colleagues regarding commissioned services quality will be presented by the commissioned services during the CQPG (stage 3). Intelligence obtained from these reports would be used to triangulate with intelligence held within the CCG.

Any intelligence triangulated with other sources of information ensures that any challenge provides a strong evidence base. The triangulated data is then discussed at multi-disciplinary reviews (stage 3) coordinated through various routes with commissioned services.

Stage 3: Multi-disciplinary Review

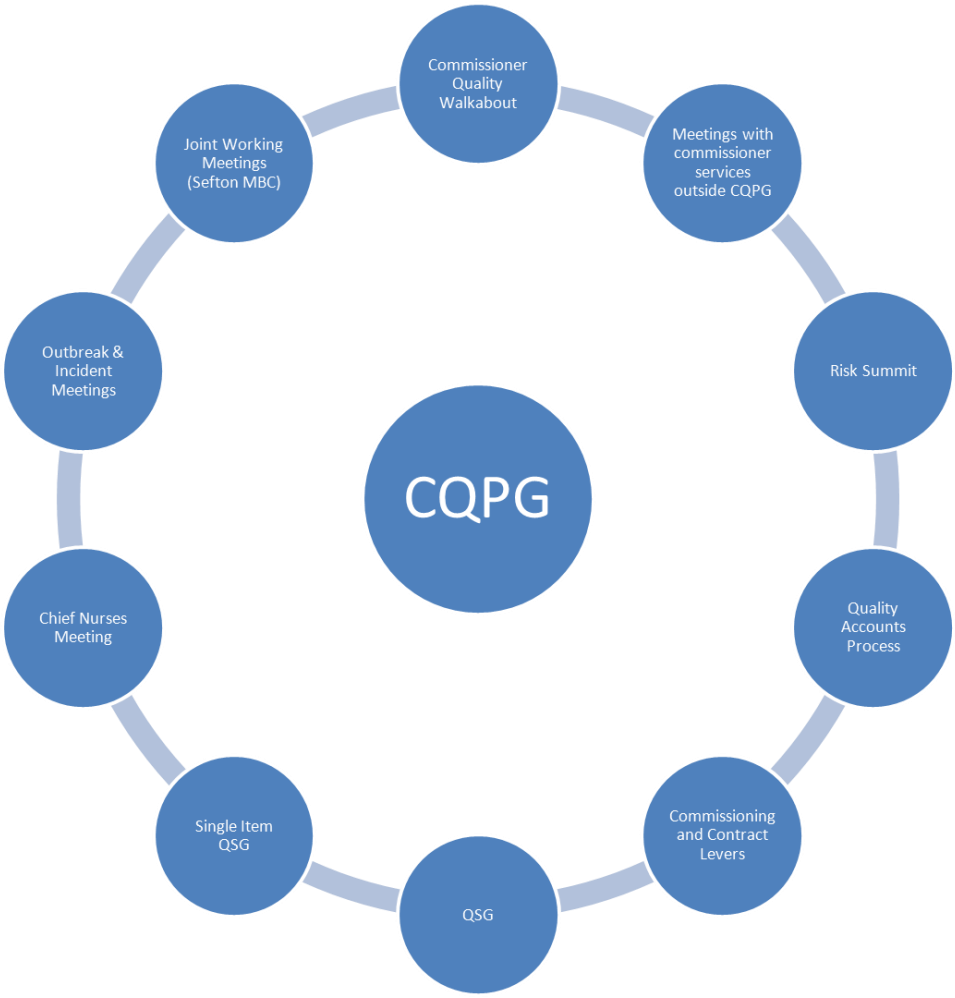
There are different types of multi-disciplinary reviews used by the CCG to work with commissioned services to ensure quality is maintained and continuously improved. These set out a model for proactively working, sharing and discussing available intelligence in detail on quality of commissioned services.

Quality outcomes obtained from data analysis (stage 1) and triangulated information (stage 2) will be discussed and scrutinised through the multi-disciplinary review meetings such as:

Clinical Quality Performance Group Meetings (CQPG):

These are formal dedicated meetings held regularly with all commissioned services where the CCG is the lead commissioner to monitor and discuss all aspects of quality of care provided and the quality element of the contract. In commissioned services where the CCG is not co-ordinating commissioner but an associate commissioner, the CCG works closely with other commissioners to receive assurance.

CQPG meetings are part of the national contracts and contract monitoring process for all the major commissioned services. These meetings are critical and form part of the CCG's detailed oversight and scrutiny process and are also used to celebrate improvements and discuss new quality developments. The commissioned services engagement diagram below demonstrates how all engagement activities lead back to the commissioned services' CQPG.



CQPG meetings in place depend on the complexity of the contract and with smaller contracts, where a CQPG meeting is not viable; quality is incorporated into the overall contracting arrangements led by a Contract Manager who will work closely with the quality team when issues are identified and will ensure the CCG are informed of issues and risks. For some of the larger independent sector contracts, CSU quality team input into the regular contract meetings which incorporate quality oversight.

CQPG meetings are chaired by clinicians; coordinating a programmed annual plan of review which enables the commissioned services to prepare the information required and, as much as possible, ensure this fits with existing reporting cycles for the CCG Board and other committees to minimise duplication of work unnecessarily. Any quality challenges and/or proposals that arise from CQPG meetings will be presented to CCG Quality Committee (QC) for an agreed approach. Where performance issues arise, plans are put in place to achieve compliance and unresolved issues are escalated to QC and the CCG Governing Body as appropriate. Key issues of the CQPG are brought to the attention of the QC. All commissioned services submit a quality dashboard with supporting quality report against agreed quality outcomes indicators identified.

Commissioner Quality Walkabout:
These are quarterly informal dialogue assurance visits jointly coordinated by the provider and the CCG's Quality Team around observation of patient pathways and care environment and hearing from front line staff and patients. These walkabouts are used as interactive, engaged and visible indicator of CCG's commitment to quality that has been identified as a key element of a good safety culture and form part of the CCG's broader improvement programme.

They are useful, practical and a visual method of triangulating the evidence and allow for the opportunity of observation outside of executive reports statistics and levels of assurance, to see if quality outcomes on the front line are being realised by both

practitioners and patients. The intelligence obtained from the visit is fed back to the commissioned service, CQPG and CCG's QC. Any identified follow up actions will be monitored through the CQPG.

The CCG will from time to time conduct ad-hoc Quality Walkabouts if it is felt that there are specific concerns with a provider in general or with a certain service, department or ward. This demonstrates a proactive approach to Quality Walkabouts as well as a reactive one outlined above.

Quality Account Process:
Quality accounts demonstrate commissioned services' commitment to achieve and improve outcomes for all of Sefton patients. All commissioned NHS services are required to provide an annual quality account for the public to read about the quality of their services. The CCG's process for reviewing and commenting on all commissioned services' quality account: the commissioned service representative will present their draft quality account at joint CCG specific meetings. The CCG's collated triangulated summary of the quality account would be fed back to the commissioned service, and submitted to the Chief Nurse or Director of Quality of the commissioned service by the Chief Nurse of the CCG.

Commissioning and Contracting Levers:
Contract monitoring is akin to quality assurance by holding commissioned services to account for delivery of contractual obligations and quality standards. The CCG is committed to using its commissioning levers through multi-disciplinary review (stage 3) to drive up quality of care for the residents of Sefton who use local health services. In order to realise the full potential of the quality strategy, the CCG ensures that quality is embedded throughout the commissioning and contracting cycle. Improved commissioning specifications for commissioned services add clarity to quality outcomes.

Quality specifications, quality review arrangements, other contractual levers, penalties and incentives such as CQUIN payment scheme are all being used to different degrees across the range of commissioned services. The CCG's commissioning, contracting, performance and quality teams work closely together through regular monitoring and review of quality reports and ensuring that the Planning Guidance is consistent with specifying the CCG's quality requirement over and above the 'essential standards of quality and safety' set by the CQC. Including that the contract is best used to support improvement in quality. Monthly contract monitoring meetings are part of the contract management process with most of the CCG's commissioned services.

Outbreak and Incidents Meetings:
These are commissioned services' meetings with the involvement and support of the CCG and NWCSU (e.g. infectious outbreak and incidents). These meetings are determined by the commissioned service.

NHS Merseyside Quality Surveillance Group (QSG):
Is a bi-monthly meeting of all commissioners, NHSE Merseyside and regulators to review and share intelligence on commissioned services. This also includes suggestions of actions to be taken where required. QSG should function as follows:

- Patient focused – members are grounded in the fact that their purpose is to maintain good quality services for patients
- High trust – an environment which facilitates open and honest conversations about quality
- Inclusive – all members feel able to contribute to discussions
- Challenge – Members feel able to offer constructive challenge to colleagues to get to the bottom of the issues and identify suitable actions

- Action orientated – all members come away from meetings with clarity as to the actions agreed and who is taking them forward

- Well informed – QSGs receive reports and data-packs which present information in a useful and distilled format to members which enable them to identify the potential quality risks

- Comprehensive – QSGs have a planned and defined business cycle which enables them to consider potential risks in all providers within their geography, across all sectors QSGs operate at two levels: locally, on the footprint of NHS England's 27 area teams.

Single Item Quality Surveillance Group (SIQSG):
Provides forum to discuss an individual provider where issues, concerns have been raised by a number of performance measure but does not constitute a risk summit. The area team will facilitate a SI QSG. An outcome of a QSG may be to present an action plan to provider, convene a SI QSG with provider present or convene a risk summit on the provider if agreed as appropriate

SIQSG with Provider Present:
Provides a forum to discuss issues and concerns which have been raised by a number of performance measures, with the provider which the issues and concerns relate to. The area team will facilitate a SI QSG. A provider may be asked to present at the meeting, an action plan which addresses the concerns and issues highlighted and assure the group that they are mitigating the risks.

An outcome of the SI QSG may be to convene a risk summit on the provider if agreed as appropriate.

Risk Summit:
Provider concerns may escalate to the establishment of the risk summit process involving the CQC. This is led and/or undertaken by NHSE North. A risk summit will be called so that the issue can be focussed on in detail and a plan of action developed.

Joint Working Meetings:
The CCG is keen to learn from others and engage in collaborative partnership working arrangements and networking opportunities across other CCGs, Healthwatch Sefton, Local Authority, NHSE, CQC, NTDA, other partners, etc. This allows for streamlining arrangement, understanding the needs for different services benchmarking and a more consistent approach to raising standards and maximising contributions to commissioning.

The Francis Report (February 2013) emphasises that commissioners should have a primary responsibility for ensuring quality as well as providers, and systemic learning is a critical function of the CCG's commitment to the safety of patients for whom it commissions services. Promoting patient safety by reducing errors is also a key priority for the NHS. When errors do occur, the CCG supports the view that the response should not be one of blame and retribution, but of organisational learning with the aim of encouraging participation in the overall process and supporting staff, rather than exposing them to recrimination.

Chief Nurses Meeting:
Focuses on compassion in practice (2012), which sets out the requirement for all organisations to promote the 6Cs; care, compassion, competence, communication, courage and commitment. The CCG nursing workforce will support the monitoring of measures to improve nursing care, standards, workforce development and promote the implementation of the 6Cs within commissioned services.

Stage 4: Support Improvement:

The CCG has identified the improvements it wishes to secure in the quality of services commissioned and using the commissioning process to drive continuous quality improvement. Continuous quality improvement requires health services to search for and apply innovative approaches to delivering healthcare, consistently and comprehensively across the system.

The CCG has structured payments and incentives to encourage commissioned services to continuous quality improvement to meet future challenges, using these payment mechanisms to contract for the delivery of high quality care and to manage those contracts. CQUINS is used to incentivise commissioned services to deliver high quality care, drawing on NICE Quality Standards and are monitored with commissioned services through CQPGs.

The CCG has identified a number of specific areas requiring managerial and clinical expertise to bring about both transactional and transformational change in how health services are delivered for the population of Sefton. GP clinical leads work in partnership with the CCG managerial locality leads to bring about these changes.

The CCG has appointed Clinical Directors / GP Clinical leads for Quality; The Clinical Director for Quality, in addition to their duties as a GP Governing Body member, will:

- work closely with the lead manager(s) within the Quality Team and the GP Clinical Lead for Quality to drive forward and deliver on key aspects of an agreed work programme for their area, in the context of the 2 and 5 year strategy

- agree a set of related personal objectives through the Personal Development Review (PDR) process

- regularly report on progress to the Governing Body and other groups as appropriate

It is also important that that the Clinical Director for Quality is able to remain in tune with member practices, truly engage with patients and communities, and actively reflect the Nolan Principles of Public Life in their leadership role, as they work with others to commission high quality services and improve health and wellbeing.

Safeguarding vulnerable adults and children

The CCG ensures that its providers have arrangements in place to safeguard and promote the welfare of adults and children in line with national policy, guidance and locally identified areas of concern. Providers identify safeguarding issues relevant to their area and we challenge providers to demonstrate that policies and procedures are in place and implemented. We review staff training to ensure staff are appropriately trained, supervised and supported and know how to report safeguarding concerns. The CCG requires providers to inform them of all incidents involving children and adults including death or harm whilst in the care of a provider. Full information can be found in our Safeguarding Strategy. The CCG works closely with our partners to participate in Serious Case Reviews and Domestic Homicide Reviews and ensure findings are included in our triangulation of data. Through partnership working with other agencies, the CCG, as a member of the Sefton Local Safeguarding Children Board (Sefton LSCB) and Sefton Safeguarding Adult Board (Sefton SAB). (LSCB/SAB) will be engaged in debate and discussion in order to improve the quality of practice and subsequent outcomes for children, young people and adults at risk in Sefton.

Equality & Diversity

The CCG understands that in order to meet the needs of a diverse community and improve access and outcomes for patients who experience barriers and disadvantage, it must be cognisant of its Public Sector Equality Duty (Section 149 Equality Act 2010) .

The E&D agenda supports the quality strategy through:

- triangulation : evidence of barriers and discrimination will be highlighted to the Quality Committee via EPEG
- Commissioning and contract levers: providers are monitored on a number of E&D quality indicators
- Equality Delivery Systems 2 findings and recommendations will be highlighted within the quality committee structure
- Equality assessment findings and recommendations will be highlighted within the quality committee structure

Patient and Public Involvement

Sefton has a diverse population and the CCG must engage with a range of people from all backgrounds, ethnicities, ages, genders and geographical locations. The CCG is committed to working with the people and communities of Sefton in an open and transparent way and has been creative in its approach to embed PPI into its work. The establishment and successful working of the multi-stakeholder Experience and Patient Engagement Group (EPEG), provides a forum and task group for this work to develop and flourish.

Patient's experience and involvement means more than simply engaging people in discussions about commissioned services. Involvement means listening to the patient voice and ensuring that the experience of individual patients and communities are heard at every level.

The CCG has designed a structure to embed listening to the patients' experience and PPI in all groups and processes that influence commissioning priorities. This structure acknowledges that there are many different ways that people can make their views heard.

The CCG Communications and Engagement Strategy gives more details of our approach to Public and Patient Involvement.

Event of Serious Quality Failure

No system can be 100% failsafe and where a problem or failure does occur there needs to be CCG-wide response and approach with three key objectives:

- Safeguarding patients;
- Ensuring continued provision of services to the population; and
- Securing rapid improvements to the quality of care at the failing commissioned service.

Such problems may relate to a specific service or be indicative of even more serious and systemic problems within a commissioned service. The CCG will reactively respond to such concerns which might arise as a result of whistleblowing, routine sharing of

intelligence or new intelligence coming to light separately by working with the commissioned service where concerns have been raised to address any quality problems as far as possible. Initial concerns will be addressed by the Senior Management Team (SMT)/ Senior Leadership Team (SLT);

A failure by any of the CCG's commissioned services to meet any quality requirements in their contract, over and above the 'essential standards of quality and safety', amounts to a contractual failure rather than a quality failure, i.e. it will not attract regulatory enforcement action;

Although, given that the requirement to meet the 'essential standards' set by CQC is built into the NHS Standard Contract, a failure to meet these also amounts to a contractual failure. In the case of care homes this will attract regulatory enforcement action in collaboration with Sefton Local Authority. High risk concerns with the potential of attracting media attention will be notified to the CCG SMT/SLT as and when necessary with support from communications management at NWCSU;

Once a judgment has been taken by the CCG SMT that there has been a breach, or that there is the potential to be or actual serious quality failure has come to light. The CCG's system, jointly with external colleagues relevant to the commissioned service will proactively and reactively work. This would enable and facilitate rapid, collective and informed judgments about quality and to ensure an aligned response between those with performance management, commissioning and regulatory activities to maintain quality without undermining or overriding individual accountabilities;

The CCG SMT identified lead will determine what action needs to be taken forward. The package of actions should include:

- Carrying out a rapid impact assessment of any potential regulatory action to be considered with the CQC, Local Authority and NHSE;
- Actions to be taken forward within defined timeframes: includes action to safeguard patients and improve quality of care, ensure continued service provision, securing improvements;
- How the action will be coordinated: who is the lead commissioner coordinating the process during collective discussions;
- Meeting at regular and appropriate intervals until action has been taken.

Serious Incidents:

Serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm);
- A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, IT failure or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- Allegations of abuse;
- Adverse media coverage or public concern about the organisation or the wider NHS;
- One of the core set of never events.

Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them.

These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.

The CCG has in place a Serious Incident Policy which sets out it is accountable for effective governance and learning following all Serious Incidents (SIs) relating to its commissioned services and is committed to working closely with all provider organisations and commissioning staff members to ensure SIs and Never Events are reported, investigated and acted upon by provider organisations with whom the CCG commissions/contract services

Supporting Quality Improvement in General Practices

From the 1st April 2013, Clinical Commissioning Groups (CCGs) have had a statutory duty regarding the continuous improvement of primary care. Following collaboration with a variety of stakeholders, a three year strategy focusing on quality areas for improvement based on safety, clinical effectiveness, and patient experience has been developed, and implemented. Recognising the current challenges of an increasing elderly population, rising numbers of patients with multiple long term conditions, and fragmentation of services, the strategy focuses on 5 key areas:

- Practice Demographics
- Workforce Development
- Clinical Services
- Estates / IT
- Health Outcomes

Providing an excellent service is key to the CCG's values, therefore as a member organisation securing continuous improvement in the quality of general practices would allow members to set the highest example to colleagues in the NHS.

The CCG takes its responsibility for supporting quality improvement outcomes and a positive patient experience in general practice very seriously. Supporting improvement within general practice will contribute to making the care received by the population much more sustainable.

The CCG recognises that it is important to support general practice to gain the right skills, capacity and capability to deliver high quality services and this can be done by working with the four CCG Localities to agree quality improvement plans.

A three year Local Quality Contract (LQC) has been implemented from August 1st 2014 to include services that go beyond those that practices are expected to provide under the GP contract. These services have been developed to fulfil the NHS Outcome Framework domains objectives, support the CCGs strategic priorities, and in response to patient needs. A key element of the LQC is additional access provided at GP surgeries across the CCG from October 2015. Outcomes will be measured, and an annual review of each area undertaken.

- List of schemes below

South Sefton	Southport and Formby
Primary Care Access	Primary Care Access
Review of A+E Attendances	Review of A+E Attendances
Exception Coding	Exception Coding
Community Health	Community Health
Phlebotomy	Phlebotomy
Shared Care	Shared Care
Drug Administration	Drug Administration
Data Validation	Data Validation
Ankle Brachial Pressure Index	Travellers / Gypsy Scheme
Practice Improvement Goals	Practice Improvement Goals

- CCG's Primary Care and Quality Team, supported by the Locality Managers, GP Education and Practice Development Leads are the identified leads for improving the quality of general practice.

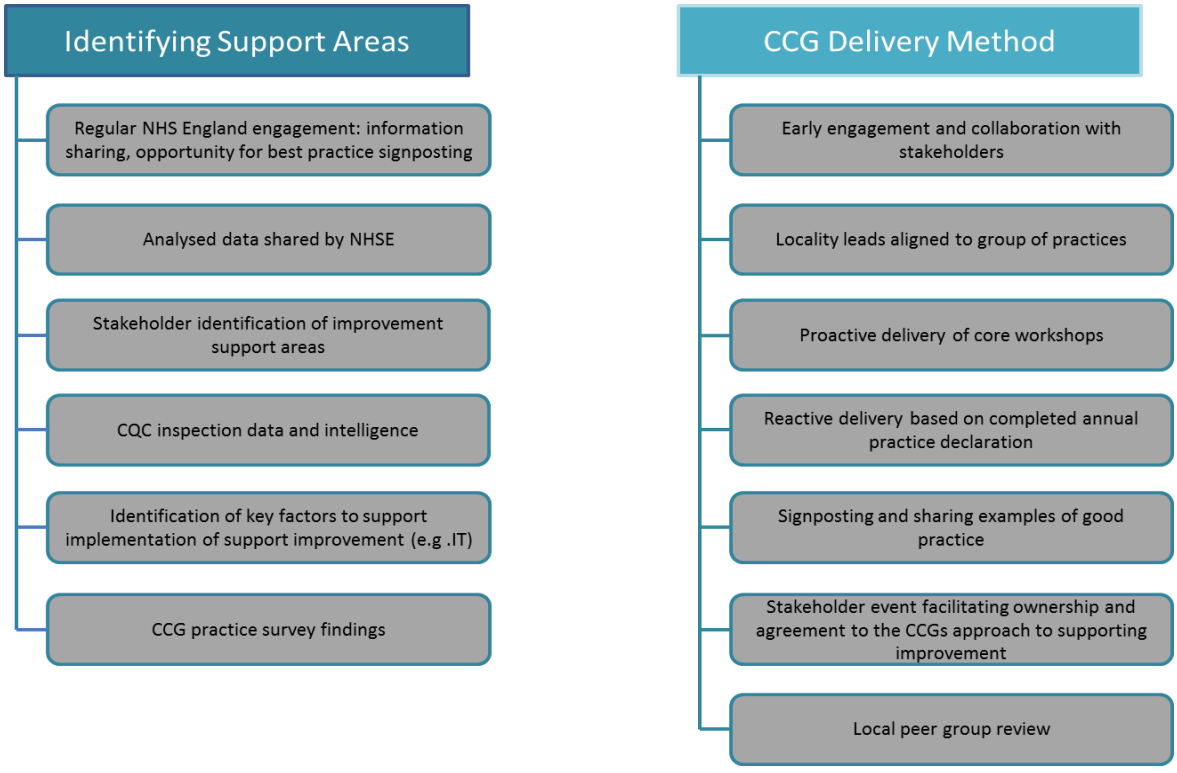
- There are four Locality Management Team and Locality Clinical Leads with specific responsibilities around identifying needs, monitoring progress and providing the support needed to ensure continuous quality improvement in their locality for all general practices in their area.

- The Locality Clinical Lead is an elected GP from the locality who also sits on the Locality Members Forum and is entitled to attend the CCG Board.

- Every GP Practice is represented on the Locality members' forums and at Locality Management Teams. There are also separate Practice Nurse Forums and Practice Managers Forums. The locality clinical leads with the locality management teams may review quality information from various sources.

- Joint working between Primary Care and Quality Team, will enable the effective delivery of the general practice support framework.

    - **The CCG is not responsible for the following:**
        - Performance and contract management of practices. This is the responsibility of the NHSE's Merseyside Area Team;
        - Identifying improvement intervention needed;
        - General practice estates management;
        - Training and development within the core contract;
        - Practice accreditation, revalidation and performer's list.
    - The CCG's coordinated approach to supporting quality improvement within general practice will be through two elements as outlined below:



- The CCG will work with its member practices to highlight the areas where the CCG can best support and facilitate improvement and to initially seek to do this via protected learning time (PLT) wider group meetings.

- The CCG will be able to offer advice and guidance to individual practices in matters concerning quality.

Future Developments

- The Practice Nurse Facilitators support nurses in general practice deliver high quality care and have a key role in the development of PLT. The Quality Team will further develop links with local HEI partners, NHSE, providers, Health Education England to support the development of the workforce of the future to deliver on the desired outcomes as identified within the strategic plan and beyond. The CCG is committed to developing the commissioning workforce of the future and is working in partnership to become an accredited hub and spoke site for student placements.

- This quality strategy will help the CCG in embedding quality into its "business as usual" by making quality the focus of every aspect of service.

- The CCG will continue to learn new and sophisticated ways of ensuring quality assurance from a commissioning perspective and from best practice.

- Or the quality strategy to be effective and successfully implemented further development needs to take place and is very much dependent on the CCG's ethos, values and actions of people matrix working across the CCG's system and at every level.

- This Quality Strategy is a live document and will be reviewed annually in line with the CCG strategy and monitored through the CCG Quality Committee to ensure momentum is maintained as it describes CCG's system.

- This quality strategy, the associated quality outcomes indicators agreed in commissioned services contract, CQC essential quality and safety standards etc. and the analysis findings against the quality strategy demonstrated within the diagram below underpins the development of the quality work plan highlighting our agreed priorities for development over the next 12 months.

- The CCG will continue to work with the LA to develop joint Quality Standards

- The CCG is committed to *Sign up to Safety*, a new national patient safety campaign that was announced in March 2014 by the Secretary of State for Health. It launched with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The CCG will commit its Safety Pledges in Q1 of 2015/16 detailing how it is:

  - Putting safety first. Commit to reduce avoidable harm in the NHS by half an make public our locally developed goals and plans

  - Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are

  - Being honest. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong

  - Collaborating. Take a lead role in supporting local collaborative learning, so that

improvements are made across all of the local services that patients use

- Being supportive. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/55	Author of the Paper: CCG Safeguarding Service Email: Des.Nurses@nhs.net Tel: 0151 495 5649
Report date: March 2015	

Title: CCG Safeguarding Strategy

Summary/Key Issues:
The purpose of this paper is to present NHS Southport & Formby CCG's Safeguarding Strategy (2015-17) to the Governing Body for approval.

Recommendation

The Governing Body is asked to approve the CCG Safeguarding Strategy.

Receive	
Approve	*x*
Ratify	

	Links to Corporate Objectives *(x those that apply)*
X	Improve quality of commissioned services, whilst achieving financial balance.
	Sustain a reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Care Closer to Home.
	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				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees	X			Presented to the Quality Committee in February 2015 – approval recommended by the Governing Body

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
March 2015

1. Executive Summary

This safeguarding strategy sets out priorities for the forthcoming years 2015-2017 and is the start of the journey to plan and commission locally delivered services that drive up quality and ensure our population receives effective, safe and personalised care.

2. Introduction and Background

2.1 The need to develop a Safeguarding Strategy was a recommendation from the CCG Safeguarding Peer Review commissioned by South Sefton, Southport & Formby and Liverpool CCGs.

2.2 The Strategy has been developed as a Merseyside wide document and reference is made within the document to the delivery of local priorities and partnership, working via the Local Safeguarding Children Board and Local Safeguarding Adult Board.

2.3 The vision for NHS Southport & Formby CCG is to maintain safe and effective safeguarding services and to strengthen arrangements for safeguarding adults and children across Sefton, working collaboratively with partner agencies. To do this the human rights, independence and well-being and secure assurance that the child or adult thought to be at risk, stays safe.

3. Conclusions

The strategy will be delivered through development and implementation of a work-plan and working alongside existing partnerships for both children and adult safeguarding. This will be monitored and reviewed through the CCG Quality Committee.

4. Recommendations

The Governing Body is asked to approve the Safeguarding Strategy

Appendices

Appendix 1- NHS Southport & Formby CCG Safeguarding Strategy (2015-17)

CCG Safeguarding Service
March 2015

NHS
Southport and Formby
Clinical Commissioning Group

NHS Southport and Formby Clinical Commissioning Group

SAFEGUARDING STRATEGY

2015- 2017

NHS Southport & Formby Commissioning Group Safeguarding Strategy

1. Introduction

This safeguarding strategy sets out our priorities for the forthcoming years 2015- 2017 and is the start of the journey to plan and commission locally delivered services that drive up quality and ensure our population receives effective, safe and personalised care. We will work in partnership to safeguard children and adults, enhancing health and well-being and protecting the rights of those in the most vulnerable situations. Patients and the quality of their care, is the focus of everything we do. We must ensure that we commission services based on the quality of care they deliver and ensure that individuals are empowered to choose services on the basis of quality and outcomes. This involves providing clear information to the public about the quality of services which are commissioned on their behalf, including information about poor quality, unexplained variation and differential health outcomes.
In addition to promoting on-going quality improvement, as commissioners, we need to be assured that existing services meet acceptable standards. Whilst regulators play a key role here, commissioners must still actively monitor the quality of services delivered by our providers. Where we are not assured about the quality of any of the services we commission, detect early warnings of a potential decline in quality or suspect a breach of unacceptable standards we have a responsibility to intervene.

1.1. NHS Southport & Formby Clinical Commissioning Group (CCG) holds the value that living a life that is free from harm and abuse is a fundamental right of every person. It acknowledges its statutory responsibility to promote the welfare of children and young people and to protect adults from abuse and risk of harm.

1.2. NHS Southport & Formby CCG will work with the Safeguarding Boards, statutory agencies and its provider organisations to ensure the effectiveness of multi-agency arrangements to safeguard and promote the well-being of children, young people and adults at risk from harm or abuse.

1.3. Evidence of continuous improvement and compliance in quality and safety outcomes for commissioned services will be achieved through the use of specific contractual arrangements and metrics with provider organisations. This will include having in place: Key Performance Indicators (KPI), CQUIN targets, quality schedules, systems to embed learning from incidents and complaints, comprehensive single and multiagency safeguarding policies and procedures and a safeguarding training strategy and framework.

1.4. In addition the CCG will support specific Francis recommendations relating to improving safety for vulnerable groups to develop an on-going culture of

quality across the health economy including assurance in relation to the legal requirements for Duty of Candour.

1.5. Safeguarding priorities are central to ensuring high quality and safe care. This strategy has been developed with reference to NHS England, Outcomes Framework 2014/15, particularly:

- Domain 4: Ensuring people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

1.6. This safeguarding strategy must be read in conjunction with the CCG Safeguarding Policy, Safeguarding Training Strategy and other relevant policies.

1.7 This strategy has been developed in collaboration with both local safeguarding boards and groups and key stakeholders locally

2. Responsibilities

2.1 Overall accountability for safeguarding within NHS Southport & Formby CCG rests with the Accountable Officer (AO). The Chief Nurse (CN) is responsible for senior clinical leadership and advocating for vulnerable groups across the CCG health economy.

2.2 The AO and CN are responsible for ensuring that robust constitution and governance arrangements are in place and maintained, and include succession planning, to ensure the delivery of all safeguarding duties and objectives.

2.3 As statutory bodies, CCGs have a responsibility for improvements in the quality of primary medical services and safeguarding services across the local economy.

2.4 NHS England and the CCG will work closely with the local authorities, Local safeguarding Children & Adult Boards to ensure there are effective NHS safeguarding arrangements across the health communities, whilst at the same time, ensuring absolute clarity about the underlining statutory responsibilities that each commissioner has for the services that they commission, together with a clear leadership role for NHS England.

3. Background

3.1. The publication of the Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework (March 2013), stated that the CCGs have the statutory responsibility for ensuring that the organisations from which they commission services, will provide a safe system that safeguards children and adults at risk of harm. The Mandate

from the Government to the NHS Commissioning Board (NHS CB) for April 2013 to March 2015 (published in November 2012) says:

"We expect to see the NHS, working together with schools and children's social services, supporting and safeguarding vulnerable, looked-after and adopted children, through a more joined-up approach to addressing their needs."

*The above quote was prior to NHS CB becoming NHS England, and as such reflects the terminology of the time.

The Mandate also sets the Governing Body a specific objective of continuing to improve safeguarding practice in the NHS, reflecting also the commitment to prevent and reduce the risk of abuse and neglect of adults.

3.2. For children and young people, the key legislation includes the Children Act (1989) and the Children Act (2004). Section 10 of the 2004 Act creates a statutory framework for local co-operation between local authorities, partner agencies and other bodies including the voluntary and community sector in order to improve the wellbeing of children in a local area.

3.3 Statutory guidance such as 'Making arrangements to promote the welfare of children under section 11 of the Children Act 2004' (2007) reinforces and describes the duties of health services. Working Together to Safeguard Children (2013) recognises the changing commissioning arrangements within the health service and lays out the role of the CCGs.

3.4 The Care Act (2014), of which Part 1 is due to be enacted in April 2015, introduces statutory arrangements in relation to adults at risk of harm and replaces the No Secrets (2000) guidance that previously provided the framework for adult safeguarding. The Care and Support statutory guidance published by the Department of Health in October 2014 supports the implementation of part 1 of the Care Act.

3.5 NHS Southport and Formby CCG is a core member of the Sefton Safeguarding Adults Board which is leading on the implementation of the Care Act on a multi-agency basis and the CCG is undertaking preparatory work in readiness for April 2015. Further key related legislation and guidance that supports safeguarding includes: Clinical Governance and Adult Safeguarding: An Integrated Process (DH, 2010) the Human Rights Act (1998) Mental Capacity Act (2005), Deprivation of Liberty Safeguards (2007) and the Domestic Violence Crime and Victims Act (2004) PREVENT (2012). This strategy recognises that this is not an exhaustive list.

3.6 Although the safeguarding frameworks for adults and children are managed separately, nationally they do often link/crossover or can run concurrently, for example in domestic abuse concerns, the Multi-Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conferences (MARAC).

3.7 The lead agency for safeguarding children and adults is the local authority whilst the National Probation Service leads on MAPPA, the Police lead on MARAC and the Community Safety Partnerships lead on domestic abuse and Domestic Homicide Reviews. Health commissioners and providers are expected to contribute to all safeguarding processes and have lead persons identified to support MAPPA and MARAC and have policies in place to respond to domestic abuse.

4. Strategy

4.1. Vision & Aim

4.1.1 The vision across NHS Southport and Formby CCG is to maintain safe and effective safeguarding services and to strengthen arrangements for safeguarding adults and children across Southport and Formby, working collaboratively with partner agencies.

4.1.2 The CCG will need to commission services that promote and protect individual human rights, independence and well-being and secure assurance that the child or adult thought to be at risk, stays safe.
They will also need to ensure that children and vulnerable adults are effectively safeguarded against abuse, neglect, discrimination, embarrassment or poor treatment, are treated with dignity and respect, and enjoy a high quality of life.

4.1.3 We know we will have achieved our vision when:
People who live and work in Southport and Formby know what signs and indicators of abuse to look out for and who to contact for advice and support.

- Local health organisations respond in a timely and effective way to concerns about abuse.
- Children and adults at risk have access to the support and services that they need from health agencies.
- Children and adults at risk have their voices heard within safeguarding procedures and services. We maximise their rights to choice and control, within the confines of their mental capacity and competence.
- Children and adults are protected when necessary and have improved quality of life as a result.

4.1.4 The CCG recognises that safeguarding children and adults is a shared responsibility and will ensure appropriate arrangements are in place to co-operate with the local authority in the operation of the safeguarding boards.

4.2. Strategic objectives

The key strategic objectives are to:

4.2.1. Provide senior and board-level leadership

- Senior leadership responsibility and lines of accountability for the CCG safeguarding arrangements are clearly outlined to employees and members of the CCG as well as to external partners
- Contribute to the work of the LSCB and LSAB and their Safeguarding Strategic Plan and provide support to ensure that the boards meet their statutory responsibilities This would include engagement with specific work streams such as Child Sexual Exploitation (CSE), the PREVENT Agenda, and implementation of the Care Act 2014 agenda which are key priority areas for Local Safeguarding Boards and CCGs including preparation for inspections across health and local authority.
- Support designated individuals to contribute to the work of the LSCB and LSAB subgroups and other national and local safeguarding implementation networks.

4.2.2. Ensure safeguarding arrangements are in place

- Integrate safeguarding within other CCG functions, such as quality and safety, patient experience, healthcare acquired infections, management of serious incidents
- Secure the expertise of designated professionals. This includes the expertise of a designated doctor for children and for looked after children and a designated paediatrician for unexpected deaths in childhood.
- Safeguarding professionals have appropriate amount of time and support to complete both individual management reviews and health overview reports
- All relevant actions identified through Serious Case Reviews (SCRs), Domestic Homicide Reviews (DHRs), Management Reviews etc. are carried out according to the timescales set out by the LSCB, LSAB and the Community Safety Partnerships (for Domestic Homicide Reviews) Panels scoping and Terms of Reference.
- There is a safeguarding adult lead and a lead for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007.

- Ensuring key priorities such as Child Sexual Exploitation, PREVENT and Female Genital Mutilation are delivered effectively locally.
- Staff including Governing Bodies are trained to embed safeguarding within the commissioning process and are able to recognise and report safeguarding concerns
- The CCG, through its designated professionals, will actively work to raise awareness of, and ensure robust arrangements are developed and in place, to address the risk and harm associated with both national and local issues.
- The CCG publicise on its website contact details for staff with specific safeguarding responsibilities, disseminate key learning and themes from local and national inquiries and provide links to signpost CCG staff and members of the public to organisations and support to safeguard adults and children at risk of or who have suffered significant harm.

4.2.3. Commission safe services:

- Ensure that all safeguarding elements are incorporated in all existing provider contracts and Service Level Agreements
- Service developments take account of the need to safeguard all patients, and are informed where appropriate, by the views of service users and by a Quality Impact Assessment
- Strengthen contractual arrangements for children and adults in 'out of area' provision for LAC and or / residential care for adults with some elements of specialist health need
- Have a clear strategy for Looked after Children (LAC) and the commissioning of appropriate services.
- Processes in place to disseminate, monitor and evaluate outcomes of all Serious Case Reviews and Domestic Homicide Reviews recommendations and actions plan within the CCG and with providers.
- Commission services which employ staff in accordance to the safer recruitment guidance.
- That demonstrates compliance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards 2007.
- Processes in place to ensure that adult care placements (such as care homes, nursing homes or independent hospitals) are based on knowledge of standards of care and safeguarding concerns by utilising intelligence from monitoring partners, such as Care Quality Commission (CQC).

- Ensure that there are effective arrangements for sharing information with partners for the protection of children and adults.
- Monitoring systems for safeguarding training and developments for all NHS providers are undertaken by the designated professionals.
- Seek assurance that commissioned providers are meeting their statutory safeguarding responsibilities, and in particular that staff are following approved NICE guidance, and considering transition of young people to adult services.

5. Deliver the strategy

5.1 A timescale will be agreed against each strategic objective and a responsible lead identified through a safeguarding work plan. This work will include additional activities as required through any review processes or changes to local and national guidance and requirements.

5.2 The CCG will ensure that its designated clinical experts are integral to decision making within the CCG and have the authority to work across local health economies, to influence and shape the culture and practice within provider services.

5.3 The CCG will, through the designated professionals, work alongside the neighbouring CCGs and Safeguarding Boards to ensure that a proactive approach is maintained both through specific work streams and also in the commissioning of services for children, looked after children and for services for adults at risk of abuse.

5.4 The strategy will be delivered through development and implementation of a work-plan and working alongside existing partnerships for both children and adult safeguarding. This will be monitored and reviewed through the CCG Quality and Performance Committee.

5.5 A timescale will be agreed against each priority, and a responsible lead identified through the safeguarding work-plan. The work plan will develop and emerge over time to include additional activity as required through any review processes or changes to either local or national guidance or requirements.

6. Monitor Assurance

6.1 The delivery of the strategy will be monitored through the Quality Committee and the development of specific action plans to report progress and provide assurance regarding delivery.

6.2. Service specifications and contract quality schedules will include clear service standards and KPIs (key performance indicators) for safeguarding

Children & Adults and promoting their welfare, consistent with the LSCB/ LSAB procedures and regular reporting on KPI compliance will be made to the CCG. The KPIs will be agreed with the provider as part of contractual negotiations and will include training level requirements, safer recruitment, supervision of staff, voice of the child, early recognition, Looked after Children, PREVENT and CSE action plans.

6.3 Service specifications and service level agreements will be reviewed annually via completion of the safeguarding audit tool to ensure safeguarding and quality elements of care are monitored effectively and consistently within provider contracts.

6.4 Contract monitoring through regular contract management meetings with providers

6.5 Where appropriate quality assurance visits to commissioned services and independent providers will be undertaken and the collation of quality and patient safety data and 'soft' intelligence will facilitate the identification, monitoring and analysis of safeguarding concerns in relation to vulnerable groups.

6.6 An Annual Report will be provided to CCG Governing Body and the Local Safeguarding Children and Adults Boards.

6.7 In line with national guidance for monitoring Quality and recognition of early warnings of service failure NHS Southport & Formby CCG will ensure the provision of safeguarding assurance for its providers through the NHS England local Quality Surveillance Group.

6.8 NHS Southport & Formby CCG will take an active role through the CN and Designated professionals in the local safeguarding assurance process with NHS England.

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/56	**Author of the Paper:**
Report date: March 2015	Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7006

Title: 2015/16 Planning Submission

Summary/Key Issues:

The CCG has revisited its current two year Operational Plan and five year Strategic Plan as part of the 2015/16 planning round informed by the new NHSE Planning Guidance issued on 24th December 2014.

These plans have considered the revision to existing plans in light of national and local pressures on A&E and admissions and reflect the discussions and agreement with the Governing Body as part of the Development Session in February 2014 and Senior Leadership Team on 10th March 2014.

The plans reflect a realistic flat 0% attribution to Non-elective activity for 2015/16. In addition activity plans related to RTT, HCAI, Cancer, Mental Health, A&E and Primary Care are set out, with descriptive supporting rationale. A full schedule of activity against the prescribed performance measures is also set out, aimed at meeting the national targets

Recommendation

Receive	
Approve	x
Ratify	

The Governing Body is asked to

Note the detail contained in the national planning guidance and the implications for the review of existing two year operational and five year operational plans.

Approve the submission of 2015/16 plans in relation to NEL activity at 0% and the re-profiled plan for future years.

Approve the submission of plans to achieve the various national performance measures including RTT, A&E, Mental Health, HCAI, Cancer and Primary Care.

Enable the necessary delegated authority via the CCG Chair, Accountable Officer, Chief Financial Officer and Chief Strategy & Outcomes Officer to progress the necessary work to enable national return requirements to me met in line with the revised planning timetable.

Links to Corporate Objectives	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Sustain reduction in non-elective admissions in 2014/15.
x	Implementation of 2014/15 phase of 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
Patient and Public Engagement	x			
Clinical Engagement	x			
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement	x			
Presented to other Committees				

Links to National Outcomes Framework	
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

Report to the Governing Body
March 2015

1. Introduction

1.1 This paper provides the Governing Body with an update on the progress, plans submissions, together with the rationale that have been used to develop the plans for 2015/2016 as part of the annual planning requirements. This builds on the paper that was presented to the Governing Body in January 2015, where an outline of the intended approach by the CCG was described.

1.2 The paper describes the plans for both South Sefton CCG and Southport and Formby CCG as part of the Sefton footprint. As such it contains and reflects the plans for both CCGs.

1.3 The approach taken by the CCG is in line with the existing two year operational and five year strategic plan and conforms to the planning guidance that was issued on the 24 December 2014 in support of the five year forward view.

1.4 In the January 2015 paper that was presented to the Governing Body, the National timetable was set out and referred to. This timetable has been revised Nationally, in large part due to the negotiations on developing a National tariff. A revised timetable was issued to the CCG on 10 March 2015 and is contained within this paper.

1.5 Previously the Governing Body supported the request for delegated authority to enable the various timetable milestones and submission requirements to be made. The need for this remains with the publication of the new timetable.

2. Background

2.1 The January update to the Governing Body described the work that the CCG has undertaken over the last 12 – 18 months in developing its strategic plan across Sefton. In considering planned submissions for 2015/2016, the CCG has affirmed and endorsed its strategic vision together with the three identified priority areas:-

1) Frail Elderly;
2) Unplanned Care;
3) Primary Care.

2.2 The CCG is now embarking upon the next stage of its strategic plan, implementation and delivery with the establishment of our “locality model” to meet the needs of the local population. The CCG commitment to the above stated priorities, now requires consideration on how best to develop and invest in key essential areas to enable service transformation and a shift in activity and resource from traditional secondary care settings to primary care, community care, intermediate care and mental health care to support;

- Self-Care;
- Avoidance of unnecessary hospital admission;
- Facilitated discharge from hospital;
- Integrated locality care through joined up local services.

2.3 It should be noted that the planning requirements for the 2015/2016 submission have changed considerably from those that were in place when the CCG developed its original two year operational and five year strategic plan twelve months ago. This is a decision that has been taken Nationally, against which the CCG is expected to conform.

2.4 The most significant change to the planning requirements from 2014/2015 to 2015/2016 relates to data sources and the counting of activity. Specifically, the previous two year operational plan and five year strategic plan was based on and arrived from MAR (monthly activity returns). MAR data is produced by providers and as such remains un-validated by commissioners and only relates to episode activity. In addition, the MAR data only referenced general and acute specialities, as such representing an incomplete subset of overall activity. The 2015/2016 plans are to be based on SUS (Secondary User Service). This SUS data has enabled the CCG to review activity in greater detail including, spells and across all specialities. In addition the SUS data is based upon spells and the dominant HRG, upon which contractual payment is ultimately made. It represents a data set that the CCG is able to validate from providers.

2.5 The change in data requirements and format has meant that it is virtually impossible to compare the previous CCG activity plan submissions as part of the 2014/2015 two year operation and five year strategic plan and the 2015/2016 plan now required by NHS England.

2.6 The CCG was asked to for its views at the end of the 2014/2015 planning round on the use of different data sets and their appropriateness and application. The feedback provided highlighted the level of dissatisfaction in using MAR based activity and advocated a shift to the use of SUS based activity. CCG feedback nationally supported this view, which has now been reflected in the 2015/2016 planning approach. However, it does pose challenges for both the CCG and in particular NHS England in their efforts to track and relate the 2015/2016 plan to the previous years.

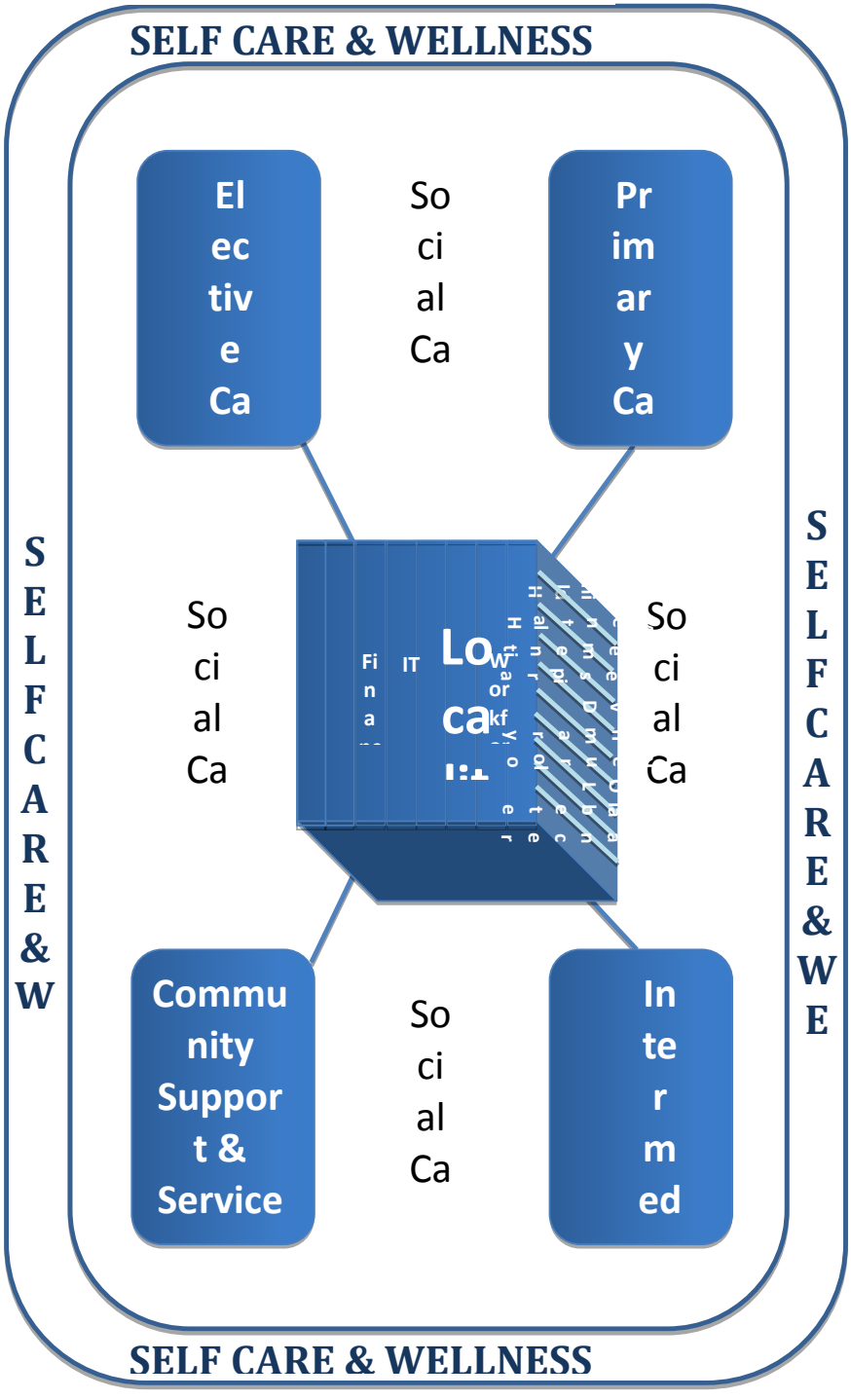
2.7 It should also be noted that at the time of developing the two year operational and five year strategic activity plans that CCG level activity was only available for the previous 12 months, with assumptions in the attribution of PCT level activity being made to the newly formed CCG footprint. This year, however a much more detailed historical picture of CCG activity is available. This has been used to inform the 2015/2016 planning submissions.

3. The Five Year Forward View

3.1 NHS England published its up-dated planning strategy in October 2014 (Five Year Forward View). This places an increasing emphasis on the prevention of ill-health and the role of public health in tackling major causes of disease. This emphasis is consistent with the CCG Strategic Plan and is in keeping with the Better Care Fund plan that has been jointly developed with Sefton Metropolitan Borough Council.

3.2 In addition, the Five Year Forward View places a resounding emphasis on self-care and local support for self-care. This is very much in keeping with the CCG locality model and adds strength to the major transformation schemes (Virtual Ward, Care Closer to Home) within the CCG strategic plan.

3.3 A focus on developing a health care system that supports individuals with multiple conditions, not just single diseases is at the heart of national policy. This is reflected in the way that the CCG is now bringing together the strategic programmes (Primary Care, Cancer, CVD, Diabetes, Children's Health, Neurology, Liver Disease, Mental Health & Dementia) in an integrated way as part of the locality model of care. This is aimed at bringing together the multiplicity of conditions that individuals may have and shaping the way in which healthcare is provided in the settings of unplanned care, elective care, community care and intermediate care. This is reflected in the diagram below.



3.4 The Five Year Forward View will present the CCG with a range of potential delivery options:

- **Multidisciplinary Community Provider:** Permitting groups of GP's to combine with Nurses and other community health services, hospital specialists, mental health and social care to create out-of-hospital integrated care;
- **Primary & Acute Care Systems:** An integrated hospital and primary care provider;
- **Urgent & Emergency Care:** Integration between A&E departments, GP out of hours services, urgent care centres, NHS 111 and ambulance services.

3.5 In keeping with the CCG priority of Primary Care, The Five Year Forward View signals a sustained commitment to list based primary care. It recognises the pressures on primary care and the need to address and stabilise core funding. The CCG has endeavoured to support this, in the first year of its strategic plan through the primary care quality contract. Future national policy aims to support the CCG in shifting investment from acute to primary and community services. This fits well with the current review of the CCG plans on activity and resources to build a sustainable approach to shifting and investment in resources.

3.6 Finally, the forward view recognises the challenging need to balance demand, efficiency and funding. Thus a review of the existing CCG strategic and financial plans is necessary to support optimum service provision, transformation in support of patient needs, within agreed funding levels and supporting QIPP delivery.

4. Planning For 2015/16

4.1 The national guidance to support CCG's in revising existing plans and strategy was published on 24th December 2014. This has prescribed a number of significant changes that the CCG has now to consider in the review of existing plans. The detail on these changes including the alterations to the business rules was described in the January 2015 paper that the Governing Body considered.

5. 2015/16 Plans

Activity plans as part of financial return

5.1 A high level activity plan formed part of the first submission on 13/01/15. As described previously, the planning requirements changed significantly in terms of data sources from MAR to SUS

5.2 For both the January and the February planning returns the data used to inform the plans was SUS except the outpatient data which used MAR because the SUS figures do not relate to the equivalent MAR figures. The official planning guidance has confirmed that the SUS definitions are yet to be defined for out patients. Referrals are also based on MAR as per the guidance.

5.3 As there is no definitive MAR measure for first outpatient all referrals all specialties a proxy has been calculated between GP first outpatient all specialties and General and Acute to gain this figure.

Overview of Planning Rationale Employed in 2014/2015 for the Two Year Operational and Five Strategic Plans

5.4 **A&E attendances -** Due to historic volatility it was originally proposed that a 0% change in 14/15 followed by -2% annually until end of 2018/19. As at the February submission, this rationale still remains until further agreement was reached on the direction of travel by the Governing Bodies.

5.5 **Unplanned admissions -** (i.e. all non-elective admissions not just those considered avoidable). As at the February submission, the rationale submitted in the original 5 year strategic plan had not been applied; the activity data was simply a roll forward of 14/15 FOT into 15/16. The same data used in the original 5 year plan was also used to plan the overarching BCF measure against which a -3.5% reduction in non-elective admissions expected during the period Q4 2014/15 – Q1 2014/15 to Q3 2015/16.

Table 1.0 Original 5 year plan trajectory (Apr 2014)

	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%

BCF Plan trajectory (Nov 2014):

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	Quarterly rate	3,090	2,977	2,978	2,848	2,958	2,885	2,885	2,739	2,920
	Num erator	8,455	8,145	8,148	7,793	8,100	7,900	7,900	7,500	8,000
	Denom inator	273,624	273,624	273,624	273,624	273,796	273,796	273,796	273,796	274,012

P4P annual change in admissions -1141
P4P annual change in admissions (%) -3.5%
P4P annual saving £1,808,485
Please enter the average cost of a non elective admission £1,585
Rationale for change from £1,490

5.6 The activity plans submitted as part of the Non Elective element of the Better Care Fund was based as per the national guidance on Non Elective (General and Acute) Finished First Consultant Episodes (FFCEs) on which the MAR is also calculated. The Better Care Fund measures activity across two financial years, but one calendar year: January-December 2015 (i.e. Q4 2014/15 – Q3 2015/16). The 'payment for performance' period is adjudged to have been successful if a 3.5% reduction on a baseline period has been achieved in the number of admissions. The original planned 3.5% reduction was equal to a reduction of 1,141 admissions. The baseline period is January-December 2014 (i.e. Q4 2013/14 – Q3 2014/15). At the time the BCF plans were submitted the baseline period was incomplete therefore national guidance was to submit a baseline based on MAR plans. Actual MAR data is now available for the baseline period which is higher than planned. This has had the effect of increasing the baseline period which means to achieve a 3.5% reduction would

require a heightened level of admissions avoided (1,218 instead of the 1,141 originally submitted).

5.7 It is proposed that the target reduction for non-electives in the BCF remains as 1,141. This equates to a 3.3% reduction as opposed to 3.5% reduction.

5.8 **Avoidable admissions.** A planned level of avoidable admissions at CCG level mirrored the Quality Premium guidance in the original 5 year plan submission. This was also a supporting measure of the BCF at Sefton level. This measure is not planned for as part of the activity and finance planning submission for 2015/16 but is simply described here as additional context.

5.9 Against the original 5 year plan which intended a 0% change in emergency admissions in 2014/15, month 8 admissions forecast to year end are projected for both CCGs to be in the region of 9% higher than the previous financial year (2013/14).

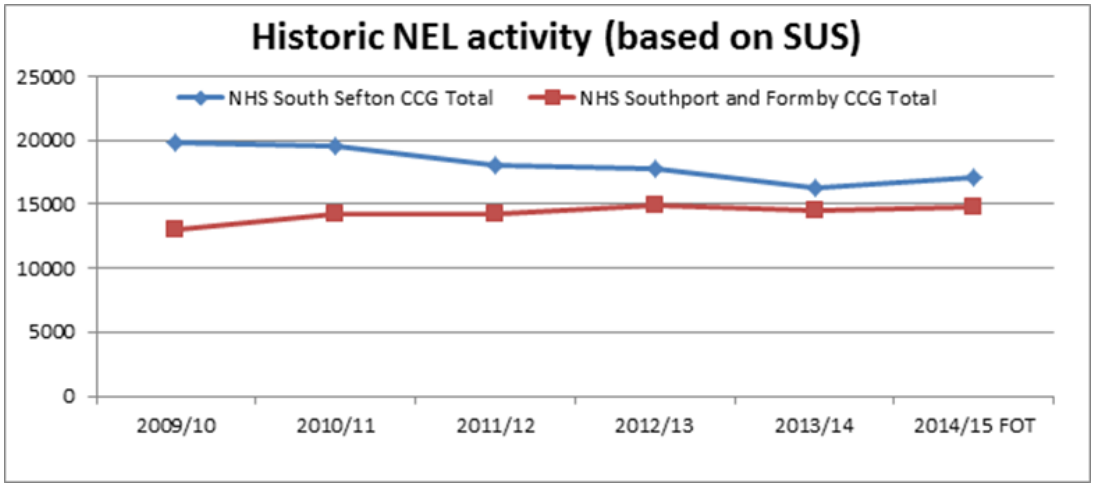
Table 2.0 Comparison of MAR Activity Changes

	2013/14 (based on month 8 forecast)	2014/15 plan	**2014/15 Actual (m8 FOT) compared to 2013/14**	2015/16 plan	2016/17 plan	2017/18 plan	2018/19 plan
South Sefton	-10.5% (-1,865 admissions from 12/13 baseline)	0%	**+9.14%**	-1.0%	-1.0%	-1.5%	-2.0%
Southport & Formby	-5.8% (-862 admissions from 12/13 baseline)	0.00%	**+9.07%**	-2.00%	-4.00%	-2.50%	-2.00%

5.10 At both CCGs Governing Body Development Sessions in February 2015, together with further consideration at the CCGs Senior Leadership Team meeting which took place on 10 March 2015, the CCGs revisited the existing strategic plan activity profile and reductions described in the table above. This analysis, based on MAR data, for comparative purposes illustrated a swing in non-elective activity from -10.5% in 2013/2014 compared to 2012/2013 baseline, to +9.14% as evidence in 2014/2015 for South Sefton CCG. Similarly for Southport and Formby CCG a swing from -.5.8% in 2013/2014 compared to 2012/2013 baseline has shifted to +9.07% in 2014/2015.

5.11 The diagram on the next page represents the trends in non-elective activity from 2009/2010. This illustrates a reduction in South Sefton related activity from 2009/2010 to 2013/2014, with an increase evident in 2014/2015. Southport and Formby illustrates an increase in non-elective activity from 2009/2010 with a further increase apparent in 2014/2015.

Table 3.0 Historic NEL Activity (based on SUS)



5.12 This volatility can be partially explained by the respective changes to the emergency pathways that have taken place at both Aintree University Hospital and Southport and Ormskirk Hospital, however it is in no way accounts for the significance. The view of the Governing Body was that, given the changes in counting activity, through pathway changes together with the changes in National requirements for planning submissions, that no robust forecast could be extrapolated at this stage. In view of this the consensus was that the existing planned profile for non-elective activity should remain flat at 0% for 2015/2016. The revised planning profile for the respective CCGs is set out in the table below.

Table 4.0 Revised 5 year CCG plan for NEL

	2015/2016 Plan	2016/2017 Plan	2017/18 plan	2018/19 plan	2019/2020 plan
South Sefton	0%	-1.0%	-1.0%	-1.5%	-2.0%
Southport & Formby	0%	-2.00%	-4.00%	-2.50%	-2.00%

5.13 The table below represents a comparative analysis between the previous CCG plans for 2015/2016, using the previously prescribed MAR dataset and the new requirement for the SUS data set. It is clearly evident that in changing the datasets that an increase is evident between the original 2015/2016 plan and the revised version (as per this years guidance). For South Sefton this represents an increase in 2437 non elective (G&A) spells. For Southport and Formby this equates to an additional 1324 non elective spells (G&A). An analysis of current utilisation based on different Points of Delivery (PODs): Non Elective, Elective (Ordinary & Day Case), Outpatients (First and Follow Up), and A&E is set out in the tables on the next page.

5.14 The rationale for January and February submissions was 2014/15 month 8 forecast to year end then replicated for 2015/16 i.e. no change. This has had the effect of 'increasing' the numbers submitted in the 2014/15 five year plan as follows:

Table 5.0 Overall CCG Plan Comparison between 2015/16 planning submission and that reflected in 2014/15, as part of the 5 year Strategic Plan

South Sefton

	Spells	Spells	Spells	Spells	Spells	Outpatients					A&E
	Non-elective spells - all specialties E.C.23	Non-elective spells - G&A E.C.4	Daycase Elective Spells - G&A E.C.2	Elective Spells - all specialties E.C.21	Ordinary Elective Spells - G&A E.C.1	All First Outpatient Attendances - all specialties E.C.24	All First Outpatient Attendances - G&A E.C.24	First Attendance following GP Referrals - all specialties E.C.25	First Attendance following GP Referrals -G&A E.C.12	All subsequent outpatient attendances - all specialties E.C.6	A&E attendances all types E.C.8
14/15 original MAR plan	-	16,177	17,920	-	3,813	-	49,327	-	27,133	-	233,521
15/16 original MAR plan	-	16,016	17,921	-	3,814	-	49,325	-	27,134	-	228,851
FOT 14/15 (m8 SUS)	21,294	18,453	18,371	22,239	3,869	54,549	48,417	26,469	23,537	134,400	54,320
NEW 15/16 SUS plan (1415 M8 FOT rolled over)	21,294	18,453	18,371	22,239	3,869	54,549	48,417	26,469	23,537	134,400	54,320
Effect of counting change: original - new 15/16 plan	-	2,437	449	-	55	-	-908	-	-3,598	-	-174,532
ACTUAL 13/14 OT (SUS)	21,772	17,417	18,663		3,934						53,566
ACTUAL 14/15 M8 FOT (MAR)	-	17,889	18,179	-	3,962	-	53,336	-	29,678	-	54,320
ACTUAL 13/14 OT (MAR)	-	16,408	18,112	-	3,845	-	49,987	-	27,553	-	53,566
% change 13/14 - 14/15 (MAR)		9.03%	0.4%		3.0%		6.7%		7.7%		1.4%
% change 13/14 - 14/15 (SUS)	-2.20%	5.95%	-1.57%		-1.66%		#DIV/0!		#DIV/0!		1.41%
Original planned % change 13/14 - 14/15 (MAR)		0%	0%		0%		0%		0%		0%

Southport & Formby **2015/16 planning requirements excludes Walk In Centre Activity hence lower number**

	Spells	Spells	Spells	Spells	Spells	Outpatients					A&E
	Non-elective spells - all specialties E.C.23	Non-elective spells - G&A E.C.4	Daycase Elective Spells - G&A E.C.2	Elective Spells - all specialties E.C.21	Ordinary Elective Spells - G&A E.C.1	All First Outpatient Attendances - all specialties E.C.24	All First Outpatient Attendances - G&A E.C.24	First Attendance following GP Referrals - all specialties E.C.25	First Attendance following GP Referrals -G&A E.C.12	All subsequent outpatient attendances - all specialties E.C.6	A&E attendances all types E.C.8
14/15 original MAR plan	-	15,611	17,168	-	3,267	-	36,993	-	23,002	-	41,342
15/16 original MAR plan	-	15,299	17,174	-	3,267	-	36,963	-	23,001	-	40,515
FOT 14/15 (m8 SUS)	17,282	16,623	17,055	20,117	3,062	48,783	43,515	25,364	22,313	115,380	39,716
NEW 15/16 SUS plan (1415 M8 FOT rolled over)	17,282	16,623	17,055	20,117	3,062	48,783	43,515	25,364	22,313	115,380	39,716
Effect of counting change: original - new 15/16 plan		1,324	-119		-206		6,552		-689		-800
ACTUAL 13/14 OT (SUS)	16,942	15,740	17,531		3,363						36,772
ACTUAL 14/15 M8 FOT (MAR)		16,766	17,588		3,075		39,519		24,621		39,716
ACTUAL 13/14 OT (MAR)		15,371	17,827		3,247		37,580		23,471		36,772
% change 13/14 - 14/15 (MAR)		9.07%	-1.3%		-5.3%		5.2%		4.9%		8.0%
% change 13/14 - 14/15 (SUS)	2.00%	5.61%	-2.72%		-8.97%		#DIV/0!		#DIV/0!		8.00%
Original planned % change 13/14 - 14/15		0%	0%		0%		0%		0%		0%

The increase above is entirely accounted for by the change in the way of counting.

Demographic Changes

5.15 In line with the previous development of CCG plans, the CCG recognised the importance of demographic changes in planning activity for the future.

5.16 Future population projections from ONS were applied to current trends to understand the impact of demography. Modest population changes are forecast over the next 5 years. The biggest percentage increase is in the over 85 age group of circa 3% per year, however in terms of the entire population of over 85s the numbers are low; circa 4,500 for South Sefton and 5,000 for Southport and Formby. Smaller percentage increases forecast in the other age groups may mean a higher number of additional people in those age groups.

Table 6.0 CCG Demographic Changes

South Sefton:

	15/16 change	16/17 change	17/18 change	18/19 change
0-19	0.00%	-0.17%	0.50%	0.32%
20-64	0.07%	-0.17%	-0.19%	-0.32%
65-74	1.28%	1.60%	0.95%	0.62%
75-84	0.46%	-0.02%	0.92%	1.85%
85+	3.50%	3.38%	3.16%	3.17%
TOTAL	0.29%	0.11%	0.25%	0.17%

Southport & Formby:

	15/16 change	16/17 change	17/18 change	18/19 change
0-19	0.08%	-0.08%	0.57%	0.34%
20-64	0.08%	-0.15%	-0.09%	-0.25%
65-74	1.27%	1.49%	0.88%	0.61%
75-84	0.48%	0.05%	0.95%	1.83%
85+	3.48%	3.36%	3.33%	3.15%
TOTAL	0.41%	0.24%	0.41%	0.32%

5.17 When applied to current utilisation the changes to activity are small. This is evident in the diagrams on the next page.

Diagram 1.0 South Sefton Demographic Changes applied to Points of Delivery

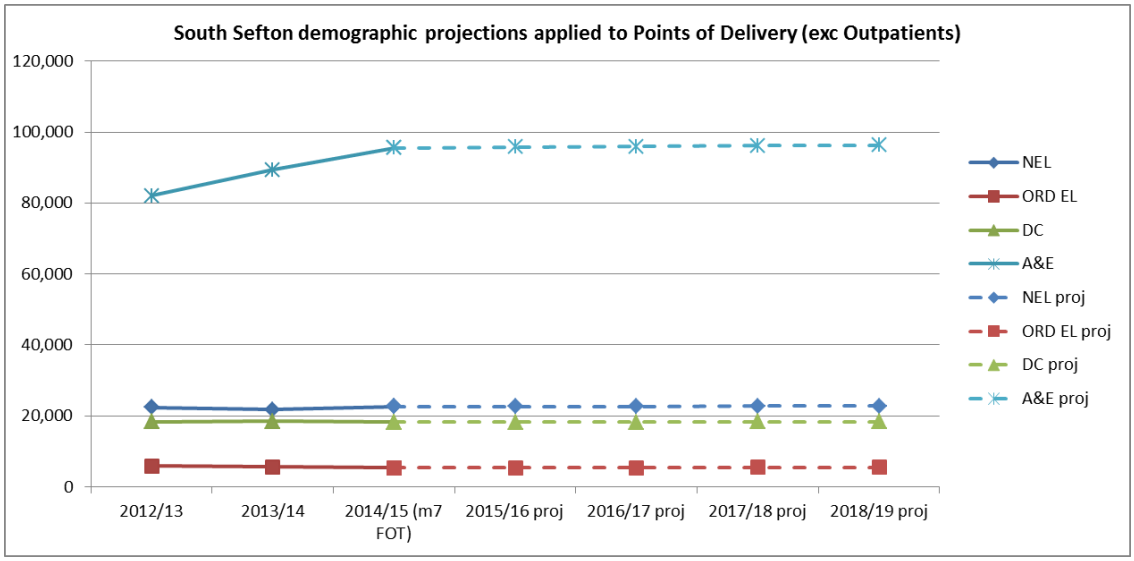


Diagram 2.0 South Sefton Demographic Changes applied to Out Patients

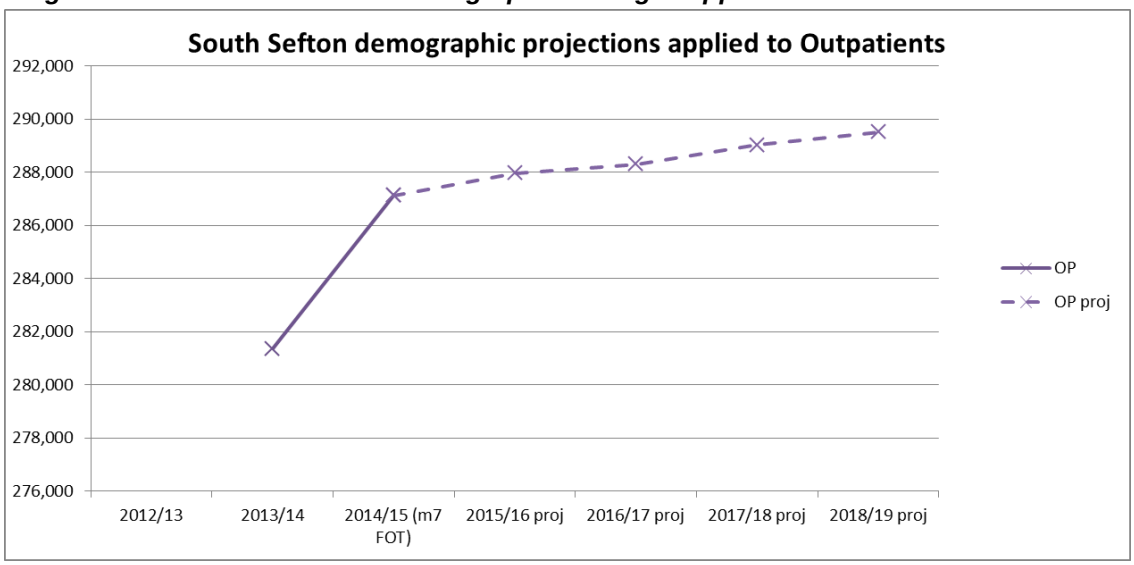


Diagram 3.0 Southport & Formby CCG Demographic Changes applied to Points of Delivery

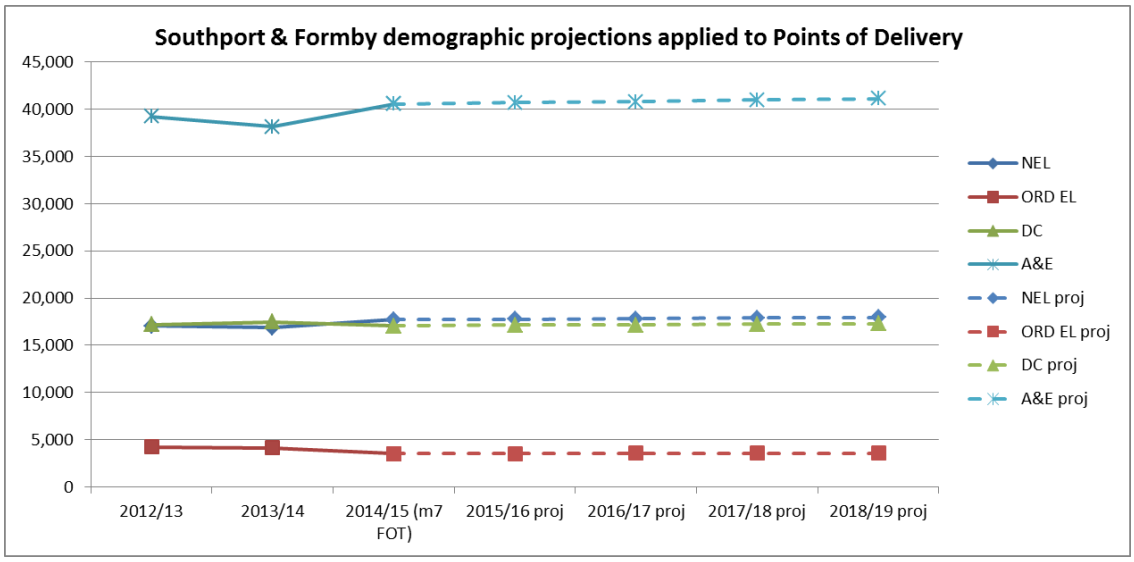
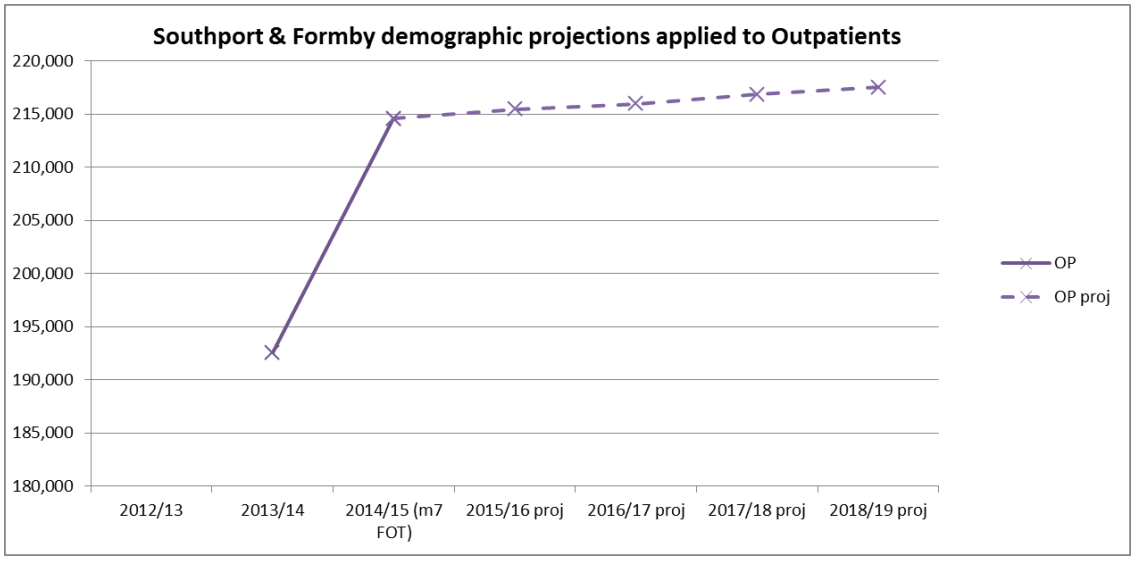


Diagram 4.0 Southport & Formby Demographic Changes applied to Outpatients



5.18 The demographic changes have been reflected in the 2015/2016 plan.

5.19 **Managing elective activity**: The CCG considered an approach to inform changes to elective plans. This included the management of follow up outpatient ratios to either current agreed contract values or to the national average, for particular specialties at specific providers. If this approach were to be adopted it would also have a

prospective influence on future elective activity. Applying a specified level of first OP attendances (based on Better Care Better Value), and managing the contract activity planning assumptions to this, the current OP:EL conversion rates could be applied to elective activity.

5.20 Clinical board members felt the peer group CCGs proposed for Southport & Formby CCG were not similar enough therefore further work is being undertaken to look at different peers as proposed by the vice chair.

5.21 Further work is being undertaken in relation to South Sefton CCG with Clinical Governing Body Members to consider a clinical approach to outpatients that maybe adopted going forward.

6. Performance Measures

6.1 A further planning submission was made on January 28th outlining plans and trajectories for a number of measures relating to the NHS Constitution, Primary Care and Other Measures.

Referral to Treatment (RTT)

6.2 The following ***Referral to Treatment*** measures are contained within the 2015/16 planning submission;

- ***EB1 RTT*** *– The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis.*
- ***EB2 RTT*** *- The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.*
- ***EB3 RTT*** *- The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.*
- ***EB4*** *- Diagnostics Test Waiting Times*

6.3 The Tables on the next page describe the planned performance and trajectories for the respective CCG's.

Table 7.0 Southport & Formby Plans

8.8.1			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis	2013-14	Completed pathways < 18 weeks	633	626	643	667	518	636	612	641	535	694	666	726
		Total Completed Pathways	686	679	714	740	566	714	726	756	632	788	758	770
		%	92.1%	92.2%	90.1%	92.8%	91.5%	91.9%	84.3%	84.8%	84.8%	88.1%	90.5%	94.3%
	2014-15	Completed pathways < 18 weeks	650	666	628	656	550	656	-	-	-	-	-	-
		Total Completed Pathways	719	726	663	704	591	697	-	-	-	-	-	-
		%	94.6%	95.8%	94.7%	93.2%	93.1%	94.1%	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	671	677	620	647	543	647	645	672	579	700	677	716
		Total Completed Pathways	709	706	654	695	583	688	716	746	645	777	745	760
		%	94.6%	95.9%	94.8%	93.1%	93.1%	94.0%	90.1%	90.1%	90.0%	90.1%	90.5%	94.2%

8.8.2			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.	2013-14	Completed pathways < 18 weeks	2407	2352	2200	2375	2128	2405	2677	2523	2097	2776	2445	2546
		Total Completed Pathways	2451	2403	2250	2453	2200	2581	2765	2606	2178	2847	2515	2596
		%	97.0%	97.9%	97.8%	96.8%	96.7%	96.6%	96.8%	96.8%	96.3%	97.5%	97.3%	98.1%
	2014-15	Completed pathways < 18 weeks	2366	2345	2715	2821	2336	2721	-	-	-	-	-	-
		Total Completed Pathways	2414	2391	2765	2875	2386	2782	-	-	-	-	-	-
		%	98.0%	98.1%	98.2%	98.1%	98.0%	97.8%	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	2506	2385	2646	2749	2276	2652	2809	2459	2043	2705	2385	2481
		Total Completed Pathways	2552	2430	2694	2802	2325	2711	2894	2539	2122	2774	2451	2530
		%	98.0%	98.1%	98.2%	98.1%	98.0%	97.8%	96.8%	96.8%	96.3%	97.5%	97.3%	98.1%

8.8.3			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	2013-14	Incomplete Pathways < 18 weeks	6054	6197	6130	6429	6467	6205	6565	6115	5964	5716	5670	5639
		Total Incomplete Pathways	6434	6539	6455	6783	6835	6528	6931	6427	6250	5915	5822	5790
		%	94.1%	94.8%	94.5%	94.8%	94.6%	95.1%	95.3%	95.1%	95.7%	96.6%	97.4%	97.4%
	2014-15	Incomplete Pathways < 18 weeks	5797	6154	6176	6265	6195	6239	-	-	-	-	-	-
		Total Incomplete Pathways	5950	6312	6309	6397	6359	6432	-	-	-	-	-	-
		%	97.4%	97.5%	97.9%	97.9%	97.4%	97.0%	-	-	-	-	-	-
	2015/16 Plan	Incomplete Pathways < 18 weeks	5915	6260	6502	6595	6521	6566	6495	6255	6106	5835	5766	5734
		Total Incomplete Pathways	6071	6441	6455	6535	6459	6565	6617	6355	6175	6036	5941	5905
		%	97.4%	97.5%	97.9%	97.9%	97.4%	97.0%	95.3%	95.1%	95.7%	96.6%	97.4%	97.4%

8.8.4			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
Diagnostics Test Waiting Times	2013-14	Number waiting > 6 weeks	3	3	5	3	7	11	20	23	9	7	6	6
		Total Number waiting	1517	1567	1646	1565	1536	1662	1579	1659	1525	1286	1767	1764
		%	0.2%	0.2%	0.3%	0.2%	0.5%	0.7%	1.3%	1.4%	0.6%	0.5%	0.3%	0.3%
	2014-15	Number waiting > 6 weeks	6	7	2	5	17	8	-	-	-	-	-	-
		Total Number waiting	1914	1961	1816	2061	2029	2154	-	-	-	-	-	-
		%	0.3%	0.4%	0.1%	0.2%	0.8%	0.4%	-	-	-	-	-	-
	2015/16 Plan	Number waiting > 6 weeks	5	7	2	5	11	7	17	15	10	5	7	7
		Total Number waiting	1695	1545	1857	1772	1714	1677	1762	1529	1705	1455	1972	1959
		%	0.3%	0.5%	0.1%	0.2%	0.6%	0.4%	1.0%	1.0%	0.6%	0.5%	0.4%	0.4%

Table 8.0 South Sefton RTT Plans

8.8.1			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis	2013-14	Completed pathways < 18 weeks	719	746	722	765	612	721	761	751	591	795	711	747
		Total Completed Pathways	785	794	766	815	641	766	817	792	627	861	773	801
		%	91.6%	94.0%	95.3%	93.6%	95.5%	93.9%	93.1%	92.3%	94.3%	92.3%	92.0%	93.3%
	2014-15	Completed pathways < 18 weeks	664	629	665	805	656	738	-	-	-	-	-	-
		Total Completed Pathways	715	665	716	860	662	796	-	-	-	-	-	-
		%	93.1%	94.9%	95.8%	93.6%	93.3%	92.7%	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	664	629	665	806	656	739	762	752	591	796	711	745
		Total Completed Pathways	715	665	716	861	662	797	816	795	627	862	774	802
		%	93.1%	94.9%	95.8%	93.6%	93.3%	92.7%	93.2%	92.3%	94.3%	92.3%	91.9%	93.3%

8.8.2			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.	2013-14	Completed pathways < 18 weeks	5415	5344	2956	3535	2753	3214	3573	3450	2779	3594	3250	3545
		Total Completed Pathways	5459	5201	3015	3615	2796	3300	3655	3538	2832	3668	3315	3424
		%	97.9%	98.2%	98.2%	97.8%	97.7%	97.4%	97.8%	97.5%	98.1%	97.9%	98.0%	97.6%
	2014-15	Completed pathways < 18 weeks	5185	5152	5444	3660	2744	3601	-	-	-	-	-	-
		Total Completed Pathways	5245	5220	5519	3951	2829	3737	-	-	-	-	-	-
		%	98.2%	97.9%	97.9%	97.7%	97.0%	96.4%	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	5135	5103	5390	3800	2701	3545	3517	3396	2736	3541	3199	3291
		Total Completed Pathways	5194	5170	5464	3889	2785	3679	3595	3465	2785	3414	3263	3371
		%	98.2%	97.9%	97.9%	97.7%	97.0%	96.4%	97.7%	97.5%	98.1%	97.9%	98.0%	97.6%

8.8.3			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	2013-14	Incomplete Pathways < 18 weeks	8077	7169	7451	7639	8306	7985	7604	7635	7482	7725	7257	7626
		Total Incomplete Pathways	8306	7376	7626	8047	8562	8206	7840	7915	7752	7945	7500	7897
		%	97.3%	97.2%	97.7%	97.4%	97.0%	97.0%	97.0%	96.5%	96.5%	97.0%	96.8%	96.6%
	2014-15	Incomplete Pathways < 18 weeks	7456	7758	7975	7662	8126	8339	-	-	-	-	-	-
		Total Incomplete Pathways	7729	8062	8267	8013	8491	8735	-	-	-	-	-	-
		%	96.5%	96.0%	96.4%	95.9%	95.7%	95.5%	-	-	-	-	-	-
	2015/16 Plan	Incomplete Pathways < 18 weeks	7456	7760	7975	7664	8128	8341	7606	7640	7484	7707	7259	7635
		Total Incomplete Pathways	7731	8064	8269	8015	8494	8736	7842	7917	7754	7945	7502	7899
		%	96.5%	96.0%	96.4%	95.9%	95.7%	95.5%	97.0%	96.5%	96.5%	97.0%	96.8%	96.6%

8.8.4			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
Diagnostics Test Waiting Times	2013-14	Number waiting > 6 weeks	16	14	17	22	15	7	17	10	22	29	23	16
		Total Number waiting	2256	2343	2252	2276	2060	1427	2050	1671	2063	2014	2122	2066
		%	0.7%	0.6%	0.8%	1.0%	0.6%	0.5%	0.8%	0.5%	1.1%	1.4%	1.1%	0.9%
	2014-15	Number waiting > 6 weeks	16	11	18	9	23	15	-	-	-	-	-	-
		Total Number waiting	1955	1994	1966	1952	1904	2185	-	-	-	-	-	-
		%	0.8%	0.6%	0.9%	0.5%	1.2%	0.7%	-	-	-	-	-	-
	2015/16 Plan	Number waiting > 6 weeks	16	12	18	10	19	15	17	9	21	20	21	19
		Total Number waiting	2012	2021	1995	1978	1950	2215	2078	1896	2111	2041	2151	2134
		%	0.8%	0.6%	0.9%	0.5%	1.0%	0.7%	0.8%	0.5%	1.0%	1.0%	1.0%	0.9%

6.4 The plans for the measures above are based on an average month of total patients on pathway, of the total April 13 - Sept 14 worked up to full year effect. This was then split by month which has been worked out using a % split from the months Oct 13 through to Sept 14 (latest 12 month's data). The numerator will either equal the latest data target we have if above the target or be made to equal the target where below.

6.5 **A&E 4 Hour Target:** In addition to the above, the 2015/16 plans require the CCG to submit ***A&E Waiting*** times (*EB5: A&E Waiting Time).* These are set out in the tables below.

Table 9.0 Southport & Formby A&E Plans

			Quarter 1	Quarter 2	Quarter 3	Quarter 4
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	2013-14	Number waiting > 4 hours	1579	723	648	1040
		Total Attendances	23877	24986	27844	27984
		% < 4 hours	**93.4%**	**97.1%**	**97.7%**	**96.3%**
	2014-15	Number waiting > 4 hours	873	758	-	-
		Total Attendances	29746	29680	-	-
RVY		% < 4 hours	**97.1%**	**97.4%**	-	-
	2015/16 Plan	Number waiting > 4 hours	1487	1484	1392	1399
		Total Attendances	29746	29680	27844	27984
		% < 4 hours	**95.0%**	**95.0%**	**95.0%**	**95.0%**

Table 10.0 South Sefton A&E Plans

			Quarter 1	Quarter 2	Quarter 3	Quarter 4
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	2013-14	Number waiting > 4 hours	1232	517	1069	1258
		Total Attendances	20769	19683	23932	27008
		% < 4 hours	**94.1%**	**97.4%**	**95.5%**	**95.3%**
	2014-15	Number waiting > 4 hours	2208	2117	-	-
		Total Attendances	28096	27625	-	-
REM		% < 4 hours	**92.1%**	**92.3%**	-	-
	2015/16 Plan	Number waiting > 4 hours	1452	1428	1237	1396
		Total Attendances	29056	28569	24750	27931
		% < 4 hours	**95.0%**	**95.0%**	**95.0%**	**95.0%**

6.6 Plans for the measure above are based on an average quarter of total patients attending A&E, of the total April 13 - Sept 14 worked up to full year effect. This was then split by quarter which has been worked out using a % split from the months Oct 13 through to Sept 14 (latest 12 months' data). The numerator will either equal the latest data target we have if above the target or be made to equal the target where below.

6.7 An adjustment was made to South Sefton's submission which is at Trust level (i.e. Aintree) to account for the effect of St Chads Walk In Centre late on 2013. This involved taking Q4 13/14, Q1 14/15 and Q2 14/15 and averaging the total attendances to a single quarter. Then multiplying by 4 to create a full year effect and then split by the percentage usage between Q3 13/14 and Q2 14/15.

6.8 An adjustment was also made to Southport & Formby's submission (i.e. Southport & Ormskirk) due to increases in activity throughout the year from Q1 13/14 to Q3 14/15. The total attendances between Q1 13/14 to Q2 14/15 were summed then divide by 6 to get a monthly average, then multiplied by 4 to create full year effect and then use % split between Q3 13/14 - Q2 14/15 to create the quarterly trajectory.

Cancer Targets

6.9 The following Cancer Performance measures are also included within the 2015/16 planning submission.

- *EB6 Cancer: All cancers 2 week wait*
- *EB7 Cancer: Two week wait for breast symptoms (where cancer not initially suspected)*
- *EB8 Cancer: Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis.*
- *EB9 Cancer: 31 Day standard for subsequent cancer treatments –surgery*
- *EB10 Cancer: 31 Day standard for subsequent cancer treatments -anti cancer drug regimens*
- *EB11 Cancer: 31 Day standard for subsequent cancer treatments - radiotherapy*
- *EB12 Cancer: All cancer 62 day urgent referral to first treatment wait*
- *EB13 Cancer: 62 day wait for first treatment following referral from an NHS cancer screening service*
- *EB14 Cancer: 62 day wait for first treatment for cancer following a consultant's decision to upgrade the patients priority*

6.10 The planned performance for the respective CCG's is set out in the tables on the next page.

Table 11.0 Southport & Formby Cancer Plans

E.B.6			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer- All Cancer two week wait	2013-14	Number waiting < 2 weeks	922	1003	1127	1029
		Total number waiting	988	1085	1191	1081
		%	93.3%	92.4%	94.6%	95.2%
	2014-15	Number waiting < 2 weeks	1044	1065	-	-
		Total number waiting	1070	1103	-	-
		%	97.6%	96.6%	-	-
	2015/16 Plan	Number waiting < 2 weeks	1021	1041	1101	1006
		Total number waiting	1046	1078	1164	1057
		%	97.6%	96.6%	94.6%	95.2%

E.B.7			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - Two week wait for breast symptoms (where cancer not initially suspected)	2013-14	Number waiting < 2 weeks	143	137	160	158
		Total number waiting	168	154	171	160
		%	85.1%	89.0%	93.6%	98.8%
	2014-15	Number waiting < 2 weeks	133	144	-	-
		Total number waiting	144	155	-	-
		%	92.4%	92.9%	-	-
	2015/16 Plan	Number waiting < 2 weeks	135	146	161	159
		Total number waiting	145	156	172	161
		%	93.1%	93.6%	93.6%	98.8%

E.B.12			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - All cancer 62 day urgent referral to first treatment wait	2013-14	Number waiting < 62 days	79	88	74	82
		Total number waiting	96	108	89	101
		%	82.3%	81.5%	83.1%	81.2%
	2014-15	Number waiting < 62 days	86	75	-	-
		Total number waiting	101	94	-	-
		%	85.1%	79.8%	-	-
	2015/16 Plan	Number waiting < 62 days	88	82	78	88
		Total number waiting	103	96	91	103
		%	85.4%	85.4%	85.7%	85.4%

E.B.13			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 62 day wait for first treatment following referral from an NHS cancer screening service	2013-14	Number waiting < 62 days	15	7	10	4
		Total number waiting	15	7	10	5
		%	100.0%	100.0%	100.0%	80.0%
	2014-15	Number waiting < 62 days	13	3	-	-
		Total number waiting	13	3	-	-
		%	100.0%	100.0%	-	-
	2015/16 Plan	Number waiting < 62 days	9	9	9	9
		Total number waiting	9	9	9	9
		%	100.0%	100.0%	100.0%	100.0%

E.B.14			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 62 day wait for first treatmnet for cancer following a consultant's decision to upgrade the patients priority	2013-14	Number waiting < 62 days	7	6	13	6
		Total number waiting	10	7	15	8
		%	70.0%	85.7%	86.7%	75.0%
	2014-15	Number waiting < 62 days	8	15	-	-
		Total number waiting	9	16	-	-
		%	88.9%	93.8%	-	-
	2015/16 Plan	Number waiting < 62 days	10	10	10	9
		Total number waiting	11	11	11	11
		%	90.9%	90.9%	90.9%	81.8%

E.B.8			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis.	2013-14	Number waiting < 31 days	203	207	206	196
		Total number waiting	207	210	207	203
		%	98.1%	98.6%	99.5%	96.6%
	2014-15	Number waiting < 31 days	213	178	-	-
		Total number waiting	214	182	-	-
		%	99.5%	97.8%	-	-
	2015/16 Plan	Number waiting < 31 days	215	180	208	198
		Total number waiting	216	184	209	205
		%	99.5%	97.8%	99.5%	96.6%

E.B.9			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - surgery	2013-14	Number waiting < 31 days	44	32	32	37
		Total number waiting	45	34	32	39
		%	97.8%	94.1%	100.0%	94.9%
	2014-15	Number waiting < 31 days	40	31	-	-
		Total number waiting	41	31	-	-
		%	97.6%	100.0%	-	-
	2015/16 Plan	Number waiting < 31 days	41	32	33	38
		Total number waiting	42	32	33	40
		%	97.6%	100.0%	100.0%	95.0%

E.B.10			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - anti cancer drug regimens	2013-14	Number waiting < 31 days	79	70	69	75
		Total number waiting	79	72	69	77
		%	100.0%	97.2%	100.0%	97.4%
	2014-15	Number waiting < 31 days	59	66	-	-
		Total number waiting	59	67	-	-
		%	100.0%	98.5%	-	-
	2015/16 Plan	Number waiting < 31 days	61	68	72	78
		Total number waiting	61	69	72	78
		%	100.0%	98.6%	100.0%	100.0%

E.B.11			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - radiotherapy	2013-14	Number waiting < 31 days	55	78	56	64
		Total number waiting	57	79	57	67
		%	96.5%	98.7%	98.2%	95.5%
	2014-15	Number waiting < 31 days	61	67	-	-
		Total number waiting	65	68	-	-
		%	93.8%	98.5%	-	-
	2015/16 Plan	Number waiting < 31 days	63	68	57	65
		Total number waiting	66	69	58	68
		%	95.5%	98.6%	98.3%	95.6%

Table 12.0 South Sefton Cancer Plans

E.B.6			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer- All Cancer two week wait	2013-14	Number waiting < 2 weeks	1313	1448	1603	1442
		Total number waiting	1350	1521	1652	1489
		%	97.3%	95.2%	97.0%	96.8%
	2014-15	Number waiting < 2 weeks	1315	1354	-	-
		Total number waiting	1375	1456	-	-
		%	95.6%	93.0%	-	-
	2015/16 Plan	Number waiting < 2 weeks	1298	1337	1582	1423
		Total number waiting	1357	1437	1631	1470
		%	95.7%	93.0%	97.0%	96.8%

E.B.7			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - Two week wait for breast symptoms (where cancer not initially suspected)	2013-14	Number waiting < 2 weeks	148	125	117	158
		Total number waiting	154	136	121	169
		%	96.1%	91.9%	96.7%	93.5%
	2014-15	Number waiting < 2 weeks	261	265	-	-
		Total number waiting	271	278	-	-
		%	96.3%	95.3%	-	-
	2015/16 Plan	Number waiting < 2 weeks	192	168	152	205
		Total number waiting	200	176	157	219
		%	96.0%	95.5%	96.8%	93.6%

E.B.12			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - All cancer 62 day urgent referral to first treatment wait	2013-14	Number waiting < 62 days	81	105	98	70
		Total number waiting	94	118	116	81
		%	86.2%	89.0%	84.5%	86.4%
	2014-15	Number waiting < 62 days	92	92	-	-
		Total number waiting	105	107	-	-
		%	87.6%	86.0%	-	-
	2015/16 Plan	Number waiting < 62 days	93	93	100	71
		Total number waiting	106	108	117	82
		%	87.7%	86.1%	85.5%	86.6%

E.B.13			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 62 day wait for first treatment following referral from an NHS cancer screening service	2013-14	Number waiting < 62 days	4	13	27	13
		Total number waiting	6	13	27	14
		%	66.7%	100.0%	100.0%	92.9%
	2014-15	Number waiting < 62 days	9	28	-	-
		Total number waiting	10	28	-	-
		%	90.0%	100.0%	-	-
	2015/16 Plan	Number waiting < 62 days	15	16	16	15
		Total number waiting	16	16	16	16
		%	93.8%	100.0%	100.0%	93.8%

E.B.14			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 62 day wait for first treatmnet for cancer following a consultant's decision to upgrade the patients priority	2013-14	Number waiting < 62 days	15	10	13	15
		Total number waiting	18	10	13	16
		%	83.3%	100.0%	100.0%	93.8%
	2014-15	Number waiting < 62 days	8	15	-	-
		Total number waiting	8	16	-	-
		%	100.0%	93.8%	-	-
	2015/16 Plan	Number waiting < 62 days	14	13	14	13
		Total number waiting	14	14	14	14
		%	100.0%	92.9%	100.0%	92.9%

E.B.8			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis.	2013-14	Number waiting < 31 days	191	223	248	217
		Total number waiting	196	227	253	222
		%	97.4%	98.2%	98.0%	97.7%
	2014-15	Number waiting < 31 days	207	249	-	-
		Total number waiting	211	252	-	-
		%	98.1%	98.8%	-	-
	2015/16 Plan	Number waiting < 31 days	200	241	240	210
		Total number waiting	204	244	245	215
		%	98.0%	98.8%	98.0%	97.7%

E.B.9			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - surgery	2013-14	Number waiting < 31 days	40	32	47	37
		Total number waiting	40	33	48	37
		%	100.0%	97.0%	97.9%	100.0%
	2014-15	Number waiting < 31 days	38	33	-	-
		Total number waiting	40	33	-	-
		%	95.0%	100.0%	-	-
	2015/16 Plan	Number waiting < 31 days	37	32	46	36
		Total number waiting	39	32	47	36
		%	94.9%	100.0%	97.9%	100.0%

E.B.10			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - anti cancer drug regimens	2013-14	Number waiting < 31 days	94	100	110	105
		Total number waiting	96	100	110	107
		%	97.9%	100.0%	100.0%	98.1%
	2014-15	Number waiting < 31 days	127	95	-	-
		Total number waiting	127	95	-	-
		%	100.0%	100.0%	-	-
	2015/16 Plan	Number waiting < 31 days	122	92	106	101
		Total number waiting	122	92	106	103
		%	100.0%	100.0%	100.0%	98.1%

E.B.11			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Cancer - 31 Day standard for subsequent cancer treatments - radiotherapy	2013-14	Number waiting < 31 days	77	65	89	65
		Total number waiting	80	70	90	66
		%	96.3%	92.9%	98.9%	98.5%
	2014-15	Number waiting < 31 days	63	79	-	-
		Total number waiting	65	83	-	-
		%	96.9%	95.2%	-	-
	2015/16 Plan	Number waiting < 31 days	63	79	89	65
		Total number waiting	65	83	90	66
		%	96.9%	95.2%	98.9%	98.5%

6.11 The plans for the measures above are quarterly and based on an average quarter of total patients on pathway, of the total April 13 - Sept 14 worked up to full year effect. This was then split by quarter which has been worked out using a % split from the months Oct 13 through to Sept 14 (latest 12 month's data). The numerator will either equal the latest data target we have if we already achieve above the target or be made to equal the target where we currently perform below.

7. Mental Health Performance

7.1 The 2015/16 plan submission also includes existing mental health targets in relation to IAPT. The plans for the respective CCG's are set out in the tables below.

***Table 13.0 Southport & Formby Plan** (EA3: IAPT Access).*

E.A.3			Quarter 1	Quarter 2	Quarter 3	Quarter 4
IAPT Access - Roll Out	2013-14	The number of people who receive psychological therapies	367	373	348	405
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	19079	19079	19079	19079
		% per quarter (e.g. 3.75%)	1.92%	1.96%	1.82%	2.12%
	2014-15	The number of people who receive psychological therapies	450	-	-	-
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	19079	-	-	-
		% per quarter (e.g. 3.75%)	2.36%	-	-	-
	2015-16 Previous plan (from year 2 of 14/15 to 18/19	The number of people who receive psychological therapies	2862			
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	19079			
		% annual	15.00%			
	2015-16 Plan	The number of people who receive psychological therapies	716	716	716	716
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	19079	19079	19079	19079
		% per quarter (e.g. 3.75%)	**3.75%**	**3.75%**	**3.75%**	**3.75%**

***Table 14.0 South Sefton Plan** (EA3: IAPT Access).*

E.A.3			Quarter 1	Quarter 2	Quarter 3	Quarter 4
IAPT Access - Roll Out	2013-14	The number of people who receive psychological therapies	556	482	562	585
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	24298	24298	24298	24298
		% per quarter (e.g. 3.75%)	2.29%	1.98%	2.31%	2.41%
	2014-15	The number of people who receive psychological therapies	580	-	-	-
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	24298	-	-	-
		% per quarter (e.g. 3.75%)	2.39%	-	-	-
	2015-16 Previous plan (from year 2 of 14/15 to 18/19	The number of people who receive psychological therapies	3645			
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	24298			
		% annual	15.00%			
	2015-16 Plan	The number of people who receive psychological therapies	912	912	912	912
		The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).	24298	24298	24298	24298
		% per quarter (e.g. 3.75%)	**3.75%**	**3.75%**	**3.75%**	**3.75%**

7.2 The standard denominator is taken as per the guidance from national Mental Health Morbidity survey in 2000, and a target of 3.75% per quarter used in order to achieve the 15% annual target set nationally.

Table 15.0 Southport & Formby Plan *(EAS2: IAPT Recovery)*

E.A.S.2			Quarter 1	Quarter 2	Quarter 3	Quarter 4
IAPT Recovery Rate	2013-14	The number of people who have completed treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	-	143	124	105
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	-	290	269	205
		%		49.3%	46.1%	51.2%
	2014-15	The number of people who have completed treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	150	-	-	-
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	280	-	-	-
		%	53.6%	-	-	-
	2015-16 Previous plan (from year 2 of 14/15 to 18/19 planning round)	The number of people who finish treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	1174			
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	2348			
		%	50.0%			
	2015-16 Plan	The number of people who finish treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	322	322	322	322
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	644	644	644	644
		%	**50.0%**	**50.0%**	**50.0%**	**50.0%**

Table 16.0 South Sefton Plan *(EAS2: IAPT Recovery)*

E.A.S.2			Quarter 1	Quarter 2	Quarter 3	Quarter 4
IAPT Recovery Rate	2013-14	The number of people who have completed treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	-	175	180	175
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	-	388	405	395
		%		45.1%	44.4%	44.3%
	2014-15	The number of people who have completed treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	180	-	-	-
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	420	-	-	-
		%	42.9%	-	-	-
	2015-16 Previous plan (from year 2 of 14/15 to 18/19 planning round)	The number of people who finish treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	1494			
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	2988			
		%	50.0%			
	2015-16 Plan	The number of people who finish treatement having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved 'caseness' and at final session did not)	429	429	429	429
		The number of people who finish treatement having attended at least two treatment contacts and coded as discharged) minus (The number of people who finish treatment not at clinical caseness at initial assessment)	857	857	857	857
		%	**50.1%**	**50.1%**	**50.1%**	**50.1%**

7.3 The national target is for 50% recovery rate but an adjustment has been made for "caseness". Caseness is the threshold at which it is appropriate to initiate treatment and some patients may not reach that threshold so should be excluded from recovery calculations. Recovery is defined as movement to a score below caseness from a score of caseness or above when pre and post treatment questionnaires have been carried out. In Q1-Q3 of 2014/15 10% of Southport and Formby and 6% of South Sefton patients did not reach caseness, therefore the number of patients entering therapy for the calculation of the recovery rate has been reduced by the same amounts (6% and 10%) and then the 50% target applied.

IAPT Waiting Times

7.4 The national target is 75% seen under 6 weeks, 95% in less than 18 weeks, therefore plans will reflect meeting these. To do so we needed to calculate the denominator i.e. the number of ended referrals who finish treatment within a quarter. It was difficult to understand current performance as the current provider reports in different time bands than those required for planning, therefore current activity was split proportionately using the number of days in each time band to calculate an average. In addition, activity was analysed across quarters. The planning submission for these waiting times is reflected in the tables below.

Table 17.0 South Sefton: Percentage of IAPT ended referrals who finish treatment within a quarter

Q1 13/14 to Q4 13/14 shows:	
Q1 13/14	25.4%
Q2 13/14	22.1%
Q3 13/14	25.7%
Q3 13/14	26.8%

Table 18.0 Southport & Formby: Percentage of IAPT ended referrals who finish treatment within a quarter

Q1 13/14 to Q4 13/14 shows:	
Q1 13/14	24.6%
Q2 13/14	25.0%
Q3 13/14	23.3%
Q3 13/14	27.1%

Table 19.0 IAPT Waiting Times

E.H.1 - A1			Quarter 1	Quarter 2	Quarter 3	Quarter 4
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	2015-16 Plan	The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 6 weeks of referral	416	416	416	416
		The number of ended referrals that finish a course of treatment in the reporting period.[1]	554	554	554	554
		%	75.1%	75.1%	75.1%	75.1%

E.H.2 - A2			Quarter 1	Quarter 2	Quarter 3	Quarter 4
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	2015-16 Plan	The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 18 weeks of referral	527	527	527	527
		The number of ended referrals who finish a course of treatment in the reporting period.[1]	554	554	554	554
		%	95.1%	95.1%	95.1%	95.1%

1. The denominators in measures E.H.1 - A1 and E.H.2 - A2 are identical. Given this, the values entered for E.H.1 - A1 are automatically used to populate the denominator in E.H.2 - A2.

Dementia Diagnosis Measures

7.5 Based on QOF registers for both CCGs. National target to reach and maintain 66.7% in 2015/16. Current performance as at Aug 2014 was 53% for South Sefton and 54.8% for Southport & Formby.

Table 20.0 Dementia Diagnosis Plans

Dementia - Estimated diagnosis rate	2015-16 Plan	Number of People diagnosed (65+)	1367	1367	1367	1367	1367	1367	1367	1367	1367	1367	1367	1367
		Estimated dementia prevalence (65+ Only (CFAS II))	2048	2048	2048	2048	2048	2048	2048	2048	2048	2048	2048	2048
		%	66.75%	66.75%	66.75%	66.75%	66.75%	66.75%	66.75%	66.75%	66.75%	66.75%	66.75%	66.75%

Primary Care Measures

7.6 For the February 27th plan a number of further Primary Care measures required plans.

7.7 ***Primary Care satisfaction:*** It should be noted that these questions are different from those that were required and prescribed as part of the plans submitted in 2014 for the 2014/15 – 2018/19 5 year and 2 year strategic plans.

ED1: Satisfaction with the quality of consultation at the GP practice which is a composite of 5 questions:

a) The combined percentage of patients who answered positively to the questions 'Last time you saw or spoke to a GP from your GP surgery, how good was that GP at giving you enough time?' and 'Last time you saw or spoke to a nurse from your GP surgery, how good was that nurse at giving you enough time?'.

b) The combined percentage of patients who answered positively to the questions 'Last time you saw or spoke to a GP from your GP surgery, how good was that GP at listening to you?' and 'Last time you saw or spoke to a nurse from your GP surgery, how good was that nurse at listening to you?'.
c) The combined percentage of patients who answered positively to the questions 'Last time you saw or spoke to a GP from your GP surgery, how good was that GP at explaining tests and treatment?' and 'Last time you saw or spoke to a nurse from your GP surgery, how good was that nurse at explaining tests and treatments?'.
d) The combined percentage of patients who answered positively to the questions 'Last time you saw or spoke to a GP from your GP surgery, how good was that GP at involving you in decisions about your care?' and 'Last time you saw or spoke to a nurse from your GP surgery, how good was that nurse at involving you in decisions about your care?'.
e) The combined percentage of patients who answered positively to the questions 'Last time you saw or spoke to a GP from your GP surgery, how good was that GP at Treating you with care and concern?' and 'Last time you saw or spoke to a nurse from your GP surgery, how good was that nurse at treating you with care and concern?'.

7.8 The rationale for improvement for this indicator was based on historical improvement: South Sefton improved by 1.3% between 2013 and 2014, and Southport & Formby improved by 0.2%. This rate of improvement is forecast to continue. 1.3% as a proportion of the 2014 South Sefton figure is a 5.66% increase whilst the 0.2% increase as a proportion of the 2014 score for Southport & Formby was 0.89%.

ED2: Patient satisfaction: Satisfaction with the overall care received at the surgery.

ED3: Patient satisfaction: Satisfaction with accessing primary care

7.9 In terms of rationale for the two indicators above, similar principles as other measures were followed i.e. where below current target, propose to meet. Where above, propose to maintain. The denominator was taken as the total number of responses to each question from previous surveys as this is a nationally administered survey. A summary of the planned submission is reflected in the tables below.

Table 21.0 Primary Care: Patient satisfaction plans

NHS SOUTH SEFTON CCG	2013	2014	Var	Has perf increased	Increase for 2015	2015 Figure	Num	Den*
ED1	**439.2%**	**440.4%**	**1.3%**	Yes	5.66%	446.1%	N/A	N/A
ED2	**83.4%**	**80.6%**	**-2.7%**	No	Use 2013	83.4%	2039	2446
ED3	**69.7%**	**67.9%**	**-1.8%**	No	Use 2013	69.7%	1684	2416
NHS SOUTHPORT AND FORMBY CCG	2013	2014	Var	Has perf increased	Increase for 2015	2015 Figure	Num	Den*
ED1	**449.3%**	**449.5%**	**0.2%**	Yes	0.89%	450.4%	N/A	N/A
ED2	**88.8%**	**89.7%**	**0.9%**	Yes	0.82%	88.8%	1731	1949
ED3	**74.6%**	**75.6%**	**1.0%**	Yes	0.77%	74.6%	1431	1918

E.D.1			**Satisfaction with the quality of consultation at GP practices** **This is a score out of 500**
The aggregated percentage of patients who gave positive answers to five selected questions in the GP survey about the quality of appointments at the GP practice		**2015/16**	**446.1**

E.D.2			**Satisfaction with the overall care received at the surgery**
The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of your GP surgery?'	**2015/16**	**Numerator - The number of patients who answered 'very good' or 'fairly good' to the question, 'Overall, how would you describe your experience of your GP surgery?'**	**2039**
		Denominator - The number of patients responding to the question 'Overall, how would you describe your experience of your GP surgery?'	**2446**
		%	83.4%

E.D.3			**Satisifcation with access to primary care**
The percentage of patients who gave positive answers to the GP survey question 'Overall, how would you describe your experience of making an appointment?'	**2015/16**	**Numerator - The number of patients answering ''Very good' or 'Fairly Good' to the question 'Overall, how would you describe your experience of making an appointment?'**	**1684**
		Denominator - The number of patients responding to the question 'Overall, how would you describe your experience of making an appointment?	**2416**
		%	69.7%

HCAI Measures

7.10 Clostridium Difficile: No seasonal trend was apparent on analysing the data. Usually NHS England prescribe a monthly trajectory as well as annual target but only an annual target has been published so far this year. As the monthly data is so variable the target has been split equally by twelfths, rounding up some months which historically appeared to have been higher than others.

Table 22.0 HACI Plans

South Sefton CCG

E.A.S.5		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	Total	
HCAI measure (C.Difficile infections)	2013-14	7	5	4	3	10	5	8	1	2	2	5	3	55	
	2014-15	4	6	7	4	5	8	-	-	-	-	-	-	34	2015-16 Objective
	2015-16 Plan	5	4	5	4	5	4	5	4	5	4	5	4	54	54

Southport & Formby CCG

E.A.S.5		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH	Total	
HCAI measure (C.Difficile infections)	2013-14	3	0	3	6	2	6	5	5	1	2	7	5	45	
	2014-15	4	2	5	4	2	3	-	-	-	-	-	-	20	2015-16 Objective
	2015-16 Plan	3	3	3	4	3	3	3	3	3	3	4	3	38	38

8. Planning Timetable

8.1 The table below sets out the latest national timetable for this planning round, together with the dates for consideration and approval via Governing Body. Engagement dates for the wider membership are also reflected.

	Timetable item (applicable to all bodies unless specifically referenced)	Original Timetable	Revised Timetable
1	Contract negotiations	Jan – 11 Mar	Jan – 31 Mar
2	Contract tracker to be submitted each Thursday	From 29 Jan	From 29 Jan
3	Submission of draft activity plan data (NHS Trusts, NHS FTs (except distressed NHS FTs))	n/a	27 Feb
4	Submission of draft finance and activity plan data (CCGs, NHS England and distressed NHS FTs)	n/a	27 Feb
5	Confirmation by providers of chosen tariff option - ETO or DTR	n/a	4 Mar, 6pm
6	Resubmission of draft activity plan data (CCGs, NHS England)	n/a	13 Mar
7	Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)	13 Feb	20 Mar
8	National contract stocktake – to check the status of contracts	20 Feb	27 Mar
9	Contract Signature Deadline	11 Mar	31 Mar
10	Full commissioner plans approved by Governing Bodies of CCGs Draft plans approved by NHS Trusts and NHS FTs	n/a	By 31 Mar
11	Post-contract signature deadline: where contracts not signed, local decisions to enter mediation*	25 Feb	1 Apr
12	Submission of full commissioner plans (CCGs, NHS England)** Submission of draft plans (NHS Trusts & NHS FTs)	27 Feb, noon	7 Apr, noon
13	Assurance of most recent plan submissions by national bodies	27 Feb – 30 Mar	7 Apr – 13 May
14	Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)	6 Mar	14 Apr
15	Contracts signed post-mediation	11 Mar, noon	17 Apr, noon
16	Entry into arbitration where contracts not signed; and submission of Dispute Resolution Process paperwork*	11 Mar, noon	17 Apr, noon
17	Contract arbitration panels and / or hearings*	13 – 24 Mar	20 – 29 Apr
18	Arbitration outcomes notified to commissioners and providers*	By 25 Mar	By 30 Apr
19	Plans approved by Boards of NHS Trusts and FTs	By 31 Mar	By early May
20	Contract and schedule revisions reflecting arbitration findings completed and signed by both parties*	By 31 Mar	By 7 May

21	Submission of final plans (NHS Trusts & FTs) Commissioner plan refresh if required (CCGs and NHS England)**	10 Apr, noon	14 May, noon
22	Assurance and reconciliation of operational plans	From 10 Apr	From 14 May

9. Conclusions

9.1 The CCG has reviewed its existing 2 year operational plan and 5 year strategic plan, in the context of the altered planning requirements, set out nationally for the 2015/16 planning round.

9.2 The CCG remains committed to the established vision and priorities that have been developed with the public, partners, providers and membership.

9.3 The CCG has reviewed the existing two year plan in light of revised national guidance, changes to data used for planning purposes and the heightened operational pressures related to A&E performance and hospital admissions.

9.4 The CCG remains committed to developing a robust forward financial and activity plan that can support the transfer of activity and resources from secondary care to primary care, intermediate care, community care and mental health.

9.5 The revised CCG activity and financial plans reflect a flat level of activity for 2015/16, based upon consideration of the historical activity trend evident and consideration on the most recent activity occurring in 2014/15.

9.6 The CCG 2015/16 plan reflects the planning requirements against the prescribed measures on RTT, A&E, Mental Health, HCAI, Cancer and Primary Care.

9.7 The CCG will continue to revisit its plans on Out-patients and Elective, going forward with the input and contribution of clinical members of the Governing Body.

10. Recommendations

10.1 The Governing Body is requested to:-

10.2 Note the detailed changes contained in the national planning guidance and the implications for the review of existing two year operational and five year operational plans.

10.3 Support the submission of activity plans based on the revised profile, with 0% increase in NEL for 2015/16.

10.4 Support the submission of Enable the necessary delegated authority via the CCG Chair, Accountable Officer, Chief Financial Officer and Chief Strategy & Outcomes Officer to progress the necessary work to enable national return requirements to me met.

Karl McCluskey
Chief Strategy & Outcomes Officer
January 2015

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/57	**Author of the Paper:** Malcolm Cunningham Head of Contracting & Procurement Email: malcolm.cunningham@southportandformbyccg.nhs.uk Tel: 0151 247 7281
Report date: March 2015	

Title: Home Oxygen Assessment Service Contract

Summary/Key Issues:

1 The service is currently being provided by Aintree University Hospitals NHS Foundation Trust;
2 The tender process has been a joint venture with South Sefton CCG;
3 The process has reached its conclusion and the procurement team have agreed the preferred bidder.

Recommendation
The Governing Body is asked to approve the award of the Home Oxygen Assessment Service Contract to Liverpool Community Health NHS Trust.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
	Sustain reduction in non-elective admissions in 2014/15
	Implementation of 2014-15 phase of Care Closer to Home
	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				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees			x	Quality Committee – December 2014

Links to National Outcomes Framework *(x those that apply)*	
	Preventing people from dying prematurely
x	Enhancing quality of life for people with long-term conditions
x	Helping people to recover from episodes of ill health or following injury
x	Ensuring that people have a positive experience of care
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
March 2015

1. Executive Summary

A good Home Oxygen Assessment service was being provided for South Sefton CCG; however a robust service was not available to patients in Southport & Formby CCG. A procurement to tender the contract across both CCG areas took place and this report summarises the process and conclusions of the procurement.

2. Introduction and Background

2.1 The service is currently being provided by Aintree University Hospitals NHS Foundation Trust. This contract has been with the Trust for some time and the Trust has provided a good service. However, there has not been a robust service in place in Southport & Formby CCG area and this needed addressing and a robust service put in place. As the procurement would take some months to complete, an interim service provided by Liverpool Community Health NHS Trust was put in place for patients in Southport & Formby CCG.

2.2 Southport & Formby CCG needed to go through a procurement process and it was decided that both CCGs would go through the procurement process together to appoint 1 contract holder for patients across both CCG areas.

2.3 The first step of the process was to hold a bidder information day to ascertain the interest by organisations in delivering the service. The bidder information day was held on 5th September 2014 at the CCG offices in Merton House. Only the incumbent provider attended the event with 2 delegates from the organisation attending.

2.4 The tender process has been completed and this paper gives you detail of the robust process followed to enable the North West CSU to recommend the award of this contract, in order to ensure we have a service provision for patients in South Sefton.

3. Key Issues

3.1 The tender opportunity for inviting expressions of interest was advertised on Contracts Finder on 6th October 2014. The Contracts Finder advert signposted interested providers to the CSU's eSourcing Portal for further information.

3.2 One document available on the eSourcing Portal was the specification and this can be found at Appendix 1.

3.3 12 expressions of interest were received via the eSourcing Portal. Each of these organisations accessed the Invitation to Tender (ITT) which required them to complete the ITT in 2 stages. Stage 1 required information about the organisation's ability to deliver the contract, namely:

- Organisational Identity and Information & Subcontracting arrangements;
- Financial Information;
- Insurances;
- Technical and professional capability and capacity;
- Equality Duties;
- Health & Safety;
- Environmental / Sustainability;
- Information Management & Technology;
- Conflict of Interest;
- Disputes.

3.3 Stage 2 of the ITT required the organisation to detail how they would deliver the contract and the specification required by the CCG.

3.4 Appendix 2 details the questions that bidders were asked for both Stage 1 and Stage 2.

3.5 Bidders were invited to submit clarification questions that were answered before bidders made their tender submissions.

3.6 From the 12 expressions of interest, 4 organisations completed a tender submission by the required deadline of 14th November 2014. These 4 organisations were:

- Aintree University Hospital NHS Trust;
- Baywater Healthcare Ltd;
- BOC Ltd (Healthcare Division);
- Liverpool Community Health NHS Trust.

3.7 The ITT submissions were evaluated by an evaluation panel independently and the evaluation panel comprised of:

Panel Member	Job Title	Organisation
James Bradley	Head of Strategic Financial Planning	S&F/SS CCG
Malcolm Cunningham	Head of Contracts & Procurement	S&F/SS CCG
Angela Curran	Locality Development Support	S&F/SS CCG
Sean Daly	Human Resources	NWCSU
Helen Graham	Procurement Manager	NWCSU
Michelle Harvey	Senior Projects Manager	Informatics Merseyside
Jenny Johnston	Medicines Management	S&F/SS CCG
Jenny Kristiansen	Locality Manager	S&F/SS CCG
Brendan Prescott	Deputy Chief Nurse / Head of Quality and Safety	S&F/SS CCG

3.8 Stage 1 was scored by an evaluation panel on an independent basis then an evaluation moderation meeting took place where the panel were able to discuss and agree scores. The tender documentation stated that bidders would be shortlisted to stage 2 if they passed all the Pass/Fail criteria; and scored more than 50% for the scored questions.

3.9 All 4 bidders met the criteria for Stage 1 evaluation and were passed through to Stage 2 evaluation.

3.10 Stage 2 was also scored by an evaluation panel on an independent basis then an evaluation moderation meeting took place where the panel were able to discuss and agree scores. From this moderation meeting, the evaluation panel agreed that the tender prices that had been submitted by all 4 of the bidders had not satisfactorily explained a breakdown of costs. The evaluation panel agreed to go back to all bidders for clarification around the financial submissions.

3.11 Clarification was made to bidders and they were asked to submit a revised financial breakdown for the contract. Bidders were given 2 weeks to submit a revised financial breakdown and then these costs were evaluated by the finance evaluator as per the methodology that had been provided to bidders.

3.12 Bidders were advised in the ITT documentation that any bidder scoring within 10% of the highest scoring bidder would be invited to present; as the presentation was worth a maximum score of 10. All 4 bidders scored within 10% of the highest scoring bidder so all 4 bidders were invited to present.

3.13 Bidder presentations took place on Wednesday 11th February 2015 to selected members of the evaluation panel. The scores for the presentation were added to the scores for Stage 2 of the written submission and the highest scoring bidder became the recommended bidder.

3.14 Appendix 3 contains an overview by each of the criterion and scores achieved for each provider.

3.15 From the scores listed in Appendix 3, Liverpool Community Health NHS Trust submitted the most economically advantageous tender bid and was able to strongly demonstrate their ability to provide this Home Oxygen Assessment Service to patients.

3.16 This award is subject to the following condition:

That LCH can demonstrate they have appointed the appropriate medical cover as outlined in the specification and as indicated in their bid and by the proposed contract start date.

The Governing Body should note that, whilst LCH is the preferred bidder as a result of an open and transparent process, the evaluation panel had minor reservations about LCH's proposed medical cover, which transpired at the bidder presentation day. The panel believes that LCH's bid provides the best overall value for money but remains unclear as to the exact nature of their proposed medical cover. LCH have made a financial provision for medical cover and have the support of a consultant physician from Southport and Ormskirk NHS Trust; however the CCGs will place a condition precedent on the contract and will seek assurance that this cover will be available across the whole of Sefton at contract commencement.

4. Conclusions

In summary the Home Oxygen Assessment Service has been out to tender through a robust and EU compliant process. Liverpool Community Health NHS Trust was the most economically advantageous bid submitted.

5. Recommendations

The Governing Body is asked to approve the award of the Home Oxygen Assessment Service contract to Liverpool Community Health NHS Trust, for a 3-year contract (with the option to extend by a further 1 x 2-year period) commencing on 1st July 2015.

Appendices

Appendix 1 – Specification
Appendix 2 – Invitation to Tender Questions to Bidders
Appendix 3 – Overall Scoring Matrix

Malcolm Cunningham
Head of Contracts & Procurement

Helen Graham
Procurement Manager, NWCSU

March 2015

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/58	**Author of the Paper:**
Report date: March 2015	Karl McCluskey Chief Strategy & Outcomes Office Email: karl.mccluskey@southportandformbyccg.nhs.uk Debbie Fagan Chief Nurse and Quality Officer Email: debbie.fagan@southportandformbyccg.nhs.uk Tel: 0151 247 7000

Title: Integrated Performance Report

Summary/Key Issues:

This report provides summary information on the activity and quality performance of the CCG at January 2015 (note time periods of data are different for each source).

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Sustain reduction in non-elective admissions in 2014/15
x	Implementation of 2014-15 phase of Care Closer to Home
	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
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
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

Southport & Formby Clinical Commissioning Group

Integrated Performance Report

NHS Southport and Formby Clinical Commissioning Group

NWCSU A partner in our clients' future

Contents

List of Tables and Graphs

1. Executive Summary

This report provides summary information on the activity and quality performance of Southport and Formby Clinical Commissioning Group at January 2015 (note: time periods of data are different for each source).

CCG Key Performance Indicators

NHS Constitution Indicators	Footprint	
A&E 4 Hour Waits	CCG	
Ambulance Category A Calls (Red 1)	CCG	
Cancer 2 Week GP Referral	CCG	
RTT 18 Week Incomplete Pathway	CCG	
Other Key Targets		
A&E 4 Hour Waits	S&ORM	
Ambulance Category A Calls (Red 1)	NWAS	
Ambulance Category A Calls (Red 2)	CCG	
Ambulance Category A Calls (Red 2)	NWAS	
Ambulance Category 19 Transportation	CCG	
Ambulance Category 19 Transportation	NWAS	
Cancer 2 Week Urgent GP Referral - Breast Symptoms	CCG	
Cancer 62 Day GP Referral	CCG	
Cancer 62 Day Screening	S&ORM	
CPA	CCG	
Emergency Admissions Composite Indicator	CCG	
Emergency Admissions for acute conditions that should not usual require hospital admission	CCG	
HCAI - C.Diff	S&ORM	
HCAI - MRSA	CCG	
HCAI - MRSA	S&ORM	
IAPT - Prevalence	CCG	
IAPT - Recovery Rate	CCG	
Local Measure: Diabetes	CCG	
RTT 18 Weeks - Admitted patients	S&ORM	
TIA	CCG	
Unplanned hospitalisation, asthma, diabetes, epilepsy under 19s	CCG	
Unplanned hospitalisation for chronic ambulatory care	CCG	

Key information from this report

The financial position is £3.174m overspent (compared to £3.481m in Month 10) on operational budget areas before the application of reserves. The CCG has experienced significant financial pressures in the first three quarters of the year, and a management action plan was agreed to achieve the planned £1.750m surplus at the end of the year.

Ambulance Activity - Category A Red 1 & 2, 8 minute response time are flagged as RED. Red 1 recorded 67.6% year to date, in month (Jan) 56.3%, the target has only been achieved in 3 months out of 10. Red 2 recorded 66.4% year to date, in month (Jan) 62.3% below the 75% target. The CCG have only achieved this target once in 2014-15 back in May. NWAS have also failed both of these targets. For Category 19 transportation the CCG recorded 88.3% year to date, in month (Jan) 83.1%, the CCG has failed to achieved this target in any month of 2014-15. NWAS are also failing the target recording 93.5% year to date which is flagged as AMBER, in month (Jan) 90.93%. The target is unlikely to be met at year end for the North West despite better performance in the Merseyside area.

A&E waits – Although the CCG failed the 95% target for this indicator with the actual for January at 87.93%, they achieved the target year to date reaching 95.33%. The CCG has failed the target in month from October onwards for 2014-15. Southport & Ormskirk are reporting 86.63% for January, which equates to 1267 attendances out of 9475 breaching the 4 hour target. Southport & Ormskirk Trust has not achieved the target each month from October 2014 with the year to date figure recorded as 94.89% just under the 95% target. An action plan and trajectory has been agreed by the Trust with Monitor and NHS England to reach 94.6% by end of Q4 14/15.

Cancer Indicators – Year to date the CCG achieved all the cancer indicators apart from two , 2 week breast symptom year to date they achieved 92.6%, in month (Dec) 90.9%, out of 33 patients 3 patient breached. And also the 62 day standard, year to date achieved 84.3%, in month (Dec) 83.3% against a target of 85%, 7 breaches out of 42 patients. Southport & Ormskirk achieved all indicators apart from 62 day screening achieving 72.2% year to date, in month (Dec) 75% against a target of 90%, out of 4 patients 1 patient breached. As previously highlighted to Trust Board, there remains risk associated with a number of cancer targets in relation to multiple providers and patient initiated delays.

CPA – The CCG failed the target of 95% in Q3 reaching 88.90% this is a fall from previous quarter. This equates to 5 out of 45 patients on CPA being not being followed up within 7 days after discharge from psychiatric inpatient care. The Trust reports this KPI on a monthly basis but the consequence of the breach is based on the quarterly response.

Emergency Admissions Composite Measure - The CCG is over the monthly plan in January and has had 596 more admissions than the same period last year. The elements of the composite contributing to over-performance are as follows: Emergency Admissions that should not usually require hospital admission - The CCG is over plan in January and has had an increase in actual admissions of 388 above the same period last year; Unplanned hospitalisation asthma, diabetes, epilepsy under 19's – The CCG is over plan for January with the increase in actual admissions 48 more than same period last year; Unplanned hospitalisation for chronic ambulatory care – The CCG is over plan for January with the increase in actual admissions being 211 more than the same period last year. A number of practices are analysing patient level data to understand trends and possible actions via localities and Finance and Resource Committee.

Friends and Family Test Score – NHS England has changed the way Friends and Family is reported. The two measures reported are: % Recommended and % Not Recommended. Southport & Ormskirk Hospital remain below the national average for Friends & Family test scores.

Measure – January 2015	Southport & Ormskirk	England Average
Inpatient – response	19.50%	36.10%
Recommended	85.13%	94%
Not Recommended	4.46%	2%
A&E – response	12.10%	20.10%
Recommended	81.60%	88%
Not Recommended	11.20%	6%

HCAI – C difficile – The CCG is achieving the target for C difficile, remaining under the planned target (actual 25 / plan 35). However Southport & Ormskirk had 1 new case in January taking them to 30 cases against a plan of 23 (year-end plan 27 so has also failed the annual target).

HCAI – MRSA – In January the CCG had no new cases of MRSA. However, the CCG remains over the plan of zero with 2 reported cases and will remain so for the rest of the year. Southport & Ormskirk also reported no new cases of MRSA and have a year to date total of 2.

IAPT Prevalence - The CCG did not achieve the 3.75% in Q3 recording 2.92% (557 patients entering psychological therapies). Although this represents an improvement on Q1 and Q2, year to date they are at 8.81%, the CCG remains adrift of the 15% target. The target was changed during the year requiring 3.75% in the final quarter of the year, indicative performance for the first 2 months of 2015 suggests they are unlikely to meet the target.

IAPT Recovery Rate - The CCG are not achieving the 50% target reaching 41.5% cumulatively to January this year the target has only been achieved in May and June. The year end target remains a significant challenge to achieve.

Local measure Diabetes - The current rate is below the plan of 59.3% with the CCG recording 46.8% for quarter 2 this is a decrease from quarter 1 (50.7%). Data quality is being investigated.

RTT 18 Weeks – Admitted patients – Southport & Ormskirk failed to achieve the 90% target in December recording 86.8%. As a result 99 out of 749 patients were still awaiting treatment after 18 weeks. A number of validation issues have been raised since the switch to a new Patient Administration System which is impacting the RTT position. Once rectified, the Trust's figures for this measure may change.

TIA – In January the CCG failed the target for TIA reaching 50%, 3 patients out of a total of 6 who experienced a TIA were not assessed and treated within 24 hours. The three breaches occurred within Southport & Ormskirk Trust. The CGG has established a concerted piece of work on the configuration for HAS, building on the work that has been undertaken by the clinical network. This is being progressed in conjunction with Liverpool CCG to determine the service construct for Liverpool and Sefton. A timetable for this work is being developed across 2015 and more immediate support solutions explored with Stroke leads.

Patient Safety Incidents Reported – Southport & Ormskirk reported 0 Serious Untoward Incidents in January. The Trust has recorded 27 incidents year to date.

2. Financial Position

2.1 Summary

This report focuses on the financial performance of Southport and Formby CCG at February 2015 (Month 11). The financial position is £3.174m overspent (compared to £3.481m in Month 10) on operational budget areas before the application of reserves. The CCG has experienced significant financial pressures in the first three quarters of the year, and a management action plan was agreed to achieve the planned £1.750m surplus at the end of the year. The majority of the actions identified have been delivered, and the CCG is forecasting achievement of the planned surplus and the business rules required by NHS England (as demonstrated in Table 1 below). However, there are significant risks outlined later in this section that require monitoring and mitigation in order to deliver the target surplus position.

Figure 1 Financial Dashboard

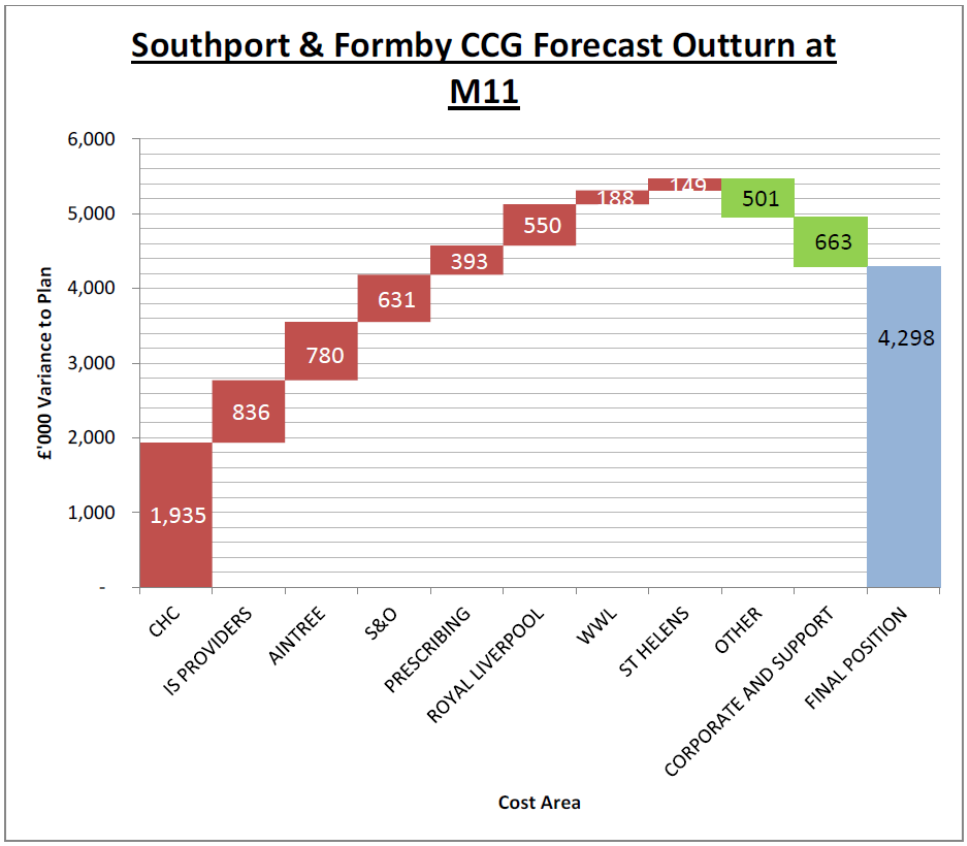
Report Section	Key Performance Indicator		This Month	Prior Month
1	Business Rule (Forecast Outturn)	1% Surplus	✓	✓
		0.5% Contingency Reserve	✓	✓
		2.5% Non-Recurrent Headroom	✓	✓
3	Surplus	Financial Surplus / (Deficit) before the application of reserves - £'000	-4,298	-4,548
4	QIPP	Unmet QIPP to be identified > 0	160	160
5	Running Costs (Forecast Outturn)	CCG running costs < National 2014/15 target of £24.78 per head	✓	✓
6	BPPC	NHS - Value YTD > 95%	98.2%	98.7%
		NHS - Volume YTD > 95%	91.2%	90.6%
		Non NHS - Value YTD > 95%	91.1%	91.4%
		Non NHS - Volume YTD > 95%	91.8%	92.0%

2.2 Changes to the RRL allocation in Month 11 were as follows:

- £65k increase – RTT adjustment. This is linked to the additional non-recurrent funding received earlier in the year to address waiting times for planned procedures. The review by NHS England concluded that the work carried out by provider Trusts for Southport and Formby patients was greater than the original allocation

2.3 The main pressures are shown below in Figure 2, notably Continuing Healthcare and Acute Care. A full breakdown of the CCG position is detailed in Appendix 1.

Figure 2 Financial Position to Date (month 11 FOT)



2.4 Whilst the financial reporting period relates to the end of February, the CCG has based its reported position on activity information received from Acute Trusts to the end of January 2015. Appendix 2 outlines the current financial data by provider, and also includes the forecast for each provider. Appendix 3 gives a breakdown by point of delivery for NHS and independent sector providers (as at Month 10), which demonstrates a significant pressure on urgent care, day cases and outpatient procedures when compared to plan.

2.5 **Southport and Ormskirk NHS Trust**

The forecast overspend at Southport and Ormskirk has remained consistent with that reported last month. The activity in month 10 follows a consistent trend to previous months, with underspends in planned care, AQP activity and maternity pathway payments, but continued overspends in emergency admissions. In total, activity was lower than budget in January.

This forecast position includes the application of the marginal rate for emergency admissions. The baseline for emergency admissions was amended to reflect 2013/14 activity levels. In accordance with

the contract, the CCG has applied the marginal rate of 30% of tariff to activity over the 2013/14 baseline. The forecast impact of the application of the marginal rate is now £0.774m. The CCG is required to publish how this resource has been invested in order to manage demand. Committee members will recall that the CCG made a significant investment of £0.900m to support Community and Urgent Care services at the start of the year. The Trust is contesting the CCGs view in relation to this matter.

The Trust continues to experience higher levels of emergency activity. A&E activity is 7% higher than planned for months 1 to 10. Unplanned admissions are higher than plan for both same day, short stay and longer stay admissions, although the activity was closer to plan in January than it had been in previous months:

- Same Day emergency admissions (primarily Ambulatory Emergency Care) - £0.177m over-spent, (28% higher than planned).
- Short stay emergency admissions - £0.115m over-spent (14% higher than planned).
- Other emergency admissions - £0.929m (6% higher than planned)

The hospital, consistent with other hospitals in the region and country, has experienced a sharp increase in demand for emergency care. As previously noted, the CCG and West Lancashire CCG have provided additional investment in Ambulatory Emergency Care, and Community Emergency Response Teams. It was anticipated that this investment would lead to a reduction in the level of admitted emergency patients. The Trust has reported on the effectiveness of the schemes implemented, and this is being reviewed by the CCG as it plans next year's expenditure commitments. These pressures are partially offset by underspends in maternity pathway payments (£0.467m; 27%), underspends in elective care (£0.664m; 16%) and AQP activity (£0.082m; 12%).

2.6 Continuing Health Care (Adult)

This area continues to be a major risk for the CCG, with year to date overspends of £1.541m. The forecast has remained consistent with that reported last month. A working group involving both the CCG and the Commissioning Support Unit meets regularly to review progress and risks.

The budget was increased by 4% from last year's expenditure levels, but the current data shows growth levels closer to 23%. Independent benchmarking has been carried out, and a comparison has been undertaken with a peer group of the 10 most similar CCGs, in relation to demographics as defined nationally. The results of this were reported to the Committee in February and show that although the CCG is in the top quintile for activity nationally, it is not an outlier against its peers. This has been reflected in the longer term financial strategy for the CCG. In addition to the activity increases in continuing healthcare, the CCG has also identified that some providers are insisting on charging higher prices. The Framework under which prices are charged expired at the end of February 2015, and there is a risk that prices will increase further once a new framework is agreed.

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2.7 Independent Sector Providers

The forecast overspend for Independent Sector providers is £836k at Month 11. The majority of this is with Ramsay Healthcare (£609k) and Spire Healthcare (£108k). Higher than anticipated activity can be seen and the appendix indicates an overall increase in planned care. This suggests that general

demand for specific elective services is increasing. The overspends are in the area of orthopaedic surgery, general surgery and ophthalmology. Outpatient activity is currently 37% higher than plan, with an upward trend in activity. Most of this relates to increases in follow up appointments.

2.8 Royal Liverpool and Broadgreen University Hospitals (RLBUH)

The forecast overspend for RLBUHT is £550k at Month 11. Activity at RLBUH is higher than planned in the following areas:

- Critical Care – at Month 10, critical care expenditure at RLBUH is **£0.125m** higher than contracted levels. This is 104% higher than the contract, with a number of long stay critical care patients.

- Wet ARMD – growth in Wet ARMD continues the growth identified in previous years. Costs in this area are **£0.085m** higher than contract. This reflects growth of 21%.

- Elective excess bed days – The expenditure to month 10 is **£0.049m** higher than plan, with one long stay patient discharged in the first quarter of the year. Records indicate that a patient who came in for an elective procedure developed pneumonia.

- Unbundled Diagnostics – The Trust was issued with a contract query in Feb 2014 as they had been failing the diagnostic wait time target since October 2013. Since that date there has been a significant increase in activity. It had been expected to plateau, but overspends have been consistently high throughout the year. To month 10, this equates to **£0.105m**.

2.9 Aintree University Hospital

The overspends at Aintree Hospital further increased in Month 10 with increases in outpatient attendances being the main driver. The overspends in the year to date are in the following areas:

- ARMD – This exceeds the plan by **£0.123m**.

- Excluded Drugs – The overspend to date is valued at **£0.096m**, and the main area of pressure is in cytokine modulators.

- Outpatient procedures – The costs are **£0.091m** higher than plan, with interventional radiology and breast surgery being the main specialties with higher than anticipated costs.

2.10 QIPP

Southport and Formby CCG has a QIPP savings target of £6.257 in 2014/15. This can be achieved through a reduction in either programme or running costs. The QIPP schemes were reviewed in quarter 3, with savings to date recognised at that point. The savings achieved in the final quarter will be assessed, and it is expected that the QIPP target will be met. The CCG continues to monitor and cost the impact of schemes actioned in 2014/15.

2.11 CCG Running Costs

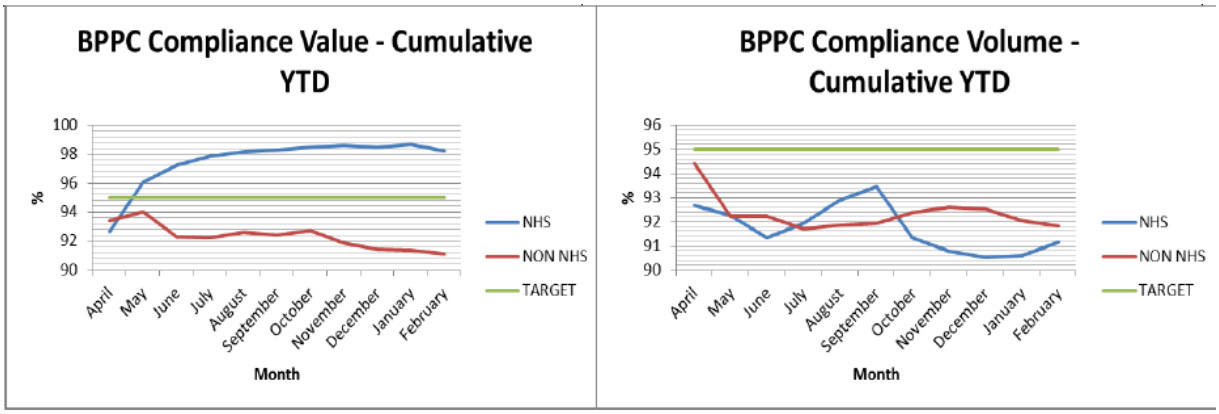
The CCG is currently operating within its running cost target which forms part of this budget area. The forecast for the year is an underspend on Running Costs and other Corporate and Support Services. This is because of a significant number of non-recurrent benefits. There have also been a number of vacancies in the staffing structure, and it is expected that some of these will be filled during Q4. It is important to note that although the CCG is operating below the 14/15 national target of £24.78 per head of population, this will be reduced to £22.11 per head in 2015/16. There are plans in place to meet this target for 2015/16 and these were agreed by the Governing Body in February 2015.

2.12 Compliance with the BPPC target

The NHS is required to adhere to the Better Payment Practice Compliance Target as part of the wider public sector drive to be a good citizen. The full year performance is reported in the annual report and subject to scrutiny by the external auditors. Current performance to date is below the 95% target for all areas, except payments to NHS providers by value. This is detailed in the figures below.

BPPC is covered in the Financial Awareness training to ensure that all parties know their responsibilities in coding and paying invoices promptly.

Figure 3 BPPC compliance



2.13 Evaluation of Risks and Opportunities

A number of risks continue to be monitored. These are outlined below:

• Overspends on Acute cost per case contracts – The CCG has experienced pressures in a number of providers. The pressures are mainly in the area of unplanned care. The forecast assumes application of the marginal rate for emergency admissions at Southport and Ormskirk NHS Trust, and the Trust is disputing this application.

• Continuing Healthcare Costs – The CCG has experienced significant pressures on the growth of CHC cases this year, which is close to 23% compared to an estimated increase in the budget of 4% compared to last year's activity. A joint working party between NWCSU and the CCG has been set up to review CHC processes, which is being chaired by the Lay Member (Audit and Governance). In addition to this benchmarking is being undertaken with other CCGs and an independent Mental Health Specialist has been commissioned to undertake a review of high risk CHC placements to identify areas for improvement.

• Continuing Healthcare restitution claims – clarity has been provided by NHS England in respect of CCG obligations for CHC restitution claims. Funding set aside in reserves at the beginning of the year forms part of a national risk pool. Although the CCG continues to make payments to recipients, this expenditure is refunded in full from the national pool. CCGs were notified in December of a forecast underutilisation against the national pool and £0.394m was returned to the CCG in Month 10.

• Estates – Latest estimates have now been received from both NHS Property Services and the organisation that administers the LIFT buildings. The CCG now has estimated charges for all premises, and this is reflected in the management action plan below. However, these are not final charges, and the values could fluctuate.

• Prescribing / Drugs costs – The PPA has published its November data which has resulted in a significant change to the CCGs forecast position leading to a forecast overspent of £0.569m for the year. The PPA estimates are prone to significant movements throughout the year and Committee members are reminded that prescribing forecasts are volatile. The forecast overspend is understood to reflect the increased price of Category M drugs which were increased from October 2014.

2.14 **Reserves and Management Action Plan**

Reserve budgets are set aside as part of the Budget Setting exercise to reflect planned investments, known risks and an element for contingency. As part of the review of risks and mitigations, the finance team and budget holders reviewed the expected expenditure levels for each earmarked reserve.

At the end of Month 4, it was recognised that the forecast costs exceeded the available reserves and subsequently a Management Action Plan was devised. Progress against this plan is outlined in the table below.

Figure 4 Reserves and agreed actions

	£000
Forecast overspend	4,298
Available reserves	(1,554)
Forecast pressures	**2,744**
Management actions implemented:	
Deferral of CVS payment	(307)
Deferral of Mandate spend	(236)
Quality Premium	(279)
Technical adjustments	(478)
CHC Restitution	(394)
Estates	(200)
NPFiT funding	(450)
Cheshire / Mersey rehab	(200)
Locality Money	(200)
Remaining shortfall	**0**

The forecast position for the CCG has improved in Month 11 due to implementation of agreed management actions. Although some costs have increased in the month (principally Aintree and prescribing), this has been offset by a number of management actions. Many other costs have remained consistent with those reported in Month 10. Actions implemented to date are sufficient to cover the current forecast overspend. Agreement has now been reached in relation to under-utilisation of the Cheshire / Mersey rehabilitation service. This pilot scheme has been funded on the basis of a population share across Mersey CCG's. It has become evident that the CCG's population is not accessing the "spoke" element of the service due to choice influenced by the location of the service (St. Helens and Liverpool). Agreement has now been reached and £0.200m will be invoiced to mid-Mersey CCGs in respect of the under-utilisation of this service by CCG patients. Despite the improved financial position, there are a number of risks, and further management actions are required to be delivered. Additional actions previously agreed to address the shortfall are outlined in **Table C**, totalling £0.100m. These schemes have been risk rated. Further detail for these schemes is outlined below:

• CQUIN underperformance - The CCG has assumed that not all Trusts will deliver their CQUIN schemes in full. The action plan assumes that 92% of schemes will be delivered although it is likely to be late in Q4 before a clear picture emerges in relation to this performance.

Figure 5 Risk Rated Management Action Plan

	£'000			
Action	**Total**	**Green**	**Amber**	**Red**
CQUIN Underperformance	**100**		100	
Grand Total	**100**	**-**	**100**	**-**

It should be noted that most of the management actions identified are non-recurrent, whereas the current financial pressures being seen are likely to impact on 15/16. It is therefore imperative that the CCG develops a sustainable plan for recurrent balance, before it enters the 2015/16 financial year.

3. Referrals

The following section provides an overview of referrals to secondary care to January 2015.

3.1 Referrals by source

Figure 6 Number of GP and 'other' referrals for the CCG across all providers for 2014/15

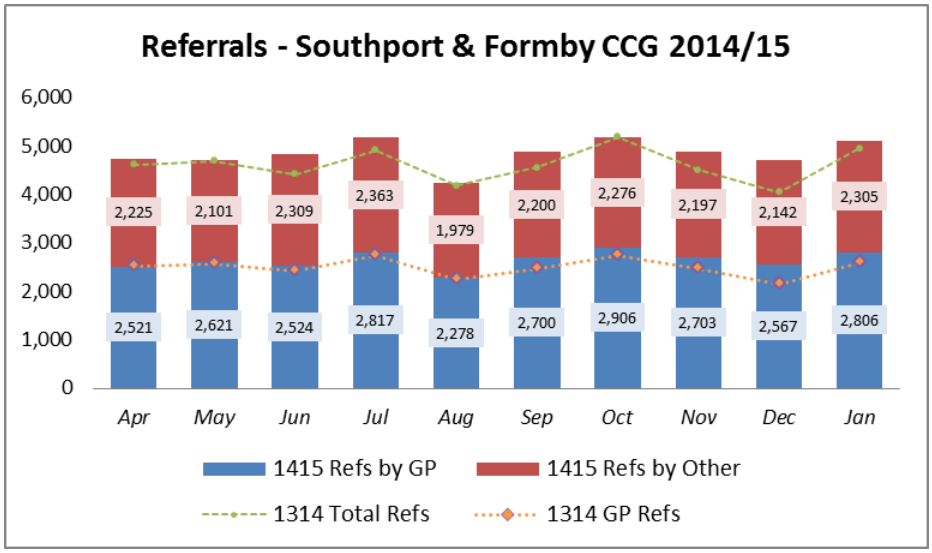


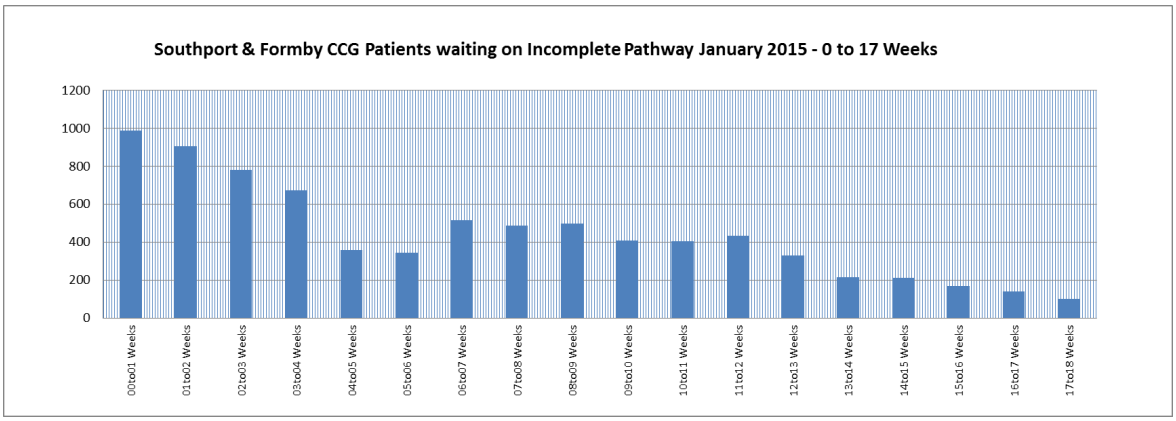
Figure 7 The number of GP and 'other' referrals for the CCG across all providers comparing 2013/14 and 2014/15 by month

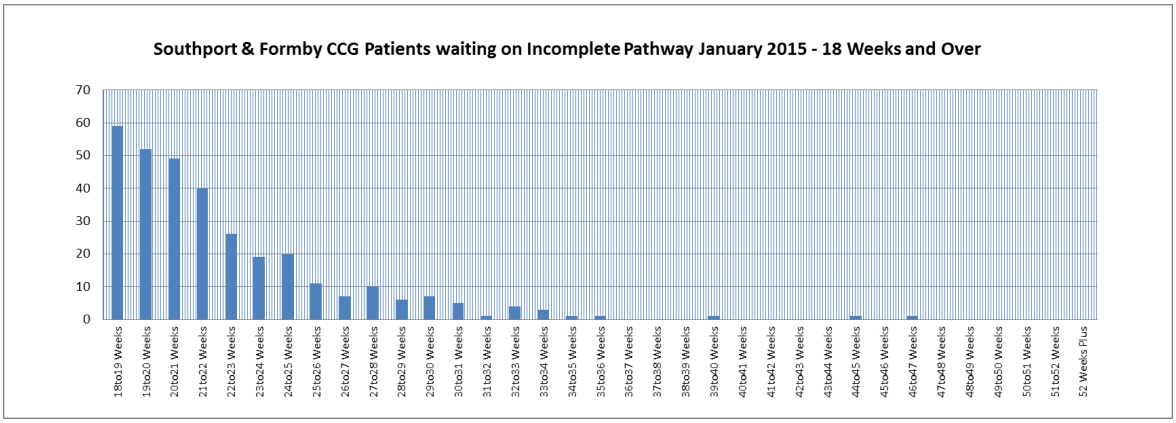
Referral Type	DD Code	Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	14/15 YTD	1314 YTD	YTD Variance
GP	03	GP Ref	2,515	2,573	2,435	2,737	2,258	2,465	2,738	2,484	2,143	2,599	2,370	2,520	2,521	2,621	2,524	2,817	2,278	2,700	2,906	2,703	2,567	2,806	26,443	20,205	6,238
GP Total			2,515	2,573	2,435	2,737	2,258	2,465	2,738	2,484	2,143	2,599	2,370	2,520	2,521	2,621	2,524	2,817	2,278	2,700	2,906	2,703	2,567	2,806	26,443	20,205	6,238
Other	01	following an emergency admission	238	215	158	220	199	181	203	153	155	211	174	185	196	174	211	200	181	188	132	7	6	10	1,305	1,567	-262
	02	following a Domiciliary Consultation	1		2			1			1								1	2	6	27	36	25	97	4	93
	04	An Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)	246	235	252	249	204	207	235	176	234	215	199	222	227	203	252	238	239	246	270	266	219	221	2,381	1,804	577
	05	A CONSULTANT, other than in an Accident and Emergency Department	656	707	671	684	594	672	756	611	585	770	686	677	720	671	672	717	597	671	823	833	869	944	7,517	5,351	2,166
	06	self-referral	62	88	98	95	81	112	119	111	84	117	65	111	91	102	102	103	83	99	108	110	131	134	1,063	766	297
	07	A Prosthetist		1		1	4	1	1		1	2	1	1		1	1	2	1	4			1	1	11	8	3
	10	following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)	8	2	7	9	10	20	13	12	14	20	15	19	12	10	13	18	14	14	8	9	17	7	122	81	41
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	59	71	61	68	53	46	61	58	61	66	53	60	52	46	69	67	48	61	43	30	43	52	511	477	34
	12	A General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)	1															2							2	1	1
	13	A Specialist NURSE (Secondary Care)	6	2	1	2	2		1		4	1		3	7	9	4	2	7	8	4	4	3	2	50	14	36
	14	An Allied Health Professional	18	12	10	13	7	6	11	7	11	4	3	140	143	150	127	201	128	113	86	137	103	122	1,310	84	1,226
	15	An OPTOMETRIST	41	42	46	50	34	57	72	59	38	58	72	66	84	37	72	47	59	71	48	47	29	47	541	401	140
	16	An Orthoptist	1					1				1								1					1	2	-1
	17	A National Screening Programme	8	3	1	1	1		14	9	2	7		28	30	29	23	23	21	15	32	27	33	29	262	37	225
	92	A GENERAL DENTAL PRACTITIONER	162	127	127	151	114	137	155	143	133	127	134	136	122	137	144	135	121	143	133	117	147	131	1,330	1,116	214
	93	A Community Dental Service	2	4	2	1		1	2	3	3		2	2		3	2		2	2	2	2	4		17	15	2
	97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	216	263	185	239	200	200	244	216	193	238	200	235	231	205	230	238	209	229	239	218	222	232	2,253	1,763	490
Other Total			1,725	1,772	1,621	1,783	1,503	1,642	1,887	1,558	1,519	1,837	1,604	1,885	1,915	1,777	1,922	1,993	1,711	1,867	1,934	1,834	1,863	1,957	18,773	13,491	5,282
Unknown			389	356	374	400	424	456	565	467	389	519	417	328	310	324	387	370	268	333	342	363	279	348	3,324	3,431	-107
Grand Total			**4,629**	**4,701**	**4,430**	**4,920**	**4,185**	**4,563**	**5,190**	**4,509**	**4,051**	**4,955**	**4,391**	**4,733**	**4,746**	**4,722**	**4,833**	**5,180**	**4,257**	**4,900**	**5,182**	**4,900**	**4,709**	**5,111**	**48,540**	**37,127**	**11,413**

4. Waiting Times

4.1 NHS Southport and Formby CCG patients waiting

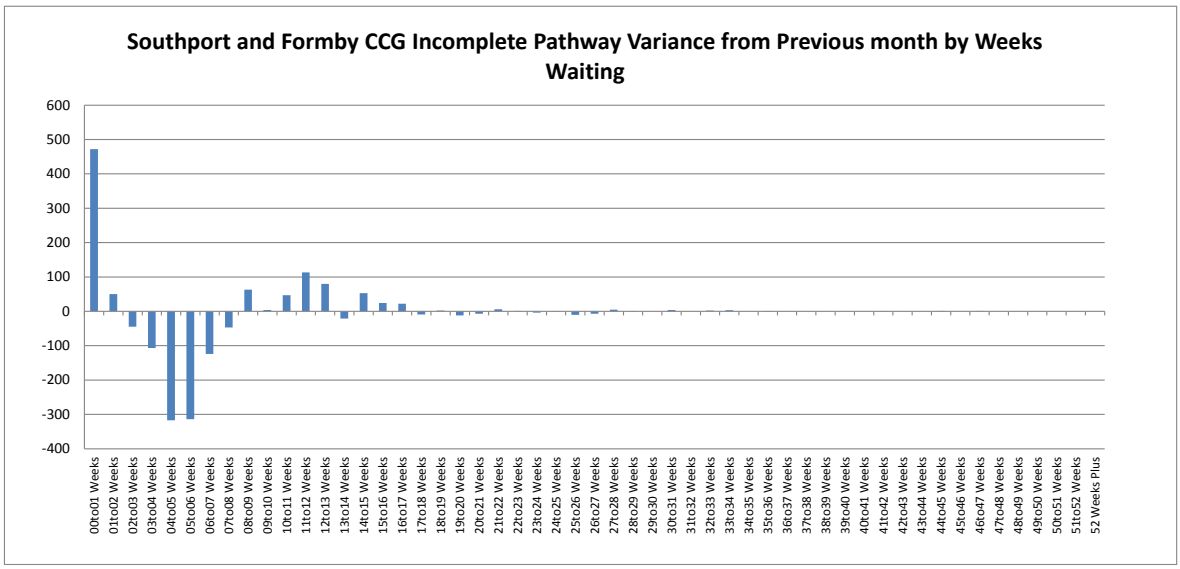
Figure 8 Patients waiting on an incomplete pathway by weeks waiting





There were 324 patients (3.9%) waiting over 18 weeks on Incomplete Pathways at the end of January 2015 which is a decrease of 19 patients (-5.5%) from Month 9.

There were no over 52 week waiters in December 2014 or January 2015.



There were 8,289 patients on the Incomplete Pathway at the end of January 2015 a decrease of 75 patients (-0.9%) since December 2014.

4.2 Top 5 Providers

Figure 9 Patients waiting (in bands) on incomplete pathway for the top 5 Providers

Trust	0to10 wks	10to18 wks	Total 0 to 17 Weeks	18to24 wks	24to30 wks	30+ wks	Total 18+ Weeks	Total Incomplete
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST (RVY)	4708	1571	6279	214	39	6	259	6538
RENACRES HOSPITAL (NVC16)	330	137	467	0	0	0	0	467
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (REM)	260	56	316	5	3	2	10	326
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST (RQ6)	230	68	298	7	10	6	23	321
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST (RBS)	59	22	81	3	1	2	6	87
Other Providers	372	152	524	16	8	2	26	550
Total All Providers	5959	2006	7965	245	61	18	324	8289

4.3 Provider assurance for long waiters

Assurance has been sought from main providers regarding their plans to ensure all long waiters (30 weeks plus) will be seen promptly.

Figure 10 Southport RTT caseload as of 18/03/2015:

Spec	30	31	32	33	34	35	36	37	
Cardiology		1							1
Dermatology	1		1						2
ENT		1			1		1		3
Gastroenterology	6	6	8				1		21
General Medicine	1								1
General Surgery						1			1
Oral Surgery	1		1	1					3
Pain Management	3	1	1	3	3				11
Respiratory Medicine	2								2
Trauma & Orthopaedics	1					1		1	3
Grand Total	**15**	**9**	**11**	**4**	**4**	**2**	**2**	**1**	**48**

Of these 12 are on the admitted pathway. Also note that the trust are still validating their PTL. Some of these patients may be removed once validated.

5. Planned Care

5.1 All Providers

Performance at Month 10 against planned care elements of the contracts held by NHS Southport & Formby CCG show an over-performance of circa £1.4m.This over-performance is primarily driven by increases at Aintree Hospital (£266k), Royal Liverpool and Broadgreen University Hospitals (£218k) and Renacres (£475k). Wrightington Wigan and Leigh contract continues to over perform with a cost variance of £200k.

Performance shows that there is a Planned Care over performance at the majority of contracted providers.

Figure 11 All Providers

Other Providers (PBR & Non PBR)	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	10,652	8,883	9,659	776	8.73%	£2,256	£1,881	£2,147	£266	14.12%
Alder Hey Childrens NHS F/T	4,509	3,705	4,099	394	10.62%	£720	£597	£566	-£31	-5.17%
Countess of Chester Hospital NHS Foundation Trus	0	0	64	64	0.00%	£0	£0	£5	£5	0.00%
East Cheshire NHS Trust	0	0	4	4	0.00%	£0	£0	£0	£0	0.00%
Liverpool Heart and Chest NHS F/T	1,243	1,038	1,265	227	21.83%	£783	£653	£717	£64	9.87%
Liverpool Womens Hospital NHS F/T	2,085	1,708	1,723	15	0.90%	£730	£598	£565	-£32	-5.38%
Royal Liverpool & Broadgreen Hospitals	11,947	9,964	11,371	1,407	14.12%	£2,636	£2,199	£2,417	£218	9.92%
ST Helens & Knowsley Hospitals	3,593	2,968	3,199	231	7.77%	£822	£679	£775	£97	14.23%
Wirral University Hospital NHS F/T	290	242	240	-2	-0.72%	£100	£84	£66	-£18	-21.07%
Central Manchester University Hospitals Nhs Foun	220	183	222	39	21.09%	£42	£35	£55	£20	58.24%
Fairfield Hospital	61	51	75	24	47.54%	£13	£11	£24	£13	120.13%
ISIGHT (SOUTHPORT)	2,518	2,098	2,326	228	10.85%	£582	£485	£540	£55	11.27%
Renacres Hospital	7,308	6,090	8,659	2,569	42.17%	£2,302	£1,919	£2,393	£475	24.75%
SPIRE LIVERPOOL HOSPITAL	480	400	652	252	62.83%	£128	£107	£181	£75	69.85%
University Hospital Of South Manchester NHS FT	191	160	145	-15	-9.35%	£35	£30	£35	£6	19.19%
Wrightington, Wigan And Leigh Nhs FT	1,927	1,606	2,114	508	31.65%	£748	£623	£823	£200	32.06%
	47,025	**39,097**	**45,817**	**6,720**	**17.19%**	**£11,898**	**£9,899**	**£11,311,950**	**£1,413**	**14.27%**

5.2 Southport and Ormskirk Hospital NHS Trust

Figure 12 Month 10 Planned Care- Southport and Ormskirk Hospital NHS Trust by POD

S&O Hospital Planned Care (PbR ONLY)	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	12,058	10,056	9,767	-289	-2.88%	£6,606	£5,510	£5,554	£45	0.81%
Elective	1,851	1,544	1,338	-206	-13.33%	£5,069	£4,228	£3,564	-£664	-15.70%
Elective Excess BedDays	392	327	197	-130	-39.74%	£90	£75	£47	-£29	-38.05%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	1,054	879	845	-34	-3.87%	£150	£125	£121	-£5	-3.63%
OPFASPCL - *Outpatient first attendance single professional consultant led*	23,023	19,201	16,700	-2,501	-13.03%	£3,355	£2,798	£2,423	-£375	-13.41%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	2,156	1,798	1,705	-93	-5.18%	£210	£175	£170	-£5	-3.01%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	48,179	40,181	40,084	-97	-0.24%	£4,137	£3,450	£3,475	£24	0.71%
Outpatient Procedure	14,692	12,253	15,007	2,754	22.48%	£2,407	£2,008	£2,714	£707	35.20%
Grand Total	**103,405**	**86,239**	**85,643**	**-596**	**-0.69%**	**£22,026**	**£18,369**	**£18,068**	**-£302**	**-1.64%**

5.2.1 Southport & Ormskirk Hospital Key Issues

Southport & Formby CCG overspend at Southport & Ormskirk trust is forecasting an underspend for planned care with an evident shift in activity to both the independent sector and other NHS providers. Within Planned Care, Outpatient Procedures is showing a £503k (31%) over performance which is offset by a £456k (13%) underspend in Elective admissions. The increase in outpatient procedures is primarily as a result of coding changes made by the trust. Some of these are agreed i.e. transfer of cystoscopies from day case to outpatient setting, and some of these are under discussion namely dermascopes (shift from outpatients to outpatient procedures) and increased depth of coding in T&O particular in the fracture clinic.

5.3 Royal Liverpool & Broadgreen Hospitals

Figure 13 Month 10 Planned Care- 5.3 Royal Liverpool & Broadgreen Hospitals by POD

Royal Liverpool & Broadgreen Hospitals Planned Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	744	620	748	128	20.55%	£575	£480	£537	£57	11.81%
Elective	278	232	240	8	3.52%	£923	£770	£743	-£27	-3.50%
Elective Excess BedDays	48	40	245	205	512.02%	£11	£9	£58	£49	530.05%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	126	105	169	64	60.83%	£20	£17	£26	£9	55.86%
OPFANFTF - *OP 1st Attendance Multi-Professional Outpatient First. Attendance Non face to Face*	0	0	5	5	0.00%	£0	£0	£0	£0	0.00%
OPFASPCL - *Outpatient first attendance single professional consultant led*	1,523	1,270	1,430	160	12.58%	£238	£199	£222	£23	11.76%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	248	207	159	-48	-23.13%	£27	£23	£14	-£8	-37.21%
OPFUPNFTF	166	138	152	14	9.79%	£4	£3	£3	£0	9.79%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	8,044	6,709	7,089	380	5.67%	£718	£598	£640	£42	6.97%
Outpatient Procedure	770	642	1,134	492	76.59%	£121	£101	£174	£73	72.91%
Grand Total	**11,947**	**9,964**	**11,371**	**1,407**	**14.12%**	**£2,636**	**£2,199**	**£2,417**	**£218**	**9.92%**

5.3.1 Royal Liverpool & Broadgreen Hospitals Key Issues

The main area of planned care over-performance at month 10 for NHS Southport & Formby CCG at Royal Liverpool Broadgreen University Hospital is elective excess bed days, daycases and outpatient procedures. In terms of Speciality, the Daycase and Outpatient Procedure over performance is focused around 3 specialties – Ophthalmology, Dermatology and Gastroenterology.

The Trust has been issued with an information query notice relating to over-performance reported since month 3. The Co-ordinating Commissioner has engaged external consultants to undertake an audit of clinical coding, and provide assurance regarding payment, which is currently underway. Preliminary findings have been shared by Capita with Co-ordinating Commissioners and further refinement against the original specification is being discussed. NWCSU will continue to liaise with the Co-ordinating Commissioner to ensure that outcomes can be shared with co-commissioners when available.

6. Unplanned Care

Performance at Month 10 against unplanned care elements of the contracts held by NHS Southport & Formby CCG shows an over-performance of circa £1.6m. This over-performance is primarily driven by increases at Southport & Ormskirk Hospital, with smaller but significant elements of over-performance also seen Alder Hey.

6.1 All Providers

Figure 14 Month 10 Unplanned Care – All Providers

Other Providers (PBR & Non PBR)	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	1,467	1,230	1,175	-55	-4.46%	£826	£692	£701	£9	1.32%
Alder Hey Childrens NHS F/T	664	553	631	78	14.04%	£277	£233	£336	£104	44.46%
Countess of Chester Hospital NHS Fou	0	0	34	34	0.00%	£0	£0	£4	£4	0.00%
East Cheshire NHS Trust	0	0	12	12	0.00%	£0	£0	£3	£3	0.00%
Liverpool Heart and Chest NHS F/T	157	131	109	-22	-16.97%	£370	£308	£340	£31	10.15%
Liverpool Womens Hospital NHS F/T	207	173	202	29	16.45%	£179	£150	£163	£13	8.92%
Royal Liverpool & Broadgreen Hospita	1,285	1,077	945	-132	-12.28%	£724	£607	£519	-£88	-14.55%
Southport & Ormskirk Hospital	51,197	42,792	47,469	4,677	10.93%	£26,149	£21,827	£23,822	£1,994	9.14%
ST Helens & Knowsley Hospitals	289	242	303	61	25.39%	£163	£137	£158	£21	15.49%
Wirral University Hospital NHS F/T	112	93	71	-22	-23.62%	£45	£37	£33	-£4	-10.59%
Central Manchester University Hospit	88	73	96	23	30.91%	£30	£25	£21	-£4	-14.55%
University Hospital Of South Manches	47	39	30	-9	-23.57%	£8	£6	£8	£1	19.66%
Wrightington, Wigan And Leigh Nhs F	62	52	54	2	4.52%	£53	£44	£18	-£26	-59.16%
Grand Total	**55,581**	**32,341**	**35,073**	**2,732**	**8.45%**	**£28,823**	**£16,698**	**£18,166**	**£1,468**	**8.79%**

6.2 Southport and Ormskirk Hospital NHS Trust

Figure 15 Month 10 Unplanned Care – Southport and Ormskirk Hospital NHS Trust by POD

S&O Hospital Unplanned Care (PbR ONLY)	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A and E	32,878	27,328	29,722	2,394	8.76%	£3,429	£2,850	£3,050	£199	6.99%
NEL/NELSD - *Non Elective/Non Elective I*	10,554	8,705	9,480	775	8.91%	£18,636	£15,451	£16,562	£1,111	7.19%
NELNE - *Non Elective Non-Emergency*	1,181	1,018	1,611	593	58.28%	£1,947	£1,676	£1,718	£43	2.54%
Emergency Excess Bed Day	169	143	215	72	50.35%	£49	£42	£60	£18	42.31%
NELST - *Non Elective Short Stay*	1,436	1,214	1,437	223	18.37%	£995	£846	£960	£115	13.58%
NELXBD - *Non Elective Excess Bed Day*	4,979	4,384	4,433	49	1.11%	£1,093	£962	£984	£22	2.25%
Grand Total	**51,197**	**42,792**	**46,898**	**4,106**	**9.60%**	**£26,149**	**£21,827**	**£23,334**	**£1,507**	**6.91%**

6.2.1 Southport and Ormskirk Hospital NHS Trust Key Issues

For non- elective, increases in A&E attendances resulted in increases in the number of medical admissions from A&E. Continuing growth in non-elective admissions particularly in the specialties of A&E, General Medicine, Paediatrics and Geriatrics continues to be investigated by NWCSU. Specifically, further investigation is taking place into excessive over performing HRGs, particularly in the Specialties mentioned previously. Southport & Ormskirk Hospital month 10 Provider Report highlights those HRGs being queried. A working group is being established to describe and understand the flows into and out of urgent care in more depth, plus the impact of the Trust's IT system upgrade in October which has led to a process of validating a number of pathways

With regard to non-Elective, the Trust feel that some of the schemes set up for specific cohorts of patients (CERT, FESSU etc) appear to be having an effect on non-elective activity, but cohorts of patients without a scheme aligned to them appear to be seeing increases in activity. S&O working through the data and will share when complete. SFCCG GP has agreed to review some of the patient level data from the AEC (HRGs which have seen significant increases e.g. skin).

At the December Joint Quality and Contract Meeting S&O advised that they have now put in place a GP Assessment Unit which is improving patient flow but is financially disadvantaging the Trust and they will be submitting a paper proposing an approach for CCGs consideration for the rest of this financial year, the CCG's Chief Nurse has also requested that this paper also incorporates Quality (improvement in A&E Friends and Family performance) and Patient Experience.

7. Mental Health

7.1 Mersey Care NHS Trust Contract

Figure 16 NHS Southport and Formby CCG – Shadow PbR Cluster Activity

	NHS Southport and Formby CCG			
PBR Cluster	2014/15 Plan	Caseload (Jan-2014)	Variance from Plan	% Variance
0 Variance	32	26	(6)	-19%
1 Common Mental Health Problems (Low Severity)	35	29	(6)	-17%
2 Common Mental Health Problems (Low Severity with greater need)	45	37	(8)	-18%
3 Non-Psychotic (Moderate Severity)	162	145	(17)	-10%
4 Non-Psychotic (Severe)	128	130	2	2%
5 Non-psychotic Disorders (Very Severe)	29	25	(4)	-14%
6 Non-Psychotic Disorder of Over-Valued Ideas	25	26	1	4%
7 Enduring Non-Psychotic Disorders (High Disability)	96	100	4	4%
8 Non-Psychotic Chaotic and Challenging Disorders	62	69	7	11%
10 First Episode Psychosis	52	55	3	6%
11 On-going Recurrent Psychosis (Low Symptoms)	282	275	(7)	-2%
12 On-going or Recurrent Psychosis (High Disability)	151	155	4	3%
13 On-going or Recurrent Psychosis (High Symptom & Disability)	105	108	3	3%
14 Psychotic Crisis	18	17	(1)	-6%
15 Severe Psychotic Depression	7	4	(3)	-43%
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	6	8	2	33%
17 Psychosis and Affective Disorder – Difficult to Engage	35	34	(1)	-3%
18 Cognitive Impairment (Low Need)	365	347	(18)	-5%
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	465	462	(3)	-1%
20 Cognitive Impairment or Dementia Complicated (High Need)	159	164	5	3%
21 Cognitive Impairment or Dementia (High Physical or Engagement)	50	49	(1)	-2%
Reviewed Not Clustered	30	21	(9)	-30%
No Cluster or Review	46	47	1	2%
Total	2,385	2,333	- 52	-2%

Figure 17 CPA – Percentage of People under followed up within 7 days of discharge

Follow up from inpatient discharge			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
CB_B19	The % of people under adult mental illness specialities who were followed up within 7 days of discharge from psychiatric inpatient care	95%	100.00%	93.75%	93.75%	100.00%	92.86%	85.71%	94.12%	100.00%	76.92%	100.00%

The Trust reports this KPI on a monthly basis but the consequence of the breach is based on the quarterly response.

This rationale for this indicator is that follow up after discharge from an inpatient spell for mental health patients on care programme approach (CPA) can reduce the risk of suicide as set out in 'National suicide prevention strategy for England' and 'Preventing suicide: A toolkit for mental health services'

Figure 18 CPA Follow up 2 days (48 hours) for higher risk groups

Follow up from inpatient discharge			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
MH_KPI.4	CPA Follow up 2 days (48 hours) for higher risk groups are defined as individuals requiring follow up within 2 days (48 hours) by CRHT, Early Intervention, Assertive Outreach or Homeless Outreach Teams.	95.00%	100.00%	100.00%	100.00%	100.00%	100.00%	91.67%	87.50%	85.00%	81.82%	100.00%

The Trust reports this KPI on a monthly basis but the consequence of the breach is based on the quarterly response.

The rationale for this locally agreed indicator is similar to the national 7 day CPA follow up target and it was developed to ensure faster follow up for those patients deemed to be high risk. High risk in Mersey Care NHS Trust is defined in their discharge and transfer policy as service users with a history of serious self-harm, previous serious suicide attempts and a diagnosis of depressive disorder should be seen within 48 hours post discharge (Preventing suicide – A Toolkit for Mental Health Services - 2009).

7.2 Inclusion Matters Sefton Contract

Figure 19 PHQ13_6 Proportion of people who complete treatment who are moving to recovery

Southport & Formby	Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Total	FOT
Entered (KPI4)		108	204	177	489	173	120	124	417	196	193	168	557	218	1681	2017
Entered (KPI4) HSCIC		**115**	**155**	**180**	**450**	**145**	**130**	**150**	**425**						**875**	**1750**
Completed (KPI5)		122	138	110	370	164	119	124	407	185	107	93	385	150	1312	1574
Completed (KPI5) HSCIC		**95**	**120**	**95**	**310**	**215**	**120**	**125**	**460**						**770**	**1540**
Moved to recovery (KPI6)		46	67	51	164	66	47	52	165	77	45	36	158	59	546	655
Moved to recovery (KPI6) HSCIC		**40**	**65**	**45**	**150**	**55**	**35**	**50**	**140**						**290**	**580**
Entered Below Caseness (KPI6b)		17	14	10	41	15	14	15	44	15	3	11	29	8	122	146
Entered Below Caseness (KPI6b) HSCIC		**10**	**10**	**10**	**30**	**15**	**15**	**15**	**45**						**75**	**150**
Prevalence	15%	0.57%	1.07%	0.93%	2.56%	0.91%	0.63%	0.65%	2.19%	1.03%	1.01%	0.88%	2.92%	1.14%	8.81%	10.57%
Recovery	50%	43.8%	54.0%	51.0%	49.8%	44.3%	44.8%	47.7%	45.5%	45.3%	43.3%	43.9%	44.4%	41.5%	45.9%	45.9%
Prevalence HSCIC	15%	**0.60%**	**0.81%**	**0.94%**	**2.36%**	**0.76%**	**0.68%**	**0.79%**	**2.23%**						**4.59%**	**9.17%**
Recovery HSCIC	50%	**47.1%**	**59.1%**	**52.9%**	**53.6%**	**27.5%**	**33.3%**	**45.5%**	**33.7%**						**41.7%**	**41.7%**

NHS England set a target of 3.75% prevalence for Quarter 4 2014/15. Quarter 3 has not achieved above the required 3.75% with current performance at 2.92%. This is an improvement on previous quarters with Q1 recording 2.56%, and Q2 recording 2.19% but the CCG are unlikely to achieve the required target in Q4.

The CCG are not achieving the 50% recovery target reaching 45.9% year to date, the target has been reached in May and June so far in 2014/15.

8. Community Health

8.1 Southport and Ormskirk Community Health

Service	Location	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD	Plan	Forecast Outturn	% Variance
Adult Therapies												7960		
Adult Therapies MS	Clinic	0	0	0	1	2	0	0	2	1	6			
	Community	4	3	3	2	2	7	11	7	6	51		61	
Adult Therapies Neurology Inc	Community	383	408	364	393	336	350	418	337	286	3585		4302	
	Clinic	7	11	9	10	16	16	10	6	6	115		138	
Adult Therapies Non Neurology inc SALT	Community	418	413	474	575	535	546	486	485	430	4810		5772	
	Clinic	23	43	53	60	71	31	47	64	38	503		604	
Adult Therapies Non Vestiular	Community	0	1	5	13	6	14	7	3	4	60		72	
	Clinic	32	24	28	35	37	35	62	54	40	401		481	
Blue Badge	Community	56	43	71	72	61	38	49	79	45	542	80	650	713.0%
CERT	Community	3739	3352	4301	3498	3699	4687	3470	2180	2561	32354	23264	38825	66.9%
Chronic Care	Community	356	539	549	447	474	570	583	611	557	5347	1453	6416	341.6%
Clinical Health Psychology	Community	97	97	93	114	95	108	93	89	70	954	0	1145	
	Clinic	0	0	0	0	0	62	54	1	6	123		148	
Community Matrons	Community	324	218	273	291	314	306	268	346	415	3220	2907	3864	32.9%
Continence	Community	466	319	400	416	346	521	491	460	441	4365	2139	5238	144.9%
	Clinic	51	62	73	62	51	81	62	60	26	594	812	713	-12.2%
Diabetes	Community	255	255	251	250	232	230	264	365	206	2598	3336	3118	-6.5%
	Clinic	240	203	231	261	164	241	256	208	143	2166	2164	2599	20.1%
Dietetics	Community	446	409	431	572	419	372	396	357	248	3923	4982	4708	-5.5%
	Clinic	13	22	17	28	37	31	40	43	29	308	339	370	9.0%
District Nurses	Community	8386	8643	8765	8949	8148	7955	8642	8204	8092	83878	100789	100654	-0.1%
	Clinic	0	0	0	0	0	0	0	0	0	0	0	0	
District Nurses OOH	Community	654	608	658	768	802	720	738	774	675	7045	8260	8454	2.3%
	Clinic	0	0	0	0	0	0	0	0	0	0	0	0	
Falls Service	Community	125	165	116	97	111	153	157	159	135	1383	1323	1660	25.4%
	Clinic	0	0	0	0	0	0	0	0	0	0	0	0	
Integrated Discharge Team	Community	2316	2243	2173	2480	2233	2278	981	2218	2115	21152	17617	25382	44.1%
Leg Ulcer	Community	17	0	1	0	0	0	0	0	0	18	328	22	-93.4%
	Clinic	193	141	146	165	166	205	191	180	190	1728	2254	2074	-8.0%
Lymphoedema	Community	25	12	18	8	18	42	33	28	0	184	0	221	
Neurology	Community	0	0	0	0	0	0	0	0	0	0	0	0	
	Clinic	0	0	0	0	0	0	0	0	0	0	0	0	
Pain Management	Community	48	149	50	103	86	65	97	86	49	760	1255	912	-27.3%
	Clinic	302	323	255	374	253	320	323	346	311	3068	3571	3682	3.1%
Palliative Care	Community	994	936	1096	1115	992	1053	1082	1098	1102	9468	0	11362	
	Clinic	0	0	0	0	0	0	0	0	0	0	0	0	
Phlebotomy	Community	0	2	0	0	0	0	0	0	0	2	0	2	
	Clinic	3319	3261	3472	3765	2906	3558	3598	3309	2638	33103	41663	39724	-4.7%
Podiatry	Community	354	460	378	448	307	222	307	401	378	3619	4451	4343	-2.4%
	Clinic	1060	1100	975	1094	919	910	957	761	780	9397	16617	11276	-32.1%
Stoma	Community	153	120	119	192	104	112	158	128	152	1401	1706	1681	-1.5%
	Clinic	0	0	0	0	0	0	0	0	0	0	0	0	
Tissue Viability	Community	38	55	38	52	34	47	50	51	34	435	0	522	
	Clinic	0	0	0	0	0	0	0	0	0	0	0	0	
Treatment Rooms	Community	0	0	0	0	3	12	4	4	5	28	0	34	
	Clinic	1718	1643	1681	1948	1721	1810	1978	1682	1880	17821	19436	21385	10.0%
Wheelchair Service	Community	123	113	55	129	84	161	152	76	82	1083	850	1300	52.9%
	Clinic	44	35	34	58	23	37	47	22	25	361	0	433	
Community	Clinic	5	9	14	36	17	32	47	61	25	267	0	320	
Total		26784	26440	27670	28880	25805	27906	26562	25282	24200	262220	261596	314664	15.7%

•Increased referrals to community matrons at month 8 linked to “Care at Home”.
•Chronic Care Coordinators-Upward trend in referrals received and a corresponding increase in the number of contacts seen.
•Comparison of activity on the Podiatry block and AQP 2013/14 and AQP and Block 2014/15 combined for November to date show that overall activity is at similar levels to the same time period last year. On

AQP podiatry both referrals and contacts are down on current planned levels. Comparison of the block plus AQP year to date 13/14 and 14/15 shows overall activity is at similar levels. Activity spend against budget to date is around 51%. On the block community contacts are within tolerance levels while clinic contacts remain below plan which shows a shift in where activity is occurring.
•Adult Hearing AQP at month 8 year to date the budget spend is 6.3% above.
•MSK AQP At month 8 year to date the budget is underspent by 16%.
•Both MSK and Adult Hearing AQP activity year to date is down on the same time period last year.
•Treatment rooms –over the past few months both referrals and patients treated in clinic have increased.
•Community Gynaecology-Activity is flowing for this service however the data set does not include the procedures and treatments carried out. Onward referrals information is also not included and this would be useful to ensure that appropriate referral are being received by the service and that onward referrals are also appropriate.
This issue was raised at the point that the data first flowed and also within the information sub group. The current IT system does not allow the recording of these data items that are within the agreed data set. This service will be moving onto EMIS web next year and it is envisaged that some of these issues will be addressed by the migration. In the meantime other ways of understanding onward referrals are being investigated.
•The CCG are working with the Trust to review Community KPIs and Quality Contract Measures and develop a new suite of indicators for inclusion in the 15/16 Contract. This will be picked up via the 15/16 Quality Planning Meetings.
•The Trust now submits a monthly Nurse Staffing Report to the Joint Quality and Contract Meeting, this report also covers Community Nursing and Long Term Conditions, they are currently achieving 74.86% (Red) against the required percentage (staff vacancies). This is a concern to all community areas with the exception of Ainsdale (91.94%). The CCG queried staffing levels in the community, particularly within the Out of Hours team as there appears to be an issue there, the Trust provided assurance that the workload is being covered by existing staff.
•At the Joint Quality and Contract Meeting in December, the Chief Nurse informed the Trust that CCGs need to review a Trust action plan both for in-patient and A&E Friends and Family Test and formal plans to roll out the community element. NHSE require assurance of this and the Trust have been asked to submit this before the February 15th meeting. The Trust confirmed that it is engaging with the CCG's EPEG Group and advised that the community roll out is imminent.

9. Third Sector Contracts

2014/15 signed NHS Contracts are in place with all third sector providers. These contracts are on a block basis and therefore there is limited financial risk to the CCG. Contract Management meetings have taken place with all providers and actions resulting from these meetings are being progressed. CCG colleagues are currently reviewing data collected on these contracts
for inclusion in future Integrated Performance Reports.

10. Quality and Performance

10.1 NHS Southport and Formby CCG Performance

		Current Period				
Performance Indicators	**Data Period**	**Target**	**Actual**	**Direction of Travel**	**Exception Commentary**	**Actions**
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) **(CCG)**	14/15 - January	35	25	↑	There were no new cases reported in January 2014, 25 cases reported YTD compared to a annual plan of 35 cases. Of the 25 cases reported YTD, 20 cases reported by Southport and Ormskirk Hospital (11 apportioned to acute and 9 apportioned to community), 3 cases reported by Aintree Hospital (1 apportioned to acute, 2 apportioned to community) and 2 case reported by Royal Liverpool Hospital (apportioned to acute).	
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Southport & Ormskirk)**	14/15 - January	23	30	↑	There 1 new case reported in January 2015, 30 cases reported YTD compared to a annual plan of 23 cases. This case was reported at West Lancs CCG. Of the 30 cases reported YTD, 11 cases reported against Southport and Formby CCG patients, 16 cases against West Lancs CCG patients, 1 case reported against a Chorley and South Ribble CCG, 1 patient Ipswich and East Suffolk CCG and 1 case reported against an Eastern Cheshire CCG patient.	The Trust is currently off trajectory with 29 cases against an annual plan (YTD) of 23. This year 16 appeals have been successfully appealed, the last appeals panel met in February, this takes the Trust's local C.Dif performance to 14 and therefore within tolerance (however the national figures remain at 30). ,The Trust's C.difficile Action Plan is monitored at the monthly CQPG & Contract Meetings. The following actions are still open: * Implementation of UV markers for quantitative measurement of cleaning effectiveness *Formalisation of programme, dissemination of results and action plans from divisions required *Development of criteria and guidance for junior medical staff * 100% of patients with diarrhoea must be isolated when followed up on test result *Please Note - Data has been taken from the National HCAI Database - this is updated centrally therefore not all local appeals will be reflected in the table.*
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	14/15 - January	0	2	↑	No new cases reported in January 2015, 2 cases reported YTD, both cases reported YTD were reported by Southport and Ormskirk Hospital in July 2014 (1 apportioned to acute and 1 apportioned to community).	The CCG currently has two year-to-date MRSA cases related to Southport & Formby CCG Patients - 1 apportioned to acute and 1 apportioned to community - as community providers cannot be held accountable for HCAIs the CCG has had the community MRSA case attributed to them. The CCG is monitoring all Trust acquired cases of MRSA through Southport & Ormskirk Hospital's Quality & Safety Committee and the monthly CQPG. *Please Note - Data has been taken from the National HCAI Database - this is updated centrally therefore not all local appeals will be reflected in the table .*

Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Southport & Ormskirk)**	14/15 - January	0	2	↑ ↑	No new cases have been reported in January, 2 cases reported YTD (as stated above) 1 in July 2014 relating to a Southport and Formby CCG patient and 1 in September related to a West Lancashire CCG patient.	There has been one MRSA case in September bringing the year-to-date total to 1 Acute acquired case. (Although the ICO has reported 2 cases - 1 apportioned to acute and 1 apportioned to community (CCG) nb community cases are not included in this Trust specific KPI) against a target of 0. At the November CQPG the Trust informed the meeting that performance is not recoverable in this financial year. MRSA cases have now be designated as 'internal never events' and the relevant teams will be meeting with the Executive Team to discuss the management of the patients and lessons learned. Regular updates and lessons learned will be report to the Trust's internal Quality & Safety Committees and the monthly CQPG.Please Note - *Data has been taken from the National HCAI Database - this is updated centrally therefore not all local appeals will be reflected in the table.*
Enhancing quality of life for people with long term conditions						
Patient experience of primary care i) GP Services	Jan-Mar 14 and Jul-Sept 14		3.18%	New Measure	Percentage of respondents reporting poor patient experience of primary care in GP Services	
Patient experience of primary care ii) GP Out of Hours services	Jan-Mar 14 and Jul-Sept 14		10.51%	New Measure	Percentage of respondents reporting poor patient experience of GP Out of Hours Services	
Patient experience of primary care i) GP Services ii) GP Out of Hours services (Combined)	Jan-Mar 14 and Jul-Sept 14	6%	4.03%	New Measure	The CCG is achieving the target for this combined measure.	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s(Cumulative)	14/15 - January	388.69	593.71	New Plans	Plans have now been agreed and included, the plans are based on the same period last year. The increase in actual admissions is 48 above the same period last year.	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	14/15 - January	872.72	1,045.46	New Plans	Plans have now been agreed and included, the plans are based on the same period last year. The increase in actual admissions is 211 higher the same period last year.	
Emergency Admissions Composite Indicator(Cumulative)	14/15 - January	2073.73	2,561.67	New Plans	This measure now includes a monthly plan, this is based on the plan set within the Outcome Measure framework and has been split using last years seasonal Performance. Admissions have increased by 596 compared with the same period last year.	

IAPT - Prevalence (Quarterly)	14/15 - Qtr3	3.75%	2.92%	↑	Quarter 3 has not achieved above the required 3.75% with current performance at 2.92%. This is an improvement on previous quarters with Q1 recording 2.56%, and Q2 recording 2.19%.	
IAPT - Prevalence (Cumulative)	14/15 - January	15.00%	8.81%	↑	The CCG are not achieving the 15% target, reaching 8.81% year to date.	Identified issue with provider not applying nationally mandated definition of KPI. Action plan in place to ensure target met by end Q4 2014/15.
IAPT - Recovery Rate (Cumulative)	14/15 - January	50%	45.90%	↓	The CCG are not achieving the 50% target reaching 45.9% year to date, the target has been reached in May and June so far in 2014/15.	
Helping people to recover from episodes of ill health or following injury						
Patient reported outcomes measures for elective procedures: Groin hernia	2012/13	Eng Ave 0.085	0.08	Refreshed data	The CCG failed to improve on previous years outcome for Groin Hernia procedures and did not achieve a rate greater than the England average.	The CCG is very close to the England Average for PROMs data, discussions are currently taking place at CCG level to establish ownership of PROMs measure and to develop an improvement plan.
Patient reported outcomes measures for elective procedures: Hip replacement	2012/13	Eng Ave 0.438	0.43	Refreshed data	The CCG improved on the previous years rate but failed to achieve a score higher than that of the England average.	
Patient reported outcomes measures for elective procedures: Knee replacement	2012/13	Eng Ave 0.318	0.31	Refreshed data	The CCG improved on the previous years rate but failed to achieve a score higher than that of the England average.	
Emergency readmissions within 30 days of discharge from hospital (Cumulative)	14/15 - January		16.47			
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	14/15 - January	303.26	294.72	New Plans	Plans have now been agreed and included, the plans are based on the same period last year. Admissions have decreased by 2 compared with the same period last year.	
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	14/15 - January	1143.7	1,461.35	New Plans	Plans have now been agreed and included, the plans are based on the same period last year. This indicator is above the same period last year by 388 admissions.	
% who had a stroke & spend at least 90% of their time on a stroke unit **(CCG)**	14/15 - January	80%	85.71%	↑	Southport & Formby CCG have achieved the target this month, after failing 6 times in 2014-15.	
% who had a stroke & spend at least 90% of their time on a stroke unit **(Southport & Ormskirk)**	14/15 - January	80%	83.30%	↑		
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(CCG)**	14/15 - January	60%	50.00%	↔	In January 3 patients out of a total of 6 who experienced a TIA were not assessed and treated within 24 hours. The CCG did not achieve the required 60% for this measure. The three breaches occurred within Southport & Ormskirk Trust.	Although Southport & Ormskirk Hospital achieved their January TIA target , the Trust's Performance Team are working with the Clinical Business Unit to review and sign off internal processes. This will provide assurance that any breaches are unavoidable given the current infrastructure. Due to the number of patients within the service a small number of breaches affect the Trust's compliance against target. Whilst capacity has been increased, patient choice and weekend presentations still pose a risk for future months.
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Southport & Ormskirk)**	14/15 - January	60%	72.70%	↑	Southport & Ormskirk have achieved the target in January, In January 3 patients of the 11 patients who experienced a TIA were not assessed and treated within 24 hours. The Trust have achieved the target 4 times in 2014/15 (April, May, July and January).	

Mental health						
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative) **(CCG)**	14/15 - Qtr3	95%	88.90%	↓	The CCG has failed the target in Q3, with 40 out of 45 patients on CPA who being followed up within 7 days after discharge from psychiatric inpatient care.	
Preventing people from dying prematurely						
Under 75 mortality rate from cancer	2013		120.20			
Under 75 mortality rate from cardiovascular disease	2013		57.50			
Under 75 mortality rate from liver disease	2013		15.80			
Under 75 mortality rate from respiratory disease	2013		22.30			
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Person)	2013	2,646.00	1,933.40	↑	The CCG recorded a rate of 1,667.1 for Males and 2,191.8 for Females. The rate for males has reduced from the previous year (2,624.7) but the Female rate has increased (2,093.5). The Rate for 'Persons' has also reduced from 2013 (2,355.0)	The annual variation is significant and the CCG is working with Public Health locally and regionally to understand this. Indications at present are that the PYLL is significantly susceptible to fluctuations due to changes such as young deaths, which introduces major swings, particularly at CCG level.
Cancer waits – 2 week wait						
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(CCG)**	14/15 - December	93%	96.49%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Southport & Ormskirk)**	14/15 - December	93%	96.06%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(CCG)**	14/15 - December	93%	92.62%	↓	Southport & Formby CCG failed the 93% target year to date, in month achieving 90.9% for December, out of 33 patients there were 3 breaches.	Southport & Formby CCG narrowly missed the 93% target due to a small number of breaches, initital forecasts for January 15 indicates that the 93% target has been met.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(Southport & Ormskirk)**	14/15 - December	93%	94.99%	↔	Please note the Trust will no longer be submitting data for the cancer measure (Patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment) as they have closed the service for patients with breast cancer.	

Cancer waits – 31 days						
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	14/15 - December	96%	98.71%	↔		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Southport & Ormskirk)**	14/15 - December	96%	99.66%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	14/15 - December	94%	96.52%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Southport & Ormskirk)**	14/15 - December	94%	100%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	14/15 - December	94%	99.01%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Southport & Ormskirk)**	14/15 - December	94%	98.82%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	14/15 - December	98%	98.97%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Southport & Ormskirk)**	14/15 - December	98%	100%	↔		
Cancer waits – 62 days						
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set (Cumulative) **(CCG)**	14/15 - December		92.68%	↓		
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set (Cumulative) **(Southport & Ormskirk)**	14/15 - December		89.58%	↔		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	14/15 - December	90%	93.75%	↓		

Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(Southport & Ormskirk)**	14/15 - December	90%	72.22%	↔	The Trust failed the target in December reaching 75.0% they also failed year to date. In December there was 1 patient breaches out of 4 patients. Year to date there have been a total of 9 patients and 2.5 patient breaches.	The Trust failed to achieve compliance against the 62 day screening referral to treatment target for December. The screening referral pathway is different from the standard pathway insofar as the 62 day period starts upon referral from national screening programmes. The extended 62 day standard relates to the three national cancer screening programmes only: • the national breast screening programme • the national bowel screening programme; • the national cervical screening programme As previously highlighted to Trust Board, there remains risk associated with a number of cancer targets in relation to multiple providers and patient initiated delays.
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	14/15 - December	85%	84.35%	↔	The CCG failed the target year to date, and for December reaching 83.3%. There were 7 breaches out of a total of 42 patients treated.	The Trust failed to achieve compliance against the 62 day GP referral to treatment target for January. Breaches were spread across a number of tumour sites and following breach themes can be identified: • Delays within diagnostic phases due to complex pathways requiring more than one provider or diagnostic test • Patient choice through holidays and delayed decisions • Two internal diagnostic delays • Patient illness
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Southport & Ormskirk)**	14/15 - December	85%	85.85%	↔		
Mixed Sex Accommodation Breaches						
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(CCG)**	14/15 - January	0.00	0.00	↔		
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(Southport & Ormskirk)**	14/15 - January	0.00	0.00	↔		

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) **(CCG)**	14/15 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(Southport & Ormskirk)**	14/15 - December	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(CCG)**	14/15 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(Southport & Ormskirk)**	14/15 - December	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	14/15 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Southport & Ormskirk)**	14/15 - December	0	0	↔		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(CCG)**	14/15 - January	90%	90.68%	↓		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(Southport & Ormskirk)**	14/15 - December	90%	86.78%	↔	The Trust failed to achieve the target of 90% in December achieving 86.78%. This equates to 99 patients out of 749 not been seen within 18 weeks. These breaches were in the following specialities:- General Surgery, Urology, Trauma & Orthopaedics, Ophthalmology, ENT, Oral Surgery, Gynaecology and 'All other'.	The Trust are experiencing issues since their IT system upgrade and are continuing to validate pathways. They continue to assure commissioners that all patients are treated in chronological order.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(CCG)**	14/15 - January	95%	95.38%	↔		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(Southport & Ormskirk)**	14/15 - December	95%	95.32%	↔		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(CCG)**	14/15 - January	92%	96.09%	↔		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(Southport & Ormskirk)**	14/15 - December	92%	95.07%	↓		

A&E waits						
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG)**	14/15 - January	95.00%	95.33%	↓		
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Southport & Ormskirk)**	14/15 - January	95.00%	94.89%	↓	Southport & Ormskirk have failed the target narrowly year to date reaching 94.89%.	The Trust have developed an action plan and trajectory with NHS England to reach 94.6% by year end.
Diagnostic test waiting times						
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	14/15 - January	1.00%	0.89%	↓		
% of patients waiting 6 weeks or more for a Diagnostic Test **(Southport & Ormskirk)**	14/15 - December	1.00%	0.26%	↑		
Category A ambulance calls						
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	14/15 - January	75%	67.56%	↓	The CCG failed to achieved the 75% year to date target.	We are part of a pilot project to have GP ambulance response provided by the independent sector which will release 999 response vehicles to improve performance.
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	14/15 - January	75%	66.39%	↓	The CCG failed to achieved the 75% year to date target. In month (Jan) the CCG recorded a percentage of 62.30% an increase from 58.25% in December. The CCG hasn't achieved the target for any months in 2014/15.	
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	14/15 - January	95%	88.32%	↓	The CCG failed to achieve the 95% year to date and also did not achieve the target in month (Jan) recording 83.08%. The CCG hasn't achieved the target for any months in 2014/15.	
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	14/15 - January	75%	69.36%	↓	NWAS failed to achieve the 75% year to date and also did not achieve the target in month (Jan) recording 65.52%.	
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	14/15 - January	75%	70.12%	↓	NWAS failed to achieve the 75% year to date and also did not achieve the target in month (Jan) recording 65.47%.	
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	14/15 - January	95%	93.50%	↔	NWAS failed to achieve the 95% year to date and also did not achieve the target in month (Jan) recording 90.93%.	
Local Measure						
Diabetes Care Processes **(CCG)**	14/15 - Qtr2	59.3%	46.8%	New Measure	This measure makes up part of the quality premium and will be measures quarterly. Current figures show the CCG is under performing against plan and performance has also dropped from quarter 1 which recorded above 50%.	The data search criteria is being adjusted as recording of smoking status may be too low. The effect will mean an overall increase for the indicator.

10.2 Friends and Family – Southport and Ormskirk Hospital NHS Trust

Figure 20 Friends and Family – Southport and Ormskirk Hospital NHS Trust

Clinical Area	Response Rate (RR) Target	RR Actual (Jan 2015)	RR - Trajectory From Previous Month (Dec 14)	Percentage Recommended (England Average)	Percentage Recommended (Jan 2015)	PR Trajectory From Previous Month (Dec 14)	Percentage Not Recommended (England Average)	Percentage Not Recommended (Jan 2015)	PNR Trajectory From Previous Month (Dec 14)
Inpatients	30%	19.5%	↓	94%	85%	↓	2%	4%	↑
A&E	20%	12.1%	↑	88%	82%	↑	6%	11%	↑
Q1 - Antenatal Care	N/A	-	-	95%	100%	↑	1%	0%	↑
Q2 - Birth	N/A	16.1%	↓	97%	86%	↓	1%	3%	↓
Q3 - Postnatal Ward	N/A	-	-	93%	84%	↓	2%	6%	↓
Q4 - Postnatal Community Ward	N/A	-	-	97%	98%	↓	1%	2%	↓

Where cell contains "-" no denominator data available

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

- % Response rate
- % Recommended
- % Not Recommended.

The Trust failed to achieve the A&E response rate target and achieved 12.1% in January against a target of 20%, there has also been a slight improvement in performance from the December position. They Trust reported below the England Average percentage recommended however they saw an improvement in monthly performance against the December position.

The Trust saw decline in performance relating to Inpatient response rate target, they also missed the England Average percentage recommended by 9% and not recommended target by 2%. The Trust remain in line with national tolerance for antenatal care, however they have seen a further decline in FFT performance for birth.

Work is on-going with the Trust to review Friends & Family Performance, the Trust has advised they are liaising with Aintree Hospital to share their A&E good practice. In addition the Trust has been invited to attend the CCG's EPEG meetings to provide regular updates against performance. At the CQPG meeting on 4th March, the Trust informed the CCG that Task and finish group now is in place

chaired by the new Director of Nursing with an Action Plan in place to review additional methods to increase FFT feedback in A&E ie text messaging service. This Action Plan will be monitored at the monthly CQPG meetings.

10.3 Complaints

Southport & Ormskirk Hospital Trust wide Complaints

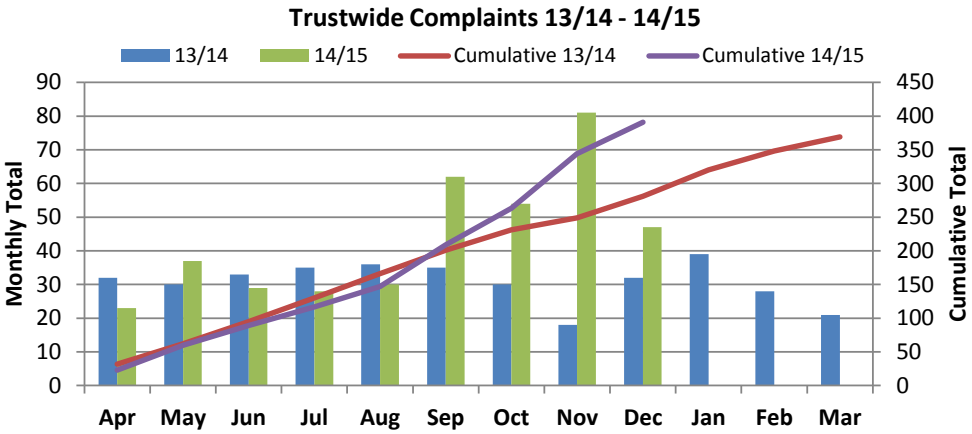
The following section has been summarised from the Trust's Quarter 3 Complaints Report which was discussed at the CQPG meeting in March. The Report now includes revised sections focusing on –

- Complaints by Outcome
- Lessons Learned
- Actions undertaken as a result of complaints

Following recommendations from the CCG's Quality Committee, it should be noted that this reports is still under development, commissioners will be asked for their feedback.

Complaints

182 complaints were received into the Trust in Q3. As expected, due to the re-classification of concerns into complaints (for concerns which cannot be closed within 1 working day) effective from September, we are currently 39% higher than the same period last year. Although in terms of overall numbers, the total number of concerns and complaints received up to the end of Q3, is actually 7.8% lower than the same period last year.



Top 3 Reasons for Complaint – Quarter 3 14/15

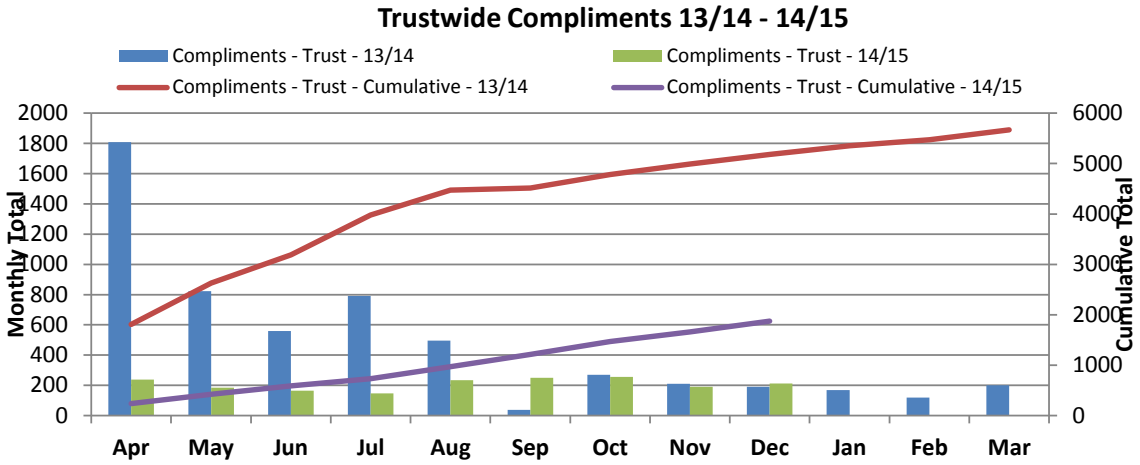
All complaints are categorised by the subjects and sub-subjects contained within them. This means that any one complaint can contain multiple subjects. The 182 complaints received in Q3 have in them 308 subjects, the breakdown of which will now be analysed.

The top three reasons for complaint in Quarter 3 were **Clinical Treatment** (28.9%), **Oral Communication** (20.5%) and **Date for Appointment** (12%). Combined, these top three subjects

account for 61.3% of all complaints received in Q3. Date for Appointment has seen a significant increase in the number of complaints in Q3, from an average of 4 complaints per month in Quarters 1 and 2, to an average of 12 in Quarter 3, possibly as a consequence of winter pressures and staffing issues impacting on patient appointments.

Compliments

The graph below shows compliment numbers this year compared to last. Numbers reported continue to be lower than last year, due to under-reporting on Datix.



10.4 Serious Untoward Incidents (SUIs)

SUIs Reported at Southport & Formby CCG level

For Southport & Formby CCG there has been 1 serious incidents reported in January 2015 - Unexpected Death of Community Patient (in receipt) and 29 Incidents reported YTD.

Number of Never Events reported in period

0 never events reported in January 15, 3 never events reported year to date.
1xSurgical Error (May – Alder Hey)
1xSerious Incident by Inpatient (not in receipt) (June – Royal Liverpool)
1xDrug Incident (general) (July – Southport & Ormskirk)

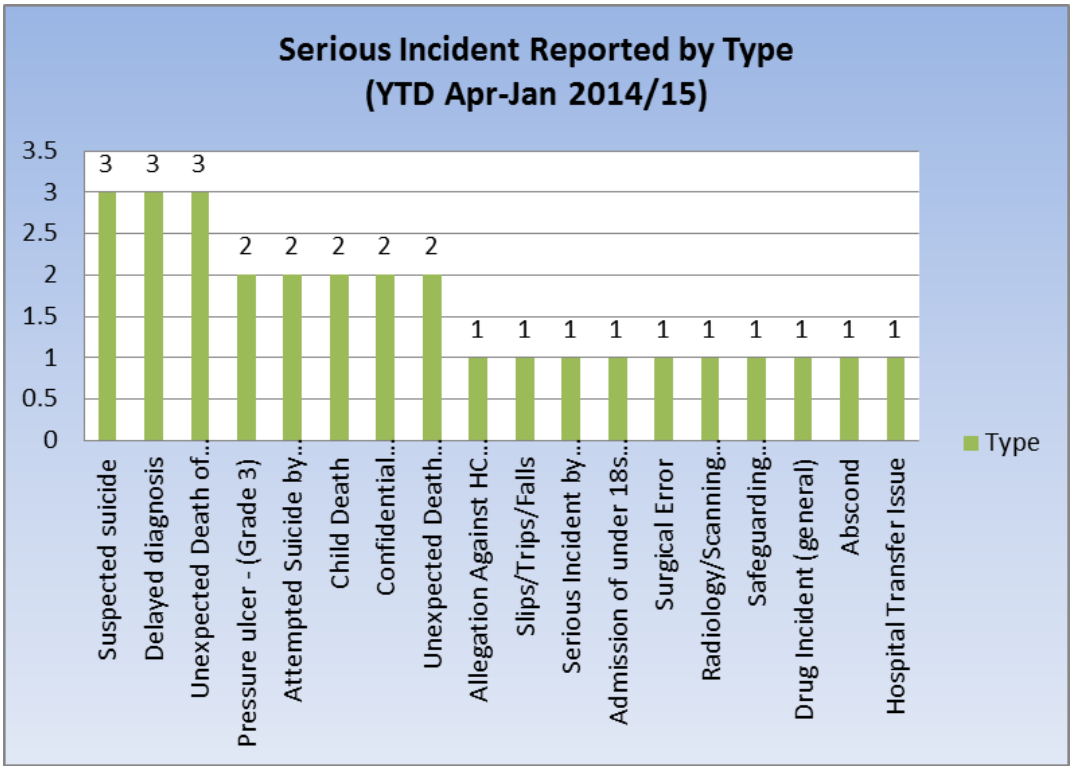
Number of repeated incidents reported YTD

The Trust has had eight incidents repeated in 2014/15.

- 3xSuspected suicide
- 3xdelayed diagnosis
- 3xUnexpected Death of Community Patient (in receipt)
- 2xConfidential Information Leak
- 2xAttempted Suicide by Outpatient (in receipt)
- 2xPressure ulcer – (Grade 3)
- 2xChild Death
- 2xUnexpected Death (General)

NHS Southport and Formby CCG reported Serious Untoward Incidents

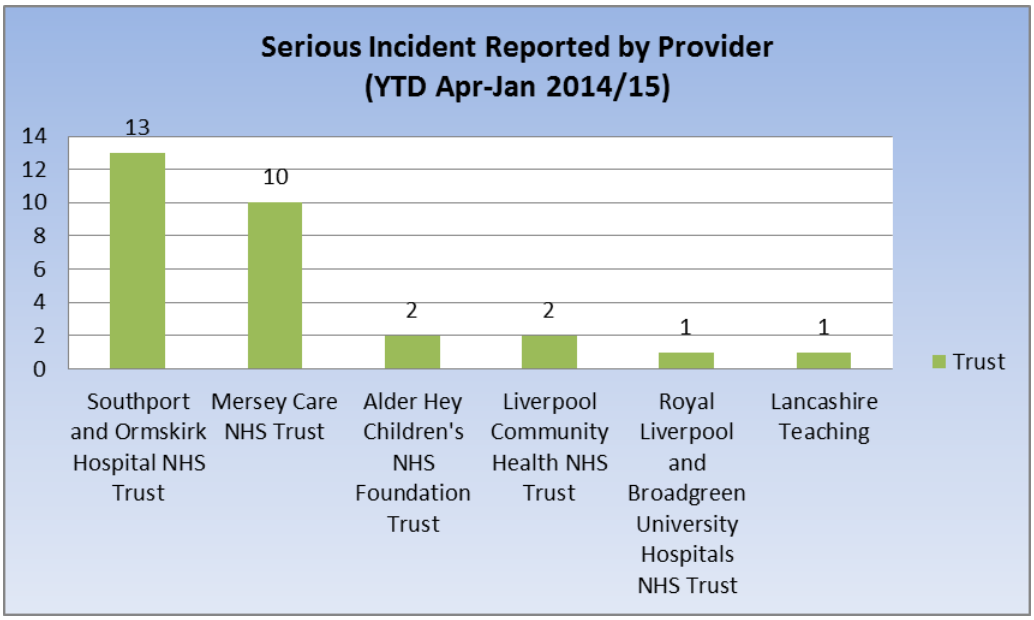
Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD
Suspected suicide		1			1	1					3
Delayed diagnosis			1				1	1			3
Confidential Information Leak				1			1				2
Unexpected Death of Community Patient (in receipt)		1				1				1	3
Child Death					1	1					2
Attempted Suicide by Outpatient (in receipt)		1						1			2
Pressure ulcer – (Grade 3)							1	1			2
Unexpected Death (general)									2		2
Slips/Trips/Falls							1				1
Safeguarding Vulnerable Child			1								1
Allegation Against HC Professional					1						1
Serious Incident by Inpatient (not in receipt)			1								1
Admission of under 18s to adult mental health ward	1										1
Surgical Error		1									1
Radiology/Scanning Incident	1										1
Abscond						1					1
Drug Incident (general)				1							1
Hospital Transfer Issue								1			1
Total	**2**	**4**	**3**	**2**	**3**	**4**	**4**	**4**	**2**	**1**	**29**



Number of Southport & Formby CCG Incidents reported by Provider

Please not the data comes from Datix and not StEIS, as such differences in the figures reported for Liverpool community health and Mersey Care will be notable. These known data issues are being worked though with the Providers and the differing data sets.

Provider / Type of Incident	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD
Alder Hey Children's NHS Foundation Trust											
Surgical Error		1									1
Allegation Against HC Professional					1						1
Lancashire Teaching Hospitals NHS Foundation Trust											
Unexpected Death (general)									1		1
Liverpool Community Health NHS Trust											
Child Death					1	1					2
Mersey Care NHS Trust											
Suspected suicide		1			1	1					3
Unexpected Death of Community Patient (in receipt)		1				1				1	3
Abscond						1					1
Admission of under 18s to adult mental health ward	1										1
Attempted Suicide by Outpatient (in receipt)		1						1			2
Royal Liverpool and Broadgreen University Hospitals NHS Trust											
Serious Incident by Inpatient (not in receipt)			1								1
Southport and Ormskirk Hospital NHS Trust											
Confidential Information Leak				1			1				2
Delayed diagnosis			1				1	1			3
Radiology/Scanning incident	1										1
Safeguarding Vulnerable Child			1								1
Slips/Trips/Falls							1				1
Drug Incident (general)				1							1
Pressure ulcer - (Grade 3)							1	1			2
Hospital Transfer Issue								1			1
Unexpected Death (general)									1		1
Grand Total	2	4	3	2	3	4	4	4	2	1	29



For Southport & Ormskirk Hospital there has been 0 serious incidents reported in January 2015, 27 Incidents reported YTD.

Number of Never Events reported in period

0 never events reported in January 15, 2 never events reported year to date both occurring in July 2014.

Number of repeated incidents reported YTD

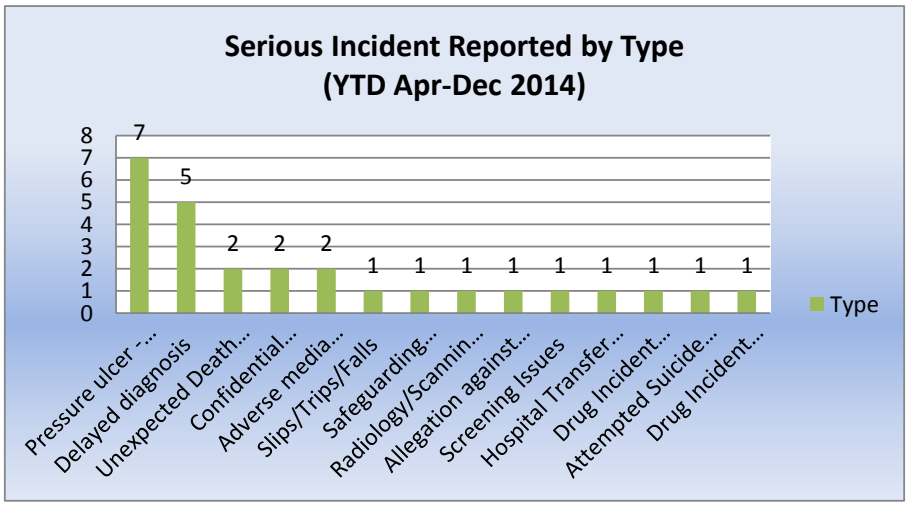
The Trust has had five incidents repeated in 2014.

- 7xPressure ulcer – (Grade 3)
- 5xDelayed diagnosis
- 2xUnexpected death (general)
- 2xConfidential Information Leak
- 2xAdverse media coverage or public concern

Number of incidents reported split by type

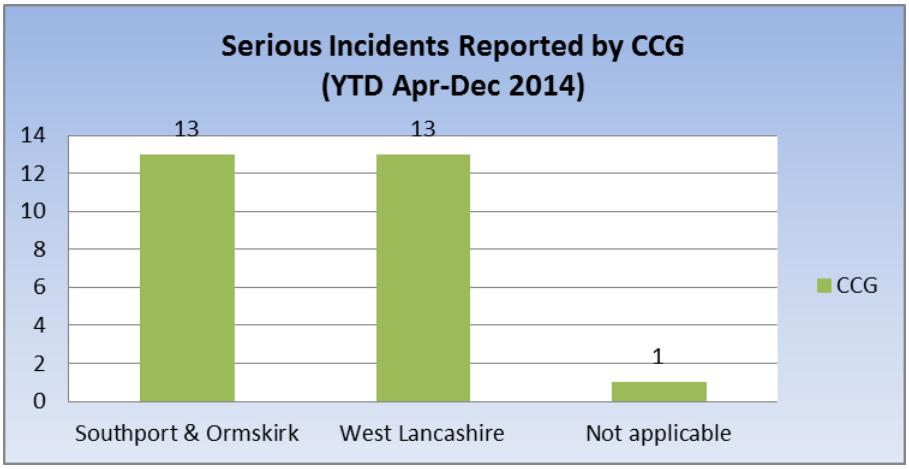
27 incidents reported YTD by the provider (Southport & Ormskirk Hospital).

Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Pressure ulcer - (Grade 3)							3	1	3	7
Delayed diagnosis			1	1			2	1		5
Unexpected Death (general)									2	2
Confidential Information Leak				1			1			2
Adverse media coverage or public concern about the organisation or the wider NHS					1	1				2
Slips/Trips/Falls							1			1
Safeguarding Vulnerable Child			1							1
Radiology/Scanning incident	1									1
Allegation against HC non-Professional								1		1
Screening Issues									1	1
Hospital Transfer Issue								1		1
Drug Incident (Chemotherapy)				1						1
Attempted Suicide by Inpatient (in receipt)							1			1
Drug Incident (general)				1						1
Grand Total	1	0	2	4	1	1	8	4	6	27



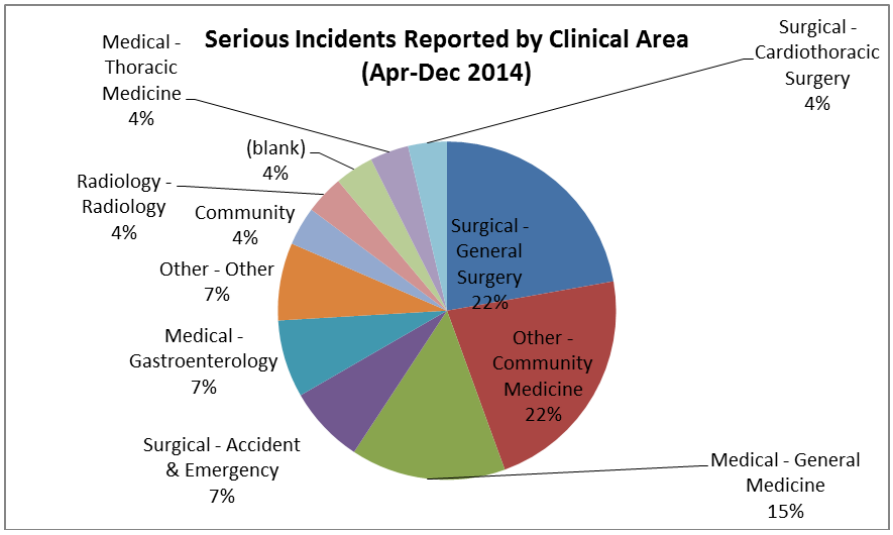
Number of Incidents reported by CCG

CCG Name / Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Southport and Formby CCG										
Confidential Information Leak				1			1			2
Delayed diagnosis			1				1	1		3
Drug Incident (general)				1						1
Hospital Transfer Issue								1		1
Pressure ulcer - (Grade 3)							1	1		2
Radiology/Scanning incident	1									1
Safeguarding Vulnerable Child			1							1
Slips/Trips/Falls							1			1
Unexpected Death (general)									1	1
West Lancashire CCG										
Adverse media coverage or public concern about the organisation or the wider NHS					1	1				2
Attempted Suicide by Inpatient (in receipt)							1			1
Delayed diagnosis				1			1			2
Drug Incident (Chemotherapy)				1						1
Pressure ulcer - (Grade 3)							2		3	5
Screening Issues									1	1
Unexpected Death (general)									1	1
Not Applicable										
Allegation against HC non-Professional								1		1
Grand Total	1	0	2	4	1	1	8	4	6	21



Incidents reported by clinical area

The majority of incidents reported split by clinical area have been categorized as ‘Surgical – General Surgery’ and ‘Other – Community Medicine’.



All incident investigations and action plans are discussed in details at the CCG's Monthly SUI Management Group Meetings.

11. Primary Care

11.1 Background

The primary care dashboard has been developed during the summer of 2014 with the intention of being used in localities so that colleagues from practices are able to see data compared to their peers in a timely and consistent format. From this, localities can use this data to request further analysis, raise queries with providers, determine local priorities for action, understand demand, and monitor improvement. The tool is to aid improvement, not a performance management tool.

11.2 Content

The dashboard is still evolving, but at this stage the following sections are included: Urgent care (A&E attendances and emergency admissions for children and adults separately), Demand (referrals, Choose & Book information, cancer and urgent referrals), and Prescribing indicators. Future developments during winter 2014 include QOF data, financial information, and public health indicators.

11.3 Format

The data is presented for all practices, grouped to locality level and RAG rated to illustrate easily variation from the CCG average, where green is better than CCG average by 10% or more, and red is worse than CCG average. Amber is defined as better than CCG average but within 10%. Data is refreshed monthly, where possible and will have a 6 week time lag from month end for secondary care data and prescribing data, and less frequent updates for the likes of annual QOF data. The dashboards have been presented to Quality Committee and to localities, and feedback has been positive. The dashboards will be available on the new Cheshire & Merseyside Intelligence Portal (CMiP)

11.4 **Summary of performance**

A summary of the primary care dashboard measures at locality level for data relating to June 2014 is presented below. The criteria for the Red, Amber, Green rating is described above.

Figure 21 Summary of Primary Care Dashboard

	A&E Attendance rate per 1,000 for under 19's (12 Mths to Nov-14)	A&E Attendance rate per 1,000 for over 19's (12 Mths to Nov-14)	Emergency Admission rate per 1,000 for under 19's (12 Mths to Nov-14)	Emergency Admission rate per 1,000 for over 19's (12 Mths to Nov-14)
Ainsdale & Birkdale	45.6	138.1	38.3	61.9
Central Southport	44.9	177.4	50.6	75.0
Formby	49.7	109.6	35.6	53.3
North Southport	38.8	141.4	39.4	67.0
Southport & Formby CCG	*44.5*	*144.4*	*41.7*	*65.2*

Appendix 1

01V NHS Southport and Formby Clinical Commissioning Group Month 11 Financial Position

Cost centre Number	Cost Centre Description	Annual Budget	Budget To Date	Actual To Date	Variance to date	End of Year	
						Expenditure Outturn	FOT Variance
		£000	£000	£000	£000	£000	£000
COMMISSIONING - NON NHS							
603501	Mental Health Contracts	812	743	743	0	812	0
603506	Child and Adolescent Mental Health	119	109	113	4	124	5
603511	Dementia	84	77	77	0	84	0
603521	Learning Difficulties	1,306	1,191	1,130	(61)	1,239	(67)
603531	Mental Health Services – Adults	0	0	0	0	0	0
603541	Mental Health Services - Collaborative Commissioning	239	239	239	0	239	0
603596	Collaborative Commissioning	409	375	337	(39)	371	(38)
603661	Out of Hours	1,069	979	945	(34)	1,030	(39)
603682	CHC Adult Fully Funded	3,799	3,370	4,808	1,438	5,621	1,822
603684	CHC Adult Joint Funded	2,738	2,628	2,644	16	2,756	18
603685	CHC Adult Joint Funded Personal health Budgets	47	45	132	87	142	95
603687	CHC Children	319	293	266	(27)	302	(17)
603691	Funded Nursing Care	3,258	2,987	2,909	(78)	3,173	(85)
603711	Community Services	1,134	1,041	1,100	60	1,199	65
603721	Hospices	864	789	789	0	864	0
603726	Intermediate Care	392	356	339	(16)	352	(40)
603796	Reablement	997	915	915	0	997	0
Sub-Total		**17,588**	**16,135**	**17,485**	**1,350**	**19,307**	**1,719**
CORPORATE & SUPPORT SERVICES							
605251	Administration and Business Support (Running Cost)	136	125	128	3	140	4
605271	CEO/Board Office (Running Cost)	605	555	499	(56)	550	(55)
605276	Chairs and Non Execs (Running Cost)	152	139	144	5	157	5
605296	Commissioning (Running Cost)	1,238	1,135	1,087	(47)	1,187	(51)
605316	Corporate costs	174	160	102	(58)	122	(52)
605346	Estates & Facilities	87	44	43	(1)	47	(40)
605351	Finance (Running Cost)	375	344	319	(25)	350	(25)
605391	Medicines Management (Running Cost)	29	27	24	(3)	27	(2)
605426	Quality assurance	59	54	52	(2)	57	(2)
605266	BUSINESS INFORMATICS	61	56	41	(15)	44	(16)
605456	Quality Premium Admin	279	256	0	(256)	0	(279)
	Sub-Total Running Costs	**3,196**	**2,893**	**2,439**	**(454)**	**2,683**	**(513)**
603646	Commissioning Schemes (Programme Cost)	741	679	627	(52)	707	(33)
603656	Medicines Management (Programme Cost)	503	461	445	(16)	486	(17)
603776	Non Recurrent Programmes (NPfIT)	721	647	647	0	621	(100)
603676	Primary Care IT	613	562	551	(11)	613	0
605371	IM & T	0	0	0	0	0	0
	Sub-Total Programme Costs	**2,578**	**2,348**	**2,270**	**(78)**	**2,427**	**(150)**
Sub-Total		**5,774**	**5,241**	**4,709**	**(532)**	**5,111**	**(663)**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS							
603571	Acute Commissioning	77,649	71,178	72,713	1,535	79,774	2,125
603576	Acute Childrens Services	2,121	1,944	2,030	85	2,214	93
603586	Ambulance Services	4,527	4,150	4,124	(26)	4,503	(24)
603616	NCAs/OATs	1,284	1,177	1,172	(5)	1,299	15
603631	Winter Pressures	2,228	1,557	1,557	(0)	2,228	0
603566	Mental Health Winter Resilience	74	0	0	0	74	0
603756	Commissioning - Non Acute	27,450	25,163	25,091	(71)	27,414	(37)
603786	Patient Transport	8	7	7	0	8	0
Sub-Total		**115,341**	**105,176**	**106,695**	**1,519**	**117,514**	**2,173**
INDEPENDENT SECTOR							
603591	Independent Sector	3,311	3,035	3,823	788	4,147	836
Sub-Total		**3,311**	**3,035**	**3,823**	**788**	**4,147**	**836**
PRIMARY CARE							
603651	Local Enhanced Services and GP Framework	2,132	1,920	1,990	70	2,169	37
603791	Programme Projects	261	238	59	(180)	64	(197)
Sub-Total		**2,393**	**2,158**	**2,048**	**(110)**	**2,233**	**(160)**
PRESCRIBING							
603606	High Cost Drugs	1,493	1,369	1,257	(111)	1,385	(108)
603666	Oxygen	194	177	109	(68)	126	(68)
603671	Prescribing	20,793	19,039	19,378	339	21,362	569
Sub-Total		**22,481**	**20,584**	**20,744**	**159**	**22,874**	**393**
Sub-Total Operating Budgets pre Reserves		**166,886**	**152,330**	**155,504**	**3,174**	**171,184**	**4,298**
RESERVES							
603761	Commissioning Reserve	4,628	3,568	394	(3,174)	330	(4,298)
Sub-Total		**4,628**	**3,568**	**394**	**(3,174)**	**330**	**(4,298)**
Grand Total I & E		**171,514**	**155,898**	**155,898**	**0**	**171,514**	**0**
RRL Allocation		(173,264)	(157,502)	(157,502)	0	(173,264)	0
(Surplus)/Deficit		(1,750)	(1,604)	(1,604)	0	(1,750)	0

NHS Southport and Formby Clinical Commissioning Group

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Appendix 2

01V NHS Southport and Formby Clinical Commissioning Group Month 11 Contract Summary

Description	Annual Budget	Budget To Date	Actual To Date	YTD Variance			Forecast Variance (Most Likely)		
				Month 11	Month 10	Movement	Month 11	Month 10	Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000
ACUTE CHILDRENS SERVICES									
ACUTE CHILDRENS SERVICES	2,121	1,944	2,030	85	76	9 ▲	93	92	2 ▲
Sub-Total	**2,121**	**1,944**	**2,030**	**85**	**76**	**9**	**93**	**92**	**2**
ACUTE COMMISSIONING									
AINTREE UNI HOSP NHS FT	4,763	4,366	5,055	690	492	197 ▲	780	542	238 ▲
AINTREE ANTICOAGULENT CLINIC	259	237	236	(2)	(6)	5 ▲	0	5	(5) ▼
ANY QUALIFIED PROVIDER	187	171	321	149	67	82 ▲	83	81	2 ▲
C MANC UNI HOS NHS FT	77	70	90	19	14	5 ▲	21	17	4 ▲
COUNTESS OF CHESTER FT	17	16	12	(4)	2	(6) ▼	(4)	2	(7) ▼
LANCS TEACH HOSP NHS FT	349	320	315	(5)	48	(54) ▼	0	58	(58) ▼
LIVP HRT/CHST HOSP NHST	1,201	1,101	1,251	150	132	18 ▲	164	158	6 ▲
LIVP WOMENS NHS FT	1,155	1,058	1,063	4	19	(14) ▼	5	23	(18) ▼
R LIV/BRG UNI HOSP NHST	4,807	4,407	4,930	523	403	120 ▲	550	564	(14) ▼
NHS LIVERPOOL CCG	0	0	(500)	(500)	0	(500) ▼	(500)	0	(500) ▼
SOUTHPORT/ORMSKIRK NHST	62,239	57,052	57,197	145	127	18 ▲	631	631	0
ST HEL/KNOWS TEACH NHST	1,381	1,266	1,403	137	141	(4) ▼	149	169	(20) ▼
UNI HOSP SMAN NHS FT	49	45	66	21	13	9 ▲	23	15	8 ▲
WALTON CENTRE NHS FT	104	95	95	0	0	0	0	0	(0)
WIRRAL UNIV TEACH HOSP	172	158	191	33	52	(19) ▼	37	50	(13) ▼
WRIGHT/WGN/LEIGH NHS FT	890	815	988	172	158	14 ▲	188	190	(1) ▼
Sub-Total	**77,649**	**71,178**	**72,711**	**1,533**	**1,662**	**(128)**	**2,125**	**2,504**	**(379)**
COMMISSIONING - NON ACUTE									
CHESH/WIRRAL PART NHSFT	9	8	8	0	(1)	1	0	(1)	1
AINTREE UNI HOSP NHS FT	0	0	22	22	22	0	0	0	0
LPOOL COMM HC NFT	2,987	2,738	2,738	0	0	0	0	0	(0)
MERSEY CARE NHST	12,231	11,212	11,212	0	0	0	0	0	(0)
NHS 111 SERVICE	196	179	172	(8)	4	(12) ▼	(9)	5	(14) ▼
SOUTHPORT/ORMSKIRK NHST	10,797	9,897	9,869	(27)	(11)	(17) ▼	31	(13)	44 ▲
S&O ANTICOAGULENT CLINIC	0	0	0	0	0	0	0	0	0
STTFFS/SHRPS HC NHS FT	1,231	1,128	1,070	(59)	1	(60) ▼	(59)	1	(60) ▼
Sub-Total	**27,450**	**25,163**	**25,090**	**(72)**	**15**	**(87)**	**(37)**	**(7)**	**(29)**
AMBULANCE SERVICES									
NW AMBUL SVC NHST	4,527	4,150	4,124	(26)	32	(57) ▼	(24)	38	(62) ▼
Sub-Total	**4,527**	**4,150**	**4,124**	**(26)**	**32**	**(57)**	**(24)**	**38**	**(62)**
Grand Total	**111,747**	**102,435**	**103,955**	**1,521**	**1,785**	**(264)**	**2,158**	**2,626**	**(468)**

Description	Annual Budget	Budget To Date	Actual To Date	YTD Variance			Forecast Variance (Most Likely)		
				Month 11	Month 10	Movement	Month 11	Month 10	Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000
RAMSAY HEALTHCARE UK	2,469	2,263	2,861	597	526	72 ▲	609	574	35 ▲
ISIGHT LTD	597	547	611	64	31	33 ▲	77	42	36 ▲
SPIRE HEALTHCARE LTD	135	124	214	90	82	9 ▲	108	112	(4) ▼
Fairfield	14	13	22	9	8	1	10	18	(8) ▼
British Pregnancy Advisory Service	15	14	24	10	10	(0)	13	17	(4) ▼
Other Cost Per Case IS Providers	81	74	91	17	(14)	32 ▲	18	(17)	35 ▲
Sub-Total	**3,311**	**3,035**	**3,823**	**788**	**643**	**146**	**836**	**747**	**89**

Appendix 3

Point of Delivery breakdown (includes NHS and Independent Sector providers)

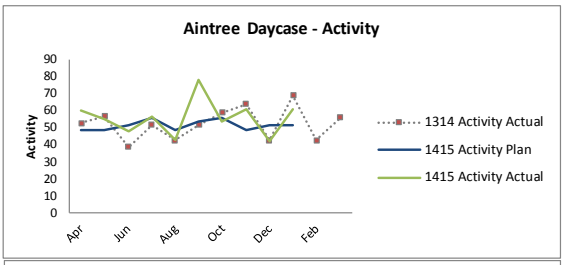
	Up to and including January 2015			
Point of Delivery	Budget to date	Actual to date	Variance to date	Variance
Day Cases	8,775,956	9,417,664	641,708	7.31%
Elective Inpatients	7,224,188	6,742,257	-481,932	-6.67%
Elective XBDs	167,612	191,828	24,216	14.45%
Outpatient - New attendances	3,952,495	3,737,089	-215,406	-5.45%
Outpatient - Follow up attendances	5,293,247	5,520,803	227,556	4.30%
Outpatient Procedures	2,654,855	3,534,481	879,626	33.13%
Unbundled diagnostics	1,024,953	1,217,871	192,918	18.82%
AandE	3,040,332	3,266,930	226,598	7.45%
Non-elective admissions	19,869,528	21,255,450	1,385,922	6.98%
Non-elective excess bed-days	1,161,797	1,116,247	-45,550	-3.92%
Maternity pathway	1,860,380	1,420,300	-440,081	-23.66%
Critical Care	1,412,123	1,599,642	187,519	13.28%
High Cost Drugs	1,990,857	2,313,433	322,576	16.20%
Grand Total	**58,428,324**	**61,333,996**	**2,905,672**	4.97%

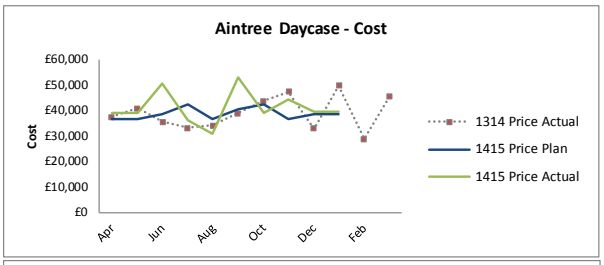
Note: This does not reflect the impact of the marginal rate for non-elective admissions at Southport and Ormskirk Trust.

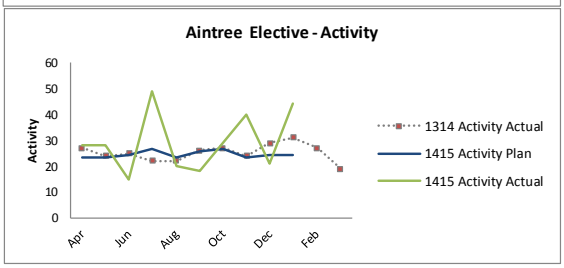
Appendix 4 Main Provider Activity & Finance Comparisons

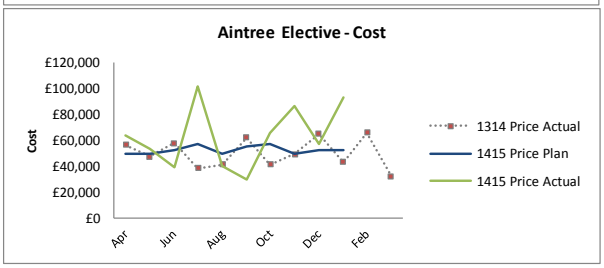
Figure 22 Month 10 Planned Care Aintree Hospital NHS Trust (13/14 and 14/15 comparison)

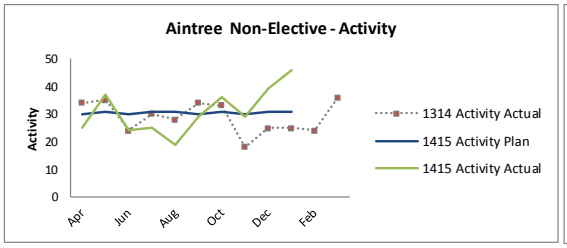
Aintree Hospital Southport & Formby CCG			2014/15 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	49	49	51	56	49	54	56	49	51	51		
		1415 Activity Actual	60	55	48	57	43	78	54	61	42	61		
	Price	1415 Price Plan	£36,975	£36,975	£38,823	£42,521	£36,975	£40,672	£42,521	£36,975	£38,823	£38,823		
		1415 Price Actual	£39,067	£39,166	£50,783	£36,422	£30,858	£53,211	£39,158	£44,585	£39,493	£39,667		
Elective	Activity	1415 Activity Plan	23	23	24	27	23	26	27	23	24	24		
		1415 Activity Actual	28	28	15	49	20	18	29	40	21	44		
	Price	1415 Price Plan	£50,066	£50,066	£52,569	£57,575	£50,066	£55,072	£57,575	£50,066	£52,569	£52,569		
		1415 Price Actual	£64,095	£52,993	£39,161	£101,361	£39,806	£30,127	£66,065	£86,628	£57,566	£92,863		
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	30	31	30	31	31	30	31	30	31	31		
		1415 Activity Actual	25	37	24	25	19	29	36	29	39	46		
	Price	1415 Price Plan	£55,035	£56,870	£55,035	£56,870	£56,870	£55,035	£56,870	£55,035	£56,870	£56,870		
		1415 Price Actual	£63,084	£93,058	£45,066	£42,774	£28,554	£50,471	£61,185	£62,611	£68,657	£78,093		
AandE	Activity	1415 Activity Plan	64	66	64	66	66	64	66	64	66	66		
		1415 Activity Actual	65	69	75	71	82	77	67	77	64	74		
	Price	1415 Price Plan	£6,615	£6,836	£6,615	£6,836	£6,836	£6,615	£6,836	£6,615	£6,836	£6,836		
		1415 Price Actual	£6,912	£7,065	£7,935	£7,232	£8,729	£8,361	£6,954	£7,453	£7,103	£8,440		

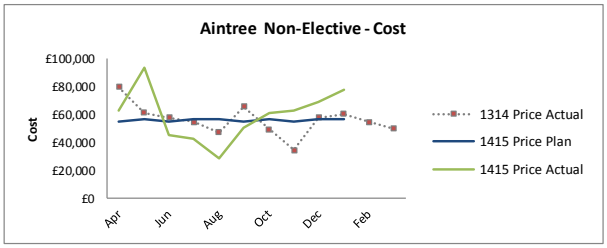


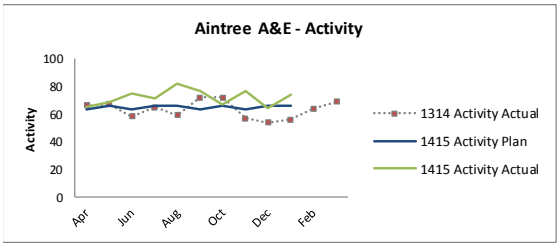












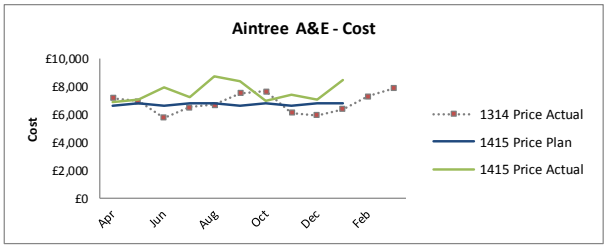
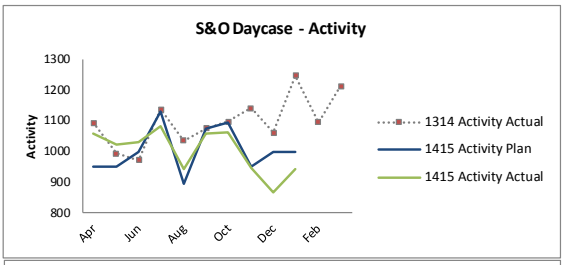
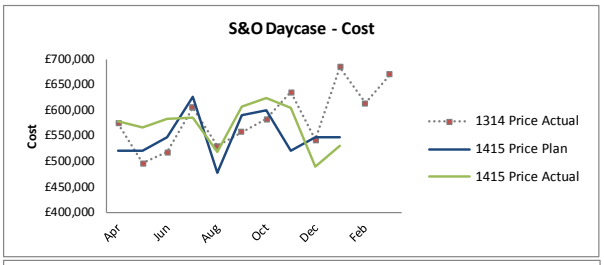
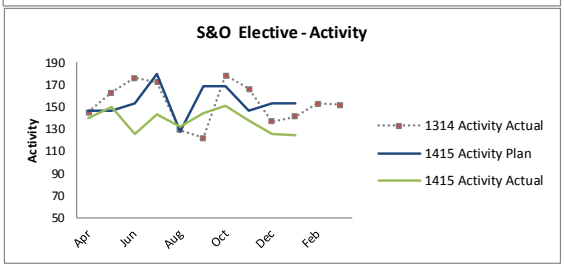


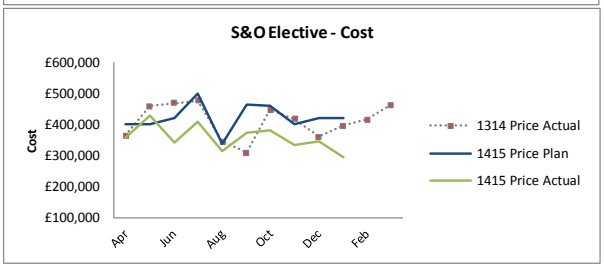
Figure 23 Month 10 Planned Care Southport and Ormskirk Hospital NHS Trust (13/14 and 14/15 comparison)

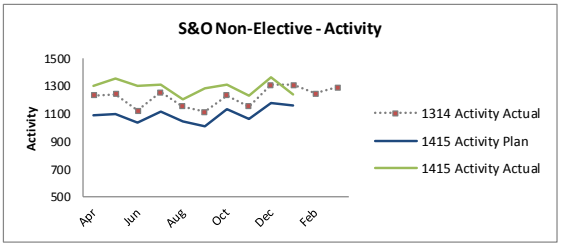
Southport & Ormskirk Hospital Southport & Formby CCG			2014/15											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	953	953	1001	1131	894	1073	1096	953	1001	1001		
		1415 Activity Actual	1060	1024	1031	1084	942	1059	1064	946	867	944		
	Price	1415 Price Plan	£522,238	£522,238	£548,350	£626,091	£479,156	£592,026	£600,574	£522,238	£548,350	£548,350		
		1415 Price Actual	£578,305	£566,859	£584,630	£586,402	£519,706	£606,915	£624,558	£604,125	£489,912	£531,233		
Elective	Activity	1415 Activity Plan	146	146	154	179	128	168	168	146	154	154		
		1415 Activity Actual	140	150	125	143	132	144	151	138	125	124		
	Price	1415 Price Plan	£400,734	£400,734	£420,771	£498,505	£337,966	£465,915	£460,844	£400,734	£420,771	£420,771		
		1415 Price Actual	£359,883	£427,076	£343,770	£407,316	£316,007	£375,257	£381,182	£335,502	£344,322	£296,750		
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	1092	1099	1035	1119	1047	1012	1133	1066	1175	1159		
		1415 Activity Actual	1304	1356	1300	1314	1200	1284	1306	1231	1360	1236		
	Price	1415 Price Plan	£1,816,601	£1,822,149	£1,721,693	£1,868,207	£1,745,465	£1,626,736	£1,855,415	£1,734,051	£1,881,886	£1,900,093		
		1415 Price Actual	£1,951,726	£1,989,344	£1,953,566	£2,041,613	£1,865,604	£1,906,128	£2,079,169	£1,875,518	£2,069,254	£1,972,912		
AandE	Activity	1415 Activity Plan	2815	2745	2722	2965	2686	2544	2725	2653	2863	2610		
		1415 Activity Actual	2896	2983	2982	3163	2815	2918	3133	2992	3199	2849		
	Price	1415 Price Plan	£293,572	£286,319	£283,934	£309,222	£280,158	£265,353	£284,232	£276,680	£298,590	£272,259		
		1415 Price Actual	£306,334	£313,885	£314,986	£325,568	£297,525	£304,554	£316,028	£290,107	£314,969	£288,807		

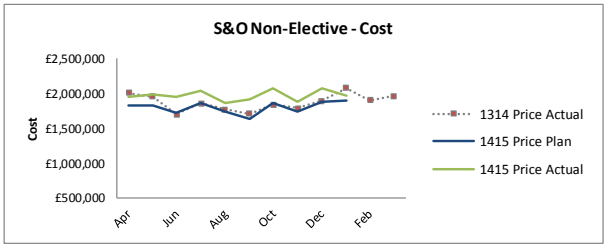


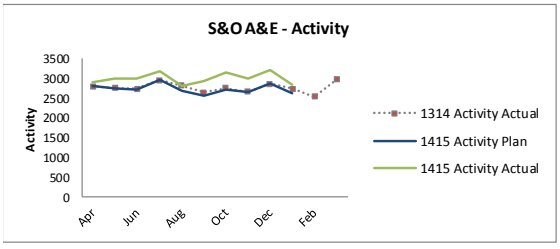


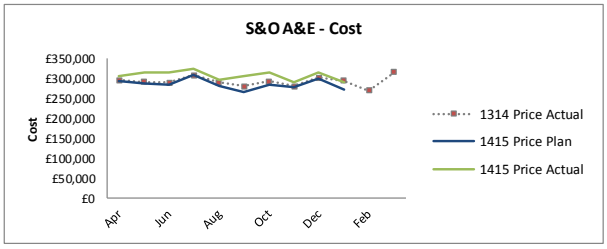












Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Wednesday, 21st January 2015	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions
• CHC costs/administration (management plan – finance report)	• Increased costs/longer review time	• Continued benchmarking/on-going face-to-face meetings with CSU
• Financial risk 2015/16	• High level of unidentified QIPP	• Continued review over February/March to balance financial position

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

- CCG financial offer 2014/15 disputed by the Trust (c£1m).
- Recommended continuation of Transform Team £96k – support End of Life Care.
- Agreed proposals to earmark previous NPFIT funding for QIPP/transformation schemes.

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Wednesday, 18th February 2015	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions
• Estates Review	• Not achieving VFM	• Establish Estates Implementation Working Group

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

- CCG remains on course to deliver it's financial duties for the year, although further management action is required. Key risks to delivery include prescribing costs, CHC and acute care.
- The CCG approved the NICE recommendation in relation to commissioning the drug Nalmefene for reducing alcohol consumption in people with alcohol dependence.
- The Committee noted a number of benchmarking reports, and asked for further clinical engagement to develop a narrative to help identify improved options for value for money/better outcomes.

Key Issues
Quality Committee

NHS
Southport and Formby
Clinical Commissioning Group

Meeting Date	**December 2014**
Chair	**Rob Caudwell**

Key Issues	Risks Identified	Mitigating Actions
• CCG Safeguarding Peer Review Action Plan	• Delivery of action plan within set timescales	• Positive progress made in the latest version of the action plan due to achievement of key deliverables i.e. Safeguarding Annual Report, Safeguarding Strategy, Service specification etc.
• Safeguarding Training for General Practice	• The need to for Safeguarding Training is relevant to the needs of General Practice	CCG Clinical Vice Chair taking a lead role as part of the PLT planning group
• Identified trend in Continuing Health Care complaints	• Clinical, financial and reputational risks for the CCG	• CHC on Corporate Risk Register • CHC complaints built into workplan of the CCG/CSU CHC Steering Group

Notifications for the Governing Body
1. **Approval of Policies** – the following policies were approved: Information Governance Policy, Confidentiality & Data Security Policy, Subject Access Request Policy, Freedom of Information Policy and the Corporate Records Management & Retention Policy. This means a reduction in the number of Information Governance Policies from 10 to 5.

Key Issues
Quality Committee

NHS
Southport and Formby
Clinical Commissioning Group

Meeting Date	**February 2015**
Chair	**Helen Nichols**

Key Issues	Risks Identified	Mitigating Actions
• Safeguarding - S&O Safeguarding Performance	• Limited assurance given by the CCG Safeguarding Service	• Contract query signalled at February 2015 meeting
• Complaints – timelines for completion and closure	• Quality of existing process	• Plans in place to performance manage CSU with regard to this function to improve quality of the service • CCG have signalled the intention to bring this service 'in-house' in 2015/16

Notifications for the Governing Body
1. **CCG Safeguarding Strategy 2015-17** – revised version presented to the Quality Committee (further amendments made by the Safeguarding Service to reflect the Care Act). The Quality Committee are recommending approval to the Governing Body.
2. **CQC Intelligent Monitoring** – Bandings of General Practices within the CCG area as of February 2015 received by the Committee.

Key Issues
SIR

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Meeting Date	**Wednesday 14th January 2015**
Chair	**Dr Niall Leonard**

Key Issues	Risks Identified	Mitigating Actions
Community Navigation (Health Trainers) The committee supported the model presented.	Need to ensure fits with CCGs locality approach Financial model also needs working through	Anna Nygaard working with CCG reps to address risks.
Ophthalmology Community Assessment Service The committee requested more detail including additional data to understand impact of the scheme.	The scheme may not deliver the expected outcomes.	Further data requested and Dr Bal Duper to attend next SIR committee.
Respiratory Strategy Jenny Kristiansen attended the Committee alongside Tracy Kirk who provided an overview of the proposed respiratory strategy.	Respiratory scheme not worked up for the North.	Fiona Doherty and the Finance Team to support Jenny Kristiansen to develop a proposal for the North.
Termination of Pregnancy (ToP) Services NHS England have introduced a new standard service specification for Termination of Pregnancy (ToP) Services. The committee accepted the recommendation for Any Qualified provider procurement for ToP based on the amended specification with a standard tariff.	The CCG is working with other Cheshire and Mersey CCGs on this development to reduce risks and manage the procurement issues.	

Recommendations to the Governing Body
1. **The Governing Body is asked to receive the contents of this Key Issues log by way of assurance**

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Audit Committee Meeting held on Wednesday, 7th January 2015	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions
• Strengthen assurance regarding the CCG Risk Register and GB Assurance Framework by Audit Committee, receiving reports for review on an annual basis (October).	• Audit Committee not receiving full assurance/ input into the CCG Risk Register and GB Assurance Framework.	• Review on an annual basis.

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

- New NHS England guidance has been published regarding management of Conflict of Interests. This will be reviewed at either March GB meeting or April Audit Committee meeting.
- Delegated Approval has been given to the CFO/Audit Committee Chair to review the CCG's IG Toolkit before signing compliance statement by end of March.
- Local Counter Fraud Services reported that all Members of CCG (excluding recent new starters) had received training on fraud awareness.
- A comprehensive discussion was held regarding the checklist (supplied by external audit) relating to the effectiveness of the Committee. It was noted that higher than average scores were reported by the Committee.
- It was suggested that the notes of primary care approvals group should be received by the Audit Committee for completeness.
- The Committee noted that the reconsolidated report on follow-up actions to audits should be received twice a year (and added to Work Plan) – suggested dates are October/April meetings.
- The external audit plan reported the following 3 generic audit risks:
  1. Risk of management override of controls – significant;
  2. Risk of fraud in revenue and expenditure recognition – significant; and
  3. Medium-term financial sustainability – elevated.

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Minutes

Wednesday 19th November 2014, 9.30am to 11.30am
Family Life Centre, Ash Street, Southport

Membership		
Helen Nichols	Lay Member (Chair)	HN
Dr Martin Evans	GP Governing Body Member	ME
Dr Hilal Mulla	GP Governing Body Member	HM
Roger Pontefract	Lay Member	RP
Colette Riley	Practice Manager	CR
Martin McDowell	Chief Finance Officer	MMcD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Ex-officio Member		
Fiona Clark	Chief Officer	FLC
In attendance		
David Smith	Deputy Chief Finance Officer	DS
James Bradley	Head of Strategic Finance Planning	JB
Susanne Lynch	CCG Lead for Medicines Management	SL
Becky Williams	Chief Analyst	BW
Minutes		
Ruth Moynihan	PA to Chief Finance Officer	RM

Attendance Tracker

Name	Membership	Nov 14	Jan 15	Feb 15	Mar 15	May 15	June 15	July 15	Sept 15	Oct 15	Nov 15	Jan 16
Helen Nichols	Lay Member (Chair)	√										
Dr Martin Evans	GP Governing Body Member	√										
Dr Hilal Mulla	GP Governing Body Member	A										
Roger Pontefract	Lay Member	√										
Colette Riley	Practice Manager	√										
Martin McDowell	Chief Finance Officer	√										
Debbie Fagan	Chief Nurse & Quality Officer	√										
Jan Leonard	Chief Redesign & Commissioning Officer	√										
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A										
Fiona Clark	Chief Officer	A										
David Smith	Deputy Chief Finance Officer	√										
James Bradley	Head of Strategic Finance Planning	√										
Susanne Lynch	CCG Lead for Medicines Management	√										
Fiona Doherty	Transformational Change Manager	A										
Becky Williams	Chief Analyst	√										

✓ = Present A = Apologies N = Non-attendance

No	Item	Action
FR14/126	**Apologies for absence** Apologies for absence were received from Dr Hilal Mulla, Fiona Clark, Tracy Jeffes, Fiona Doherty, Malcolm Cunningham and Karl McCluskey.	
FR14/127	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflicts of interest.	
FR14/128	**Minutes of the previous meeting** The Minutes of the previous meeting were approved as a true and accurate record except for the following two points raised by HN: 1. In paragraph 4 of FR14/118 the meeting between MMcD and the Director of Finance was to be clarified as being with the Southport and Ormskirk Trust. 2. There is a typing error in the last paragraph of FR14/119. The word "outlay" should read "outlier".	
FR14/129	**Action points from the previous meeting** **FR13/78e** – cost reduction via coding for case for change glaucoma - BW confirmed this was month 9 of the programme and a fuller report would be available at month 12. BW stated that if optometrists were to receive more patients then they would have to make investment in extra equipment, but a 1 year contract is a barrier to this and an extension to a 3 year contract might encourage more people to join up to a scheme. HN asked if there was any reduction in secondary care? Although hard to track, BW would try to identify and understand if this had been achieved. It was noted that it was more difficult to outcode outpatients as opposed to inpatients. **FR14/84 & FR14/116** - Reducing A&E attendances - JL stated that although admission numbers were still high this did not reflect the "true story" and that BW is undertaking a piece of work to identify and understand patient flows into A&E. MMcD acknowledged this as a multi-faceted issue and together with RP suggested putting all ideas together for a future development session. When JL has received BW's report, JL will put an action plan together for a future development session. **FR14/86** – Benchmarking/high spending areas - DS confirmed Karl McCluskey is compiling a report on this and will bring it to the development session in December. HN requested this item to be listed on January's agenda. MMcD raised the issue of programme budgeting and noted that there are 23 categories of spends. The figures are to be collated and compared on a national basis and the results will be brought to the Committee in January 2015, with the intention of shaping and influencing future discussions on spending.	BW JL DS MMcD

No	Item	Action
FR14/129	**Action points from the previous meeting *(continued)*** **FR14/123** – Category M drugs – mental health costs - MMcD confirmed this will be part of programme budgeting and will be addressed by above exercise. **FR14/94** – APC Recommendations – to be reported in May 2015.	
FR14/130	**Month 7 Finance Report** This report focussed on the financial performance of the CCG at October 2014 (Month 7), which is £2.187m overspent (£1.417m in M6) on operational budget areas before the application of Reserves. The CCG experienced financial pressures in the first half of the year, and management actions are required in order to achieve the planned £1.750m surplus at the end of the year. With implementation of the management action plan detailed in section 8, the CCG remains on track to meet all the business rules required by NHS England. JB noted an improvement in comparison to last month with the reason being reset of threshold for emergency admissions, which has improved forecast by £600k. JB noted that the CCG had made considerable investment at the start of the year in "system improvement schemes". HN asked when the CHC review would be complete. DS confirmed there were different phases and the Nurse Health Consultant is starting to review this. DF said she was starting to look at mental health within CHC. DF is to follow this up this week and will discuss next steps within the next couple of weeks. An update will be available next week at the SLT. MMcD said we are working with another CCG from outside of Merseyside to do some benchmarking. HN asked if this person is looking at it from a clinical perspective? DF confirmed yes. MMcD said once we get first report back we will understand scope of the task and the impact in terms of how we progress next steps. With regard to continuing healthcare restitution claims MMcD said that indications locally were this pool was being significantly under-utilised. If this is reflected across the county, it may lead to some funding being returned. HN said it would be more favourable to get a small number of high value claims settled before the end of the year and requested a report on this. MMcD confirmed it would feature in the CSU report, requested. With regard to the Management Action Plan, MMcD would like to bring an update in January in respect of QIPP options for 2015/16.	MMcD

No	Item	Action
FR14/130	**Month 7 Finance Report *(continued)*** HN asked if the winter resilience funding is new and MMcD confirmed it was and the second tranche was announced last weekend. This figure was £300m nationally with £1.327m being secured locally. In summary MMcD referred to Appendix 1 where the grand total spend was £171.1m. To date the spend was just under £14m per month. The remaining months of the year are predicted to spend at £14.6m on average, highlighting expected pressures. MMcD noted it is important to measure run rate each month. Therefore there is a need to measure the run rate on a monthly basis to ensure we are on target.	
	Action taken by the Committee	
	The report was noted.	
FR14/131	**IFR Update Report** The report provided the Committee with an IFR activity report and costs for Quarter 2 2014. As there were small numbers coming through each month JL asked for the report to be presented quarterly, with items being forwarded to NHS England if it was their responsibility. RP said that the reporting was purely for information purposes only.	
	Action taken by the Committee	
	The Committee received the report by way of assurance.	
FR14/132	**Better Care Fund** MMcD gave the Committee a verbal update on the Better Care Fund. MMcD said the submission report had been received, and confirmed we had been categorised as being approved with conditions. MMcD has held discussions with providers and discussed what the difference between approved with conditions and approved with support was. MMcD is to attend a Provider's Forum on Monday 24 November. RP asked who would be at the Forum and MMcD confirmed it would be the main NHS providers. MMcD is to report back to the SLT and Governing Body next week on the Forum.	
	Action taken by the Committee	
	The Committee received the update by way of assurance.	
FR14/133	**Quality Premium Dashboard** This paper updated the Committee on 2013/14 Quality Premium performance of which an indication of likely payment from NHS England has now been received (subject to final confirmation). The paper also updated the Committee on progress against the 2014/15 Quality Premium indicators.	

No	Item	Action
FR14/133	**Quality Premium Dashboard *(continued)*** The final 2013/14 data is yet to be confirmed by NHS England, however the CCG has received a copy of the data used by NHS England to measure performance, and indicative financial totals. Indicative data from NHS England for 2013/14 reveals that Southport & Formby CCG should receive a payment of £279k against a total possible payment (if all indicators were within tolerance) of £595k. In terms of 2014/15, taking a likely case scenario approach, the total amount payable under the likely case scenario is £322k against a total possible payment (if all indicators were within tolerance) of £613k. This is an improving position from last month's estimate. BW confirmed that emergency admissions were now on the dashboard and all four indicators had been broken down into the relevant parts and sent out to the localities for their use. ME agreed this breakdown was important. Re IAPT BW said that in August 2014 on scrutiny of the activity it became apparent that IMS were not applying the nationally mandated definition for measuring this KPI appropriately and therefore were now forecasting to miss the target unless action was taken. A remedial action plan is in place, and NHS England has also signalled that should providers reach 3.75% in Q4 of 14/15 they will be considered as having met the target. This means our provider is more likely to recover the position by year end. BW and SL confirmed that the method for recording mental health incidents as part of the medication related incidents measure was skewed for Mental Health providers because of the nature of incidents they have, even more so for Mersey Care given they have high secure patients. BW will be asking SMT and SLT to consider the removal of this provider from the measure. The other two providers' measures (Southport & Ormskirk and Liverpool Community Health) are performing on track.	
	Action taken by the Committee	
	The Committee received the report by way of assurance.	
FR14/134	**Prescribing Performance Report** This report presented the Committee with an update on prescribing spend for August 2014. The Southport and Formby CCG position for month 5 (August 2014) is a forecast underspend of £270k or -1.35% on a budget of £20k. Currently Southport and Formby CCG are forecasting an under spend for their prescribing budget. However a national increase in the cost of drugs included in category M of the drug tariff will come in to effect from the 1st October 2014. The estimated cost of the increase in price of category M drugs for Southport and Formby CCG is £169k until the end of the financial year. All GP practices have been notified of the pressure on their prescribing budgets and informed the medicines management team will be focussing on cost savings over the next couple of months. Potential savings will be discussed at practice and locality level. Monitoring of the impact on the increased price of category M will be done on a monthly basis.	

No	Item	Action
FR14/134	**Prescribing Performance Report *(continued)*** SL confirmed she had seen sight of month 6 and there is a change. More monitoring is required on a monthly basis is required ie tracking population changes so that necessary adjustments can be made. SL has asked the team to change their focus leading up to Christmas and said the team are having individual conversations with practices but need input from clinicians. SL asked where will this leave practices with the PQS payment. MMcD said principle had been agreed as to where we can measure switches and adhere to these then budgets to take account of these practices. This is to be worked through with SL's team over the next few months and SL is to come back with a report. SL and MMcD are to discuss how this will work and will stick to the principle. HN confirmed that the principle had previously been agreed to adjust budgets when necessary. MMcD asked if there were any plans for 2015/16 areas in terms of patients being removed from drugs and SL replied pregabalin. MMcD said this needs to move more into the QIPP agenda.	SL
	Action taken by the Committee	
	The Committee received the report by way of assurance.	
FR14/135	**Capital Plans and updates** With regard to 2015/16 MMcD is to meet with NHS England next month and will keep the Committee updated on the outcome.	
	Action taken by the Committee	
	The Committee received the report by way of assurance.	
FR14/136	**Any Other Business** RP gave an advanced apology for his non-attendance at the next meeting in January. No other business was discussed.	
FR14/137	**Date of Next Meeting** Wednesday 21st January 2015, 9.30am to 11.30am Family Life Centre, Ash Street, Southport	

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Minutes

Wednesday 21st January 2015, 9.30am to 11.30am
Family Life Centre, Ash Street, Southport

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Martin McDowell	Chief Finance Officer	MMcD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Ex-officio Member		
Fiona Clark	Chief Officer	FLC
In attendance		
Malcolm Cunningham	Head of Primary Care & Contracting	MC
David Smith	Deputy Chief Finance Officer	DS
James Bradley	Head of Strategic Finance Planning	JB
Susanne Lynch	CCG Lead for Medicines Management	SL
Moira McGuinness	Locality Lead	MMcG
Apologies		
Dr Hilal Mulla	GP Governing Body Member	HM
Roger Pontefract	Lay Member	RP
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Fiona Doherty	Transformational Change Manager	FD
Becky Williams	Chief Analyst	BW
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Dr Hilal Mulla	GP Governing Body Member	A	A									
Roger Pontefract	Lay Member	√	A									
Colette Riley	Practice Manager	√	√									
Martin McDowell	Chief Finance Officer	√	√									
Debbie Fagan	Chief Nurse & Quality Officer	√	√									
Jan Leonard	Chief Redesign & Commissioning Officer	√	√									
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A	A									
Fiona Clark	Chief Officer	A	A									
David Smith	Deputy Chief Finance Officer	√	√									
James Bradley	Head of Strategic Finance Planning	√	√									
Susanne Lynch	CCG Lead for Medicines Management	√	√									
Karl McCluskey	Chief Strategy & Outcomes Officer	A	A									
Malcolm Cunningham	Head of Primary Care & Contracting	A	√									
Fiona Doherty	Transformational Change Manager	A	A									
Becky Williams	Chief Analyst	√	A									

No	Item	Action
FR15/01	**Apologies for absence** Apologies for absence were received from Roger Pontefract, Dr Hilal Mulla, Fiona Clark, Tracy Jeffes, Karl McCluskey, Fiona Doherty and Becky Williams.	
FR15/02	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflicts of interest.	
FR15/03	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record and signed off by the Chair.	
FR15/04	**Action points from the previous meeting** **FR14/84 & 14/116** – *reducing A&E attendances* – JL confirmed that GPs are to be put into A&E to relieve pressure, an initiative mandated by NHS England. **FR14/129** – JL is to put an action plan together for a future development session once work being undertaken by BW is complete; this is to be carried forward to next month's action tracker. All other action points from the previous meeting are on this month's agenda for discussion.	JL
FR15/05	**Month 9 Finance Report** This paper presented the Finance & Resource Committee with an overview of the financial position for NHS Southport and Formby Clinical Commissioning Group as at Month 9, and outlined the key financial risks facing the CCG. JB highlighted the fact that the CCG's forecast financial position includes two items contested by the Trust: • use of the marginal rate for emergency tariff (MRET) performance above 2013/14 baseline (c£600k); and • additional IM & T support for the Trust (450k). MMcD confirmed that the CCG's adoption of the First Issue (MRET) was in line with the Memorandum of Agreement signed by both parties, and that the CCG could demonstrate that it had invested the balance of funding in supporting initiatives designed to take the pressure off the urgent care system. He also confirmed that additional funding to support IM & T would be a discretionary payment, over and above tariff, and that the CCG was under no obligation to make the payment. At this stage, MMcD recommended that the payment should not be made.	

No	Item	Action
FR15/05	**Month 9 Finance Report *(continued)***	

HN asked what steps may need to be taken to reach agreement. MMcD reported that the CEO (Trust)/CO (CCG) would need to meet before deciding on whether mediation or formal arbitration would be required.

With regard to remaining risks in this financial year, JB detailed 3 potentially volatile areas, notably:

- acute costs
- increasing CHC pools
- prescribing costs

JB reported that £394k of the CCG's original contribution of £634k to the top sliced national pool to deal with CHC restitution claims.

As at Month 8, the national pool had paid out claims totalling c15%, and expected to pay out c38% of the pool. The CCG's figures were slightly higher than those reported. NHS England expected to see an equivalent increase in CCG surplus figures as a consequence of this position. MMcD informed the Committee that we had been identifying a return as part of the action plan to meet surplus target, and subsequently had informed the Area Team CFO that the CCG would not be able to comply with proposed increase to its surplus.

JB introduced the items in Table C: the management actions. HN noted that the CCG had the rehab scheme still listed as "amber", given that she had thought return of funding between CCGs may be unlikely. MMcD noted that the Q3 report was due from the rehab network and that Mersey CFOs were still discussing the position. He expected that the CCG would receive some funding back due to low activity at the units in Liverpool and St Helens.

He also noted that there had been notification of £100k funding to be returned from iMerseyside since the paper had been written.

HN noted the 95% target and asked if the training done had helped performance. JB confirmed it had, but noted this last month had not been great as disputed invoices can have a big impact on performance. MMcD suggested testing this point with the auditors.

HN asked if there will be a commensurate fall in the S&O services when establishing budgets for next year. JL said that trends will be reviewed and this is likely to affect key specialities at the Trust.

No	Item	Action
FR15/05	**Month 9 Finance Report *(continued)*** DS tabled the results of a benchmarking review on CHC/FNC costs for Q1 and Q2. The key points to note were: • At Q2 the CCG was ranked 2nd (out of 211 nationally) for FNC activity and 3rd for expenditure per head of population. • At Q2 the CCG was ranked 29th (out of 211 nationally) for CHC activity and 56th for expenditure per head of population. • The Q1 CHC figures were likely to be inaccurate due to issues with data recording at the time. • Local intelligence should be shared with other CCGs across Merseyside to understand reasons behind shifts in Q1 and Q2, with a view to sharing best practice. • The Committee agreed benchmarking was useful and asked for further analysis to identify areas with similar population characteristics to the CCG. Recommendations: The Committee agreed the recommendations in the report to: • support the transfer of funding for NPfIT and Locality Development schemes to bridge the financial gap facing the CCG; and • to note that the CCG's ability to deliver its financial targets for 2014/15 is extremely challenged and reliant upon the delivery of its management action plan, which has limited additional flexibility. MMcD noted that it remained the CCG's intention to consolidate the locality development money into an expanded local primary care quality contract in 2015/16, and a further will be brought to the Committee.	
	Action taken by the Committee The Committee received the report and noted that the CCG remains on target to deliver its financial duties for 2014/15, noting that risks remained in the system. The Committee approved the recommendations within the report.	

No	Item	Action
FR15/06	**Updated Financial Strategy 2014/15 – 2018/19** This report set out an update to the longer term financial strategy and the assumptions which underpin it. The report had been updated to reflect changes in expenditure patterns for the first three quarters of the year. It also reflected the latest planning guidance issued by NHS England, particularly with reference to funding allocations. JB reported that the CCG was receiving the lowest level of growth of 1.94%, which was disappointing when compared to average growth of 3.74%. *Business Rules:* HN said that the non-elective admissions change will help S&O. MMcD said it was worth noting that this also applies to specialised services, which is more contentious as these have very high costs. MMcD said that Monitor's proposal had been challenged, which was likely to lead to delay in finalising the tariff. *Continuing Healthcare (CHC):* HN said that expecting 5% increase was a big risk in the light of much higher growth rates experienced in the last two years. JB said there is an issue from a price perspective in that we are getting a very good price, and that our prices had not increased in the last 2 years, which presented a risk. HN asked for the 2 years to be graphed, along with the national average. MMcD agreed the 2 year time frame should give us the answers. JB is to produce this work and bring it to the next meeting. *CHC Restitution*: MMcD noted that the figures presented in Appendix 2 were likely to be too low and that an extra £0.500m may be required in each of the next two years to meet the CCG's liabilities. QIPP: HN was concerned about high value of QIPP figure of £3.647m. MMcD said that a number of options would be shared with the Governing Body in February regarding the assumptions made. MMcD noted that a QIPP Sub-Committee will be required with members drawn from this Committee. HN noted that it needed to focus on delivering real cash savings. MMcD said he would look at QIPP and investment plans to look at striking a balance. MMcD and KMcC are to present a report to the Governing Body meeting in February.	JB
	Action taken by the Committee	
	The Committee received the report by way of assurance.	

No	Item	Action
FR15/07	**PMO Dashboard** MMcD proposed linking into the new QIPP Committee as described above.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/08	**Transform Programme** The Transform programme is building on the previous Gold Standards Framework Acute Hospitals pilot to change the culture of end of life care within the hospital setting, reduce avoidable admissions, speed people through the system and encourage appropriate discharges. Southport and Formby Clinical Commission Group have funded this team non-recurrently during 2014/15. Service Improvement and Redesign Committee approved the clinical model in January 2015. MMcG gave an overview on what the team was doing and looking to achieve, and said the first 10 months had been really successful. MMcG sought agreement to the requested figure of £96k per year to allow the team to plan ahead. It was confirmed that this was not in the plans for 2015/16, although it had delivered benefits in keeping people out of hospital. MMcD noted that the scheme is likely to release pressure on hospital beds as opposed to saving money, and the Committee should not focus upon the potential for cash savings. It was also noted that this scheme had increased the number of patients dying in preferred location. HN was concerned that this programme was based on quality and not financial return, and that £100k could be better invested to produce a return. MMcD said he will take this point to the next Governing Body meeting ie a return on the CCG's investments needs to be looked at.	
	Action taken by the Committee	
	The Committee received the report by way of assurance and approved the funding request therein.	

No	Item	Action
FR15/09	**Prescribing Performance Report** (a) Q2 Report This paper presented the Committee with a report on prescribing performance for the second quarter of 2014/15 for Southport and Formby CCG practices. *Appendix 2:* SL has spoken with MMcD and is now looking to take on some rebate schemes. SL said advice on prescribing pregabalin remains under challenge; a legal discussion is taking place with Pfizer and SL has taken legal advice on this. MMcD said there has been ongoing discussion on age related macular degeneration, now subject to a collective challenge by the CCGs through NHSCC. MMcD said if the changes are accepted it has the potential to deliver significant changes. (b) Month 7 Report This paper presented the Committee with an update on prescribing spend for October 2014 (month 7). *Appendix 1:* SL confirmed that a significant amount of monitoring is being done regarding category M. DS questioned what the grey list was and SL confirmed it was a list of drugs that the CCG did not feel were appropriate to be prescribed. SL said these were discussed with pharmacists on a regular basis. MMcD wanted it to be noted that some budget changes are not factored in at this stage, which may distort individual practice positions. Action taken by the Committee The Committee received the reports by way of assurance.	
FR15/10	**HR Performance Report** All indicators are green at the time of reporting with the exception of: • PDRs – this is being addressed throughout the year and the majority of PDRs have been undertaken. The paperwork is being processed and we are liaising with the Learning and Development Team to capture the data so that it can be reported through the balance scorecard. • Statutory and mandatory training – this indicator has improved significantly in recent weeks and is now approaching the 85% target. A clear plan of action to achieve target has been developed. On behalf of TJ, MMcD said that all PDR was being captured as we speak and a more realistic figure is expected next time.	

No	Item	Action
	Action taken by the Committee	
	The Committee received the report by way of assurance.	
FR15/11	**External Updates/Benchmarking and VFM reports** This will go into the QIPP group.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/12	**Quality Premium Dashboard** This paper updated the Committee on progress against the 2014/15 Quality Premium indicators. JL agreed the dashboard was not reflecting good performance this month. JL said BW has been out to localities to share this information. CR asked for a copy of 9 indicators relating to the local scheme on diabetes; JL said it was an issue picking up smoking data and that this will not be updated on the report until Q3. Regarding the diabetes dashboard, SL said we should push to get this out. JL is to produce a paper copy of the diabetes dashboard for circulation. HN said we needed to ensure information is readily and easily available for next year. JL is to ask BW to do an assessment of where practices need to be to hit target.	JL
	Action taken by the Committee	
	The Committee received the report by way of assurance.	
FR15/13	**QIPP Update** This update was provided earlier in agenda item FR15/06.	
	Action taken by the Committee	
	The Committee received the update by way of assurance.	

No	Item	Action
FR15/14	**Better Care Fund Update** MMcD gave an update on the Better Care Fund and said he needed to bring a draft Section 75 to Committee for review next month; work is ongoing to understand what this will mean. Both the Governing Body and Finance and Resource Committee will receive an update next month. Action taken by the Committee The Committee received the update by way of assurance.	
FR15/15	**IM & T Funding 2015/16** This paper outlined the background to the funding streams for IT inherited by the CCG, and made a number of recommendations for funding in 2015/16. MMcD confirmed this paper has been to SLT for review and that SLT approved the recommendations. MMcD said it was important to note the conflict regarding funding of GP business systems in 2015/16, and noted that it was highly unlikely that this would be continued in 2016/17 as transitional funding will be removed. MMcD noted the opportunities that exist for the CCG to find external/national investment to support transformational IM & T investments. Action taken by the Committee The Committee received the report by way of assurance. A conflict of interest is to be recorded for Members of the Committee employed in, or having interests in, general practice.	
FR15/16	**Review of Annual Work Plan** The work plan listed the agenda items for the financial year 2015/16. This was reviewed and HN asked for the External Update and VFM report to be added to the agenda at each meeting. MMcD advised that Estates Utilisation will be added to the work plan for February's agenda, which will be a review on some of the CCG's key buildings. JL noted the IFR report is to be changed to a quarterly submission. Further feedback on the work plan was requested and changes will be made to it as and when these are received.	RM

No	Item	Action
	Action taken by the Committee	
	The Committee noted the content of the work plan.	
FR15/17	**2015/16 Meeting Dates** This paper set out the planned dates of the Southport and Formby CCG Finance and Resource Committee meetings for 2015/2016.	
	Action taken by the Committee	
	The Committee noted the meeting schedule.	
FR15/18	**Any Other Business** HN stated that, in his absence, HM had requested the Committee discuss Mental Health Funding. HM and his team are producing a mental health review and JL confirmed it is currently being pulled together; this will go to SMT, with the possibility of going to SLT first. MMcD said HM will be at the Governing Body meeting and can be discussed further. Due to the tight schedule of today's meeting this item has been deferred to February's agenda.	
FR15/19	**Date of Next Meeting** Wednesday 18th February 2015, 9.30am to 11.30am Family Life Centre, Ash Street, Southport	

Quality Committee Minutes

Date: Wednesday 17th December 2014 11.30am to 1.30pm
Venue: Family Life Centre, Southport

Membership		
Dr Rob Caudwell	Clinical Governing Body Member (Chair)	RC
Paul Ashby	Practice Manager Governing Body Member	PA
Dr Doug Callow	Clinical Director Lead for Quality	DC
Malcolm Cunningham	Head of Contracting & Procurement	MC
Billie Dodd	Head of CCG Development	BD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
Helen Nichols	Lay Governing Body Member	HN
Ex officio members		
Fiona Clark	Chief Officer	FLC
Also in attendance		
James Hester	Programme Manager – Quality & Safety	JH
Minutes		
Sue Griffiths	PA to Chief Nurse & Quality Team	SG

Membership Attendance Tracker

Name	Membership	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 18	Jan 21	Feb 15	Mar 15
Dr Rob Caudwell	GP Governing Body Member (Chair as of Jun 2014)	A	√	√	L	√	A	A	√	√			
Paul Ashby	Practice Manager, Ainsdale Medical Centre				L	√	A	A	√	A			
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	√	√	√	√	A	√	L	√	A			
Malcolm Cunningham	CCG Head of Primary Care & Contracting	√	A	√	L	A	A	A	A	A			
Billie Dodd	Head of CCG Development	√	A	A	A	A	√	√	√	√			
Debbie Fagan	Chief Nurse & Quality Officer	√	√	√	√	√	√	√	√	√			
Martin McDowell	Chief Finance Officer	√	√	√	L	L	A	L	√	√			
Helen Nichols	Governing Body and Lay Member	√	√	√	√	A	√	L	√	√			
Dr Kati Scholtz	GP Locality Lead – North	√	√	√	L	L	A						

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/177	**Apologies for absence** Apologies for absence were received from Fiona Clark, Malcolm Cunningham, Paul Ashby, Brendan Prescott, Jo Simpson, Suzanne Lynch, Ann Dunne.	
14/178	**Declarations of interest regarding agenda items** None declared.	
14/179	**Minutes of the previous meeting/key issues log** Minutes and Key Issues log approved as true reflection of the previous meeting.	
14/180	**Matters Arising / Action Tracker** **14/135(i) NWAS 111** - Call Report for July 2014 Activity. **Outcome: Action not due until January 2015** **14/150 Quality Committee Workplan** - Agenda item at today's meeting. **Outcome: Action item on today's meeting** **14/156 Primary Care Dashboard** - This is not due until February 2015. **Outcome: Action not due until February 2015** **14/166 Corporate Governance Support Group Key Issues Log** - Agenda item at today's meeting. **Outcome: Action item on today's meeting** **14/168(I) Provider Quality Report (Mortality Rates at S&O)** – Completed **Outcome: Action completed and removed from tracker** **14/168(II)** – **Provider Quality Report (Mortality Rates at S&O) –** Not due until January 2015. **Outcome: Action not due until January 2015**	
14/181	**Chief Nurse Report** DF presented the Chief Nurse Report to the S&F CCG meeting. DF asked the Committee to note the feedback from NHSE regarding the Child Health Information System that confirmed that there were no issues with the system in Merseyside. HN provided further information on the CHC Steering Group that has been established in her capacity as Chair of that meeting. DC asked for clarification of what the key risks are in relation to CHC for the CCG. DF and MMcD summarised the main clinical, financial and reputational risks that currently exist. **Action taken by the Committee** The Quality Committee received the report.	

No	Item	Action
14/182	**Cold Chain Incidents in General Practice** This agenda item was deferred until further notice by SL. DF informed the Committee of the link between this agenda item and the discussion at the last meeting with regard to the offer from NHSE/PHE to provide Root Cause Analysis training within General Practice. DF also informed the Committee that SL had been liaising within NHSE/PHE regarding recent cold chain incidents that had occurred across Sefton. **Action taken by the Committee** Agenda item deferred until further discussion with SL.	
14/183	**Safeguarding Peer Review Action Plan** DF presented the updated CCG Safeguarding Peer Review Action Plan. The Committee noted the positive progress that had been made. DC asked how Safeguarding Training could be better offered to / and made more relevant to General Practice. DF stated that such training needs to be for both safeguarding children and vulnerable adults. RC offered to support this development as he was now involved in the planning of local PLT events. **Action taken by the Committee** The Quality Committee received the report. RC to discuss at the next PLT Development Meeting and to report back in February 2015.	
14/184	**CCG CQC Safeguarding Declaration** DF presented the declaration for recommendation for approval to the Governing Body which has been prepared by the CCG Safeguarding Service. DF gave the background to the need to approve the declaration and publish on the CCG public website. HN asked if we were assured regarding the elements in relation to arrangements with the Independent Sector, the systems that are in place for flagging children and adults and for when there are safeguarding concerns in relation to children who miss out-patient appointments. DF described the systems in place and the support the CCG receives in relation to this from the Safeguarding Service. **Action taken by the Committee** The Quality Committee received the report and supported the recommendation for presentation to the Governing Body for approval.	
14/185	**CCG Safeguarding Strategy 2015-17** DF presented the safeguarding strategy to the Committee for recommendation for approval to the Governing Body. The Committee discussed the extent to which it was core across Merseyside and specific to deliver the priorities for Sefton. DF stated that the implementation will be underpinned by an action plan/workplan for the Safeguarding Service which will evidence Sefton specifics and that this had been discussed with Ann Dunne from the Safeguarding Service.	
	Action taken by the Committee The Quality Committee received the report and supported the recommendation for presentation to the Governing Body for approval.	

14/186	**Quality Committee Workplan (revised)** JH presented the revised workplan to the Committee and asked those in attendance to consider:- • Firstly, if they felt it reflected the revised Terms of Reference and there was a visible line of sight between EPEG and the Corporate Governance Group for the relevant delegated functions. • Secondly, the feasibility of having Joint Internal Quality Committee Meetings with SSCCG. The Committee agreed that the revised Workplan appeared to cover the necessary areas of responsibility and DF asked if a diagram could also be produced that showed the relationships and subject matter discussed in EPEG and the Corporate Governance Group to sit alongside the workplan. The Committee asked JH to undertake further work on the idea of a Joint Internal Quality Committee for further discussion at the February 2015 meeting. **Action taken by the Committee** JH to complete workplan with the requested diagram and present back a final version to the February 2015 meeting.	
14/187	**CCG Pals & Complaints Overview Report** JH presented the report which also included as appendix information for the 12 month period 01.11.13 - 31.10.14. MMcD stated that the information contained would require the CCG to gain mutual assurance from NHSE in areas of where they have specific commissioning responsibility e.g. dentistry. DC, BD and RC raised the issue of the increased workload in relation to dental problems that was being experienced within services such as General Practice and NHS111. HN requested that further information is required regarding the types of contact being made to PALS in relation to dental issues to ascertain whether they were being approached for signposting to a dentist or if it was in relation to a possible complaint. BD suggested that a member of the CCG team could liaise with Lyn Cooke, CCG Communications Lead, to see how we could utilise the CCG external website more in order to provide further information to the general public regarding dental services. HN also asked for further information relating to what independent contractors were contacting PALS regarding. The Committee raised concern regarding the average time to close a complaint being 52 working days. DF informed the Committee regarding some of the issues the CCG is experiencing regarding the quality of the complaints management service being delivered from the CSU and what actions the CCG Senior Team are undertaking to address this issue. The Committee asked for a break down regarding the process, where the delays are taking place within the system and actions being undertaken and MMcD suggested a robust KPI being included within the CSU contract. DF also made the linkages between the current concerns in relation to CHC and the number of complaints and asked for further information as to whether these were actual complaints or disputes that were being categorised as a complaint.	

	Action taken by the Committee The Quality Committee approved the recommendation for all complaints and PALS reports to be received by EPEG with a report being presented to the Quality Committee from EPEG for purposes of assurance.	
14/188	**Corporate Governance Group Report** JH presented the amended key issues log that had been previously presented to the Quality Committee. HN asked the Committee to note that the Risk Management Strategy had been recommended for approval to the Governing Body at a previous meeting. **Action taken by the Committee** JH presented the amended key issues log that had been previously presented to the Quality Committee.	
14/189	**Information Governance Group Report** JH presented the paper which requested approval for the:- • Information Governance Policy. • Confidentiality & Data Security Policy. • Subject Access Request Policy. • Freedom of Information Policy. • Corporate Records Management & Retention Policy. JH explained that the approval of these policies will reduce the number of Information Governance Policies in place from 10 to 5. JH stated that these had all been scrutinised at the Corporate Governance Group. MMcD stated that the Senior Leadership Team had approved a IM&T Steering Group to be established within the CCG which would be joint with SSCCG and that in future the development and review of such policies would be overseen in that forum with reporting to the Quality Committee - a member of the Quality Team would also be present at the IM&T Steering Group to ensure that there was an explicit link to the quality agenda. **Action taken by the Committee** The Quality Committee approved the policies as detailed above.	

14/190	**Information** a) Corporate Governance Support Group Revised Action Log October 2014. This was addressed in agenda item 14/188. b) Joint Internal Serious Incident Review Group Minutes October 2014. JH informed the Committee that these minutes were not yet ready to be received due to the data stick that was used by the admin team being mislaid. This has been reported as an incident and has since been found. MMcD asked for assurances that in the time it was mislaid that nobody had accessed the content. JH stated that it was currently thought to be unlikely due to where the data stick was found but he would ensure that this was clarified as part of the incident process. In the absence of the Joint Serious Incident Review Group Minutes. JH informed the Quality Committee that the CCG had requested Southport & Ormskirk Hospitals NHS Trust undertake an aggregated review regarding Information Governance Breaches due to the number of serious incidents reported on StEIS by the provider.	
14/191	**Key Issues Log** The following key issues were identified by the Quality Committee to be brought to the attention of the Governing Body:- 1) Policies approved. 2) Positive progress made against the recommendations in the CCG Safeguarding Peer Review. 3) Development of Safeguarding Training for General Practice as part. of PLT. 4) An identified trend in complaints relating to CHC.	

No	Item	Action
14/192	**Any Other Business** DF informed the Quality Committee about the recent publication of the CQC Intelligent Monitoring bandings with regard to Primary Care. As far as the CCG are aware there are no SFCCG practices that appear in Band 1 (lowest banding). RC and DC informed the Committee as to how the CQC arrive at the banding. DF to bring a report to the February 2015 meeting and the information contained within will be considered along with the newly developed CCG Primary Care Dashboard by way of intelligence to support quality improvement. DC informed the Quality Committee about the recent results of the GP survey he recently facilitated. The results will be considered and the themes used to inform the development of the Quality Schedule / KPIs for Southport & Ormskirk Hospitals NHS Trust and matched against the milestones for the future for the Trust. DC informed the Quality Committee that the first meeting had taken place for the E-Discharge Audit. RC informed the Quality Committee that the Friends & Family Test within General Practice was being implemented and that consideration would need to be given as to how information is gathered and reported into the CCG as with other providers to support the primary care quality role of the CCG. BD informed the Quality Committee that a 12 hr trolley breach was reported at Southport & Ormskirk Hospitals NHS Trust earlier this week and that she had been in contact with the Trust for the purposes of commissioner assurance and support. RC reported that there is an increase in Respiratory Syncytial Virus (RSV) locally. RC will be raising at the Community Children's Nursing Outreach Team (CCNOT) Meeting on 18th December 2014 ways in which the team can support admission avoidance / reduced length of stay for this cohort of young children and BD will be exploring ways of providing written information / leaflets etc. as has been done in recent years.	
14/193	**Date of next meeting** Wednesday 21st January 2015 11.30am – 1.30pm Family Life Centre, Southport	

Quality Committee Minutes

Date: Wednesday 21st January 2015, 11.30am to 1.30pm
Venue: Family Life Centre, Southport

Membership		
Dr Rob Caudwell	Clinical Governing Body Member (Chair)	RC
Paul Ashby	Practice Manager Governing Body Member	PA
Dr Doug Callow	Clinical Director Lead for Quality	DC
Malcolm Cunningham	Head of Contracting & Procurement	MC
Billie Dodd	Head of CCG Development	BD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
Helen Nichols	Lay Governing Body Member	HN
Ex officio members		
Fiona Clark	Chief Officer	FLC
Also in attendance		
Tracey Forshaw	Deputy Head Safeguarding Adults	
James Hester	Programme Manager – Quality & Safety	JH
Martin Jones	Matron – Infection Prevention & Control	MJ
Amal Musa	Student Nurse	AM
Brendan Prescott	Deputy Chief Nurse / Head of Quality & Safety	BP
Jo Simpson	Quality & Performance Manager, CMCSU	JS
Minutes		
Sue Griffiths	PA to Chief Nurse & Quality Team	SG

Membership Attendance Tracker

Name	Membership	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 18	Jan 21	Feb 15	Mar 15
Dr Rob Caudwell	GP Governing Body Member (Chair as of Jun 2014)	A	√	√	L	√	A	A	√	√	√		
Paul Ashby	Practice Manager, Ainsdale Medical Centre				L	√	A	A	√	A	√		
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	√	√	√	√	A	√	L	√	A	√		
Malcolm Cunningham	CCG Head of Primary Care & Contracting	√	A	√	L	A	A	A	A	A	A		
Billie Dodd	Head of CCG Development	√	A	A	A	A	√	√	√	√	A		
Debbie Fagan	Chief Nurse & Quality Officer	√	√	√	√	√	√	√	√	√	√		
Martin McDowell	Chief Finance Officer	√	√	√	L	L	A	L	√	√	√		
Helen Nichols	Governing Body and Lay Member	√	√	√	√	A	√	L	√	√	√		
Dr Kati Scholtz	GP Locality Lead – North	√	√	√	L	L	A						

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/001	**Apologies for absence** Apologies for absence were received from FC and MC.	
15/002	**Declarations of interest regarding agenda items** None declared for the agenda items. DF, JH, MMcD and BP declared their dual roles between SFCCG & SSCCG. AM in attendance as an observer – on a placement with the CCG.	
15/003	**Minutes of the previous meeting/key issues log** Minutes and Key Issues log approved as true reflection of the previous meeting.	

No	Item	Action
15/004	**Matters Arising / Action Tracker** **14/136(i) NWAS 111** - Call Report for July 2014 Activity. No update as of yet from AD. To be carried over to February 2015. **Outcome: Carried over to February 2015.** **14/156 Primary Care Dashboard** - This is not due until February 2015. **Outcome: Action not due until February 2015.** **14/168(II)** – **Provider Quality Report (Mortality Rates at S&O) –** Agenda item at this meeting. Action can be closed. **Outcome: Action complete and to be removed from the tracker.** **14/182 Cold Chain Incidents in General Practice** – Agenda item at this meeting. Action can be closed. **Outcome: Action complete and to be removed from the tracker.** **14/183 Safeguarding Peer Review Action Plan** – RC to discuss at the next PLT Development Meeting and to report back in February 2015. **Outcome: Action not due until February 2015.** **14/186(i) Quality Committee Workplan (Revised)** - JH to complete workplan with the requested diagram and present back a final version to the February 2015 meeting. **Outcome: Action not due until February 2015.** **14/186(ii) (originates from 14/150) Joint Internal Quality Committee Proposal** – JH to undertake further scoping work on the proposal and present back at the February 2015 meeting. **Outcome: Action not due until February 2015.** **14/187(i) CCG PALS & Complaints Queries** – JH reported that these issues will be an agenda item for discussion at the February 2015 EPEG meeting. Report to come back to the Quality Committee via EPEG in February 2015. **Outcome: Action deferred until February 2015.** **14/187(ii) PALS Contacts for Dental Services** (utilisation of CCG Website) – JH reported that this issue is an agenda item for discussion at the February 2015 EPEG Meeting. Report to come back to the Quality Committee via EPEG in February 2015. **Outcome: Action deferred until February 2015.** **14/187 Timelines for closure of CCG Complaints** – Discussion has taken place with TJ regarding KPIs in the CSU contract. **Outcome: Action complete and to be removed from the tracker.** TF gave an update with regard to the following matters arising: • **14/183** (relates to 14/183 above) – this needs to be mindful of the alignment with the Local Safeguarding Adult Board training programme. • **14/185** (CCG Safeguarding Strategy 2015-17) – this will need to be re-presented to the Quality Committee due to further changes that were required so that the strategy is in line with the latest guidance from the Care Act.	

No	Item	Action
15/005	**Presentation – Nursing Home Catheter Care Project** MJ presented the Nursing Home Catheter Care Project that was completed at the end of 2013. Analysis of the findings was completed in the autumn of 2014. One of the triggers for undertaking this project was the intelligence that the Infection Prevent Control Team had regarding the links between Catheter Care and MRSA Bacteraemia. MJ stated that catheters are the biggest risk for infection in Sefton. DC asked if there was any difference with regard to rates of infection between the use of Foley / in-dwelling catheters and supra pubic catheters. MJ stated that in other parts of the world supra-pubic catheters were more widely used and there was evidence to support that infection rates were lower. MJ stated that some areas had a catheter service that ensured patients with long-term in-dwelling catheters had the necessary annual urology review. MJ stated that further projects needed to be undertaken, but the information contained within the presentation could be utilised as follows: • To establish Quality Markers within appropriate contracts. • Support how hospital care is communicated to care homes with regard to rationale for catheter insertion and catheter care / review – catheter passports are being introduced. • To support work around antibiotic prescribing to lower possible exposure of patients to C.difficile.	
	Action taken by the Committee	
	The Quality Committee received the presentation and requested the following actions to be undertaken: i) Quality Team to explore further the idea of a specific catheter service. ii) Quality Team to look at development of KPIs in relevant contracts.	DF DF

15/006	**Safeguarding Service Update Report** TF presented this report to the Quality Committee. TF asked the Committee to take particular note of the following: • Reasonable level of assurance for Aintree University Hospital NHS Foundation Trust (AUH). The Safeguarding Service has met with the Trust in January 2015 to discuss current KPIs and expectations for 2015/16. This meeting was reported to be positive with neither parties reporting any grave issues. • Reasonable level of assurance for Merseycare NHS Trust. • Reasonable level of assurance for Liverpool Community Health NHS Trust. • Limited level of assurance from Southport & Ormskirk Hospitals NHS Trust (S&O) at this current time. The Trust has received a RED RAG rating by the Safeguarding Service due to the late submission for children and an extension requested for the adult components. TF stated that this needed to be considered along with the Safeguarding Quality Walkaround that was undertaken by the Safeguarding Service at the Trust. DF stated that the Trust had been asked at the last Contract Meeting, to provide an action plan in response to the outcome of the Walkaround. The issue was discussed as to whether or not consideration needed to be given to issuing a contract query. • The submission of adult safeguarding performance information from Alder Hey Children's NHS Foundation Trust. • The extension that has been granted to Liverpool Women's Hospital NHS Foundation Trust for the submission of data by Liverpool CCG as the co-ordinating commissioner. • Status of the two current Domestic Homicide Reviews that are being undertaken in Sefton. • Consultation document on PREVENT – Safeguarding Service has been in contact with the relevant providers, as per e-mail from DF following CCG Chief Officer request. • Financial contribution request from the Sefton Safeguarding Adult Board to all Board members / Partner agencies. DF stated that this had been received and was being discussed within the CCG. DF stated that the Board was to be on a statutory footing as per the LSCB but further information had been requested regarding the financial formula that had been reached for partners. • The Safeguarding Annual Report that was included as an appendix – this had been received directly by the Governing Body due to timings of the Quality Committee / Governing Body meeting schedules. **Action taken by the Committee** The Quality Committee received the report and requested the following actions be undertaken: i) DF to discuss with Safeguarding Service and JL the possible need to issue a contract query due to the Safeguarding Performance at S&O.	DF
15/007	**Child Sexual Exploitation** DF presented the report to the Quality Committee on behalf of the Safeguarding Service. It was noted that the Committee has received previous updates on Child Sexual Exploitation (CSE), but this report provided a specific focus on this agenda and highlighted the work undertaken by the Safeguarding Service on behalf of the CCG to support it in meeting its responsibilities in this national priority area. DF stated that a revised paper containing the information within this report was being presented at the next Governing Body Meeting. The Committee noted the content and supported the recommendations made within the paper.	

	Action taken by the Committee The Quality Committee received the report and approved the recommendations made within the paper. The Quality Committee also noted that CSE was an agenda item for discussion at the next Governing Body.	
15/008	**Provider Quality Report** JS presented the provider Quality Performance Report to the Committee. S&O performance in relation to HSMR and SHMI discussed and it was noted that there is a separate agenda item on the meeting agenda to discuss this in more detail. The Trust performance with regard to the Stroke and Cancer measures were discussed along with the work being undertaken within the CCG by the Programme Leads. DF stated that at the last CCG Checkpoint assurance meeting, the Chief Officer had asked NHSE for 'system support' in relation to the Cancer measures. Recent S&O A&E performance was discussed and the Committee acknowledged the pressures currently being faced by the provider but also the work being undertaken by the CCG at a system level. DF informed the Committee that the CCG Chief Officer had undertaken 2 opportunistic Walkarounds in the SDGH A&E department. In addition, DF reported that she had undertaken a Quality Walkaround in A&E with NHSE Deputy Director of Nursing & Quality and the Chief Nurse from WLCCG to gain further assurance regarding patient safety, patient experience and that appropriate standards of care were being maintained at this time of pressure. Friends & Family Test (FFT) scores remain an issue at the Trust. JH informed the Committee of the work being undertaken with the Trust and on behalf of the Quality Committee by EPEG. DF informed the Committee that at the last contract meeting the CCG had requested up to date action plans from the Trust for all components of the FFT. Merseycare's previous underperformance in relation to all appropriate service users being offered Brief Intervention advice as per Every Contact Counts was noted along with a slight improvement in this area in Q2. Underperformance in relation to care plans following on from an in-patient discharge (number of patients on a CPA who have been offered a copy of their plan) was noted but it was highlighted that this involves low patient numbers. Discussions are on-going at the regular Quality Contract Meetings. Performance information with regard to other CCG providers was noted, including the recent 3 Never Events at Liverpool Community Health NHS Trust with regard to wrong site surgery (dental), however none of these patients were from SFCCG. DF informed the Quality Committee of recent pressures at AUH in relation to A&E performance and that a Quality Walkaround has been planned for 22 January 2015. **Action taken by the Committee** The Quality Committee received the report and noted the work being undertaken by the CCG teams and supporting committees to gain the necessary assurances.	
15/009	**Serious Incident Report** JH presented the Serious Incident Report to the Committee. JH stated that the CCG had requested that S&O undertake an aggregated review with regard to Information Governance incidents. However, the Trust has requested that the Information Commissioner undertake a review within the Trust so the CCG will await sight of this report and recommendations.	
	Action taken by the Committee The Quality Committee received the report.	

15/010	**Trust Mortality Report** DF presented the Trust Mortality Report which had been discussed at the S&O Public Board and the last Contract Meeting detailing the relevant issues and the work being undertaken by the Trust to understand this area of performance in more detail. HN noted the linkages between stroke performance within the Trust and details within the Mortality Report which included the comment from the Dr Foster Report that there is no validity to the commonly held view that the Trust has a more elderly and ill demographic. DF reported that the Trust had been in contact with the CCG Chair requesting attendance at their Mortality Steering Group. RC stated that he had requested that DF attend. DF reported that she had received the invite to attend the February 2015 meeting and would be liaising back with the relevant CCG Clinical Leads as appropriate. **Action taken by the Committee** The Quality Committee received the report.	
15/011	**Cold Chain Report** BP presented the report on behalf of SL. The incidents which occurred affected several practices across the Sefton area and BP highlighted both the potential quality of care/patient safety issues that may have occurred and the actions taken along with the financial cost of loss of vaccines that had occurred. The CCG Medicine's Management Team are in the process of offering all GP practices a Cold Chain Audit as a response to the local breaks in the cold chain that had occurred. The report recommended the Quality Committee to approve the completion of a Cold Chain Audit within General Practice, Medicines Management to advise individual practices on how to manage risks associated with the cold chain, awareness to be raised of the CCG Cold Chain Policy for use by General Practice and for the Medicines Management Team to liaise with the Practice Nurse Facilitators to arrange training for Practice Nurses. **Action taken by the Committee** The Quality Committee received the paper and approved the recommendations.	
15/012	**GP Quality Lead Update** DC presented the GP Quality Lead Update to the Committee. Key issues raised included the possibility of the GP Quality Audit information being utilised to inform KPI and CQUIN development with providers and that issues are being worked through regarding the issues that have become apparent with the E-discharge information from S&O e.g. Medication. DC raised the issue of NHS111 and possible unintended consequence of increasing activity in A&E and the geographical cover arrangements with the current GP Out of Hours provider. RC stated that he was attending an open event in February 2015 and had discussed concerns with MC as the contract lead and currently the service was deemed to be safe and of an acceptable quality. However, this will continue to be closely monitored. RC informed the Committee of the recent attendance at the CCG Senior Leadership Team by the newly appointed Chairman of S&O. **Action taken by the Committee** The Quality Committee received the verbal reports from DC and RC. In addition, the Quality Committee requested the following action to be undertaken: i) Quality Team to liaise with DC to consider the information from the GP audit informing KPIs / CQUIN development.	DF

15/013	**Locality Update** RC informed the Committee of the bid that had been submitted by SFCCG for the Prime Minister's Challenge Fund and described the process. The CCG are awaiting the outcome of the bid submission. **Action taken by the Committee** The Quality Committee received the verbal report.	
15/014	**Rotavirus Study** BP presented the paper and asked the Quality Committee to approve the Rotavirus Study and proposed data sharing agreement. The issue was raised as to whether or not General Practice had sufficient resource to send relevant information to the researchers. BP highlighted that the Quality Committee was being asked to approve for practices to be contacted and that it was up to the individual GPs if they wanted to be involved in the study. RC and DC stated that they would be happy to support the recommendation subject to this being discussed with the LMC. **Action taken by the Committee** The Quality Committee approved the recommendation subject to agreement by the LMC. BP to contact the LMC.	BP
15/015	**Risk Assurance Framework** JH presented the Corporate Risk Register (CRR) and Governing Body Assurance Framework (GBAF) to the Committee. JH stated that both had been reviewed by the CCG Corporate Governance Group and by the Senior Management Team. HN stated that although it was evident that the format of the reporting was much improved there did appear to be more scope for further progress to be made to increase the pace in mitigating the risks as it would appear that some of the risks had remained static for a period of time. DF to discuss this with TJ. With regard to the GBAF Principle Risk 4.1, HN queried if there was reasonable assurance from GPs that they were having their preferences delivered – DF to raise this with BD for re-consideration. MMcD raised the issue about the aspirational nature of Corporate Objective 2 and requested that the correct objective features in both the GBAF and the report front covers. **Action taken by the Committee** The Quality Committee considered the GBAF and CRR prior to presenting to the Governing Body. In addition, the Quality Committee requested the following actions to be undertaken: i) DF to discuss with TJ the static nature of some of the risks in the CRR. ii) DF to raise with BD HN's comments regarding Principle Risk 4.1. iii) DF to discuss with TJ and Admin Team.	DF DF DF
15/016	**Any Other Business** JH informed the Committee that EPEG would be reviewing provider performance in relation to FFT, including staff FFT, and that the providers had been invited to the next EPEG meeting. The relationship between this and agenda item 15/008 was noted. BP informed the Committee about the evaluation that is being undertaken by Edge Hill and the Practice Pharmacists – a report will come back to the Quality Committee on completion of the evaluation.	
15/017	**Date of next meeting** Wednesday 18th February 2015 11.30am – 1.30pm Family Life Centre, Southport	

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Service Improvement and Redesign Committee Minutes

Wednesday 14 January 2015, 9:30 a.m. – 11:30 a.m.
Venue: Classroom 4, Crosby Lakeside Adventure Centre, Crosby Coastal Park, Waterloo, L22 1RR

Attendees		
Dr Niall Leonard	Vice Chair, Southport and Formby CCG	NL
Dr Dan McDowell	Secondary Care Doctor, South Sefton CCG	DMcD
Dr Kati Scholtz	Governing Body Member, Southport and Formby CCG	KS
Dr Jeff Simmonds	Secondary Care Doctor, Southport and Formby CCG	JS
Steve Astles	Head of CCG Development, South Sefton CCG	SA
Dominic Banks	Finance Management Trainee	DB
Dr Pete Chamberlain	Lead Clinician for Strategy and Innovation, South Sefton CCG	PC
Dr Debbie Harvey	Macmillan GP, Commissioning GP and Care Home Lead, South Sefton CCG	DH
Fiona Doherty	Transformational Change Manager, South Sefton CCG & Southport and Formby CCG	FD
Terry Hill	Locality Manager, South Sefton CCG	TH
Jenny Kristiansen	Locality Manager, South Sefton CCG	JK
Jan Leonard	Chief Redesign and Commissioning Officer, South Sefton CCG & Southport and Formby CCG	JL
Sarah McGrath	Locality Manager, Southport and Formby CCG	SMcG
Moira McGuiness	Lead Clinician for Strategy and Innovation, South Sefton CCG	MMcG
Colette Page	Practice Nurse, South Sefton CCG & Southport and Formby CCG	CP
Angela Parkinson	Locality Manager, South Sefton CCG	AP
Brendan Prescott	Deputy Chief Nurse, South Sefton CCG & Southport and Formby CCG	BP
Colette Riley	Practice Manager, Governing Body Member, Southport and Formby CCG	CR
David Smith	Deputy Chief Finance Officer, South Sefton CCG & Southport and Formby CCG	DS
Jane Uglow	Locality Manager, Southport and Formby CCG	JU
In attendance		AN
Anna Nygaard (item 15/05)	Head of Health Improvement, Sefton Public Health	
Tracy Kirk (item 15/06)	Consultant Respiratory Nurse from Primary Care Respiratory Care Training Centre	TK

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

Name	Membership	Sept 14	Nov 14	Jan 15	Mar 15	May 15	July 15	Sept 15	Nov 15
Dr Niall Leonard	Vice Chair, Southport and Formby CCG	√	A	√					
Dr Dan McDowell	Secondary Care Doctor, South Sefton CCG	√	√	√					
Dr Kati Schotz	Governing Body Member, S&F CCG	√	√	√					
Dr Jeff Simmonds	Secondary Care Doctor, S&F CCG	A	√	√					
Dr Paul Thomas	Governing Body Member, South Sefton CCG	√	√	A					
Colette Riley	Governing Body Member, S&F CCG	√	A	√					
Karl McCluskey	Chief Strategy & Outcomes Officer, South Sefton CCG and S&F CCG	√	√	A					
Jan Leonard	Chief Redesign and Commissioning Officer, South Sefton CCG & Southport and Formby	√	√	√					
Steve Astles	Head of CCG Development, South Sefton CCG	√	√	√					
David Smith	Deputy Chief Finance Officer, South Sefton CCG & S&F CCG	√	√	√					
Billie Dodd	Head of CCG Development, S&F CCG	√	√	√					

No	Item	Action
15/01	**Apologies** Apologies were received from Dr Paul Thomas, Billie Dodd, Karl McCluskey, and Pippa Rose,	
15/02	**Minutes of Last Meeting** The minutes of the last meeting were agreed subject to an amendment under the primary care section.	
15/03	**Matters Arising** It was agreed to remove item 14.17 from the action tracker as these items will be feedback when the programme leads attend future SIR meetings to update the committee about their programmes. Item 14.3 Jan Leonard has spoken to Debbie Fairclough re voting rights and the terms of reference will be amended and submitted for the next meeting. Item 14.15 This data will not be in a position to be rolled out until March. It was agreed that the QOF data will be rolled out through localities rather the committee. Item 14.16 The Terms of reference have been amended re committees in common. They will be recirculated once the position on voting rights has been added. Item 14.17 Jan Leonard wants to meet with the Walton Centre before she seeks a nomination from the South. There is talk of neurology commissioning coming back to CCGs from Specialised Commissioning and Jan Leonard will keep the committee updated re this. Moira McGuinness confirmed that the South Sefton End of Life Strategy is ready to be signed off at the next LIT meeting. Item 14.19 Steve Astles and Billie Dodd have met with Becky Williams regarding indicators. Item 14.22 Angie Parkinson to feedback at the May committee.	JL FD JL JL
15/04	**Revised Terms of Reference** The revised terms of reference were accepted once the following changes have been made:- • Remove programme lead for quality and safety • Change CCG Finance Lead to Deputy Chief Finance Officer It was agreed that Dr Paul Thomas will become the Chair from March 2015 and Dr Kati Scholtz will be the Vice Chair. Dr Pete Chamberlain and Dr Debbie Harvey will attend the SIR committee when appropriate.	CL CL CL
15/05	**Case for Change** • Community Navigation (Health Trainers) Anna Nygaard presented the case. Dr Pete Chamberlain reflected that there is some evidence available regarding the positive impact that Health Trainers have in the community.	

	Anne Nygaard invited the committee for feedback to ensure the model meets CCGs locality requirement. Health Trainers attached to hubs would also reduce burden on GP practices and appointments. The committee also stated it would like the model to include support for younger people. The model was agreed in principle and Dr Niall Leonard and Dr Pete Chamberlain offered support in working up the case alongside project lead Tracy Jeffes. This paper is due to be taken to the Finance and Resource Committee in March for approval. • Ophthalmology Community Assessment Service Sarah McGrath gave the committee an update re the above and the work which had been undertaken so far. The committee requested more detail including additional data to understand impact of the scheme. Finance and Resource Committee would also consider the case and would focus on the issue around tariff levels. The committee requested that Dr Bal Duper attend the next committee meeting in his role as his Clinical Lead to help discussions. Sarah McGrath will go back to the clinics to see if she can pull some more data together. It was also agreed that a nominal tariff would need to be built into the model to cover contact with GPs. • End of Life (Transform Team) Committee discussed Transform team and the model was agreed. The case will now go to the Finance and Resource Committee for final sign off.	NL/PC/TJ SMcG MMcG
15/06	**Programme Progress Briefing** • Diabetes Terry Hill attended the committee. The committee noted the report. • Respiratory Strategy Jenny Kristiansen attended the Committee alongside Tracy Kirk who provided a quick overview of the proposed respiratory strategy. In the South funding has already been secured and work undertaken is already reducing A&E admissions. Jenny Kristiansen wants to expand the project to run across both CCGs. The update was well received by the committee and the committee supported the proposed strategy. Fiona Doherty and the Finance Team to support Jenny Kristiansen to develop a proposal for the North.	
15/07	**Termination of Pregnancy (ToP) Services** NHS England have introduced a new standard service specification for Termination of Pregnancy (ToP) Services and have independently accredited private sector providers as being compliant with the specification and are therefore suitable to provide ToP services to the UK population. Cheshire and Merseyside CCGs were invited to participate in a review of ToP services to standardise referral pathways and specifications. As a result of this there are a number of procurement options available. The	

	committee accepted the recommendation for option 2 which will see an Any Qualified provider procurement based on the amended specification with a standard tariff. This will result in a three year contract being awarded, offering greater choice for patients and assurance over quality. Jan Leonard discussed the options with the committee and option 2 was approved.	
15/08	**Any Other Business** • IAPT Update Jan Leonard updated the committee about the problems with the current IAPT provider with regards to their reporting mechanisms. The current provider has been given a strict management plan and performance is currently improving. However it appears unlikely that the position will recover in order to achieve the quality premium payment. Cheshire and Wirral Partnerships was awarded the IAPT contract due to commence April 2015. Dr Debbie Harvey informed the committee that we are currently looking at a tender for five end of life beds and she is going to visit Kemp Lodge Nursing Home in Waterloo today.	
15/09	**Date of Next Meeting** • 4 March 2015 at 9:30 a.m. venue CLAC	

NHS
Southport and Formby
Clinical Commissioning Group

Audit Committee Minutes

Wednesday 7th January 2015 at 9.30am to 11.00am
Family Life Centre, Southport

Attendees		
Helen Nichols	Lay Member (Chair)	HN
Roger Pontefract	Lay Member	RP
Paul Ashby	Practice Manager	PA
Colette Riley	Practice Manager	CR
In Attendance		
Wendy Currums	Local Counter Fraud Specialist, MIAA	WC
Debbie Fagan	Chief Nurse & Quality Officer	DF
Ken Jones	Chief Accountant	KJ
Martin McDowell	Chief Finance Officer	MMcD
Adrian Poll	Audit Manager, MIAA	AP
Ian Roberts	Senior Manager, PricewaterhouseCoopers	IR
Elizabeth Tay	Audit Manager, PricewaterhouseCoopers	ET
Apologies		
Jeff Simmonds	Lay Member and Governing Body Member	JS
Mark Jones	Audit Director, PricewaterhouseCoopers	MJ
David Smith	Deputy Chief Finance Officer	DS
Debbie Fairclough	Head of Client Relations, CMCSU	DFr
Minutes		
Ruth Moynihan	PA to Chief Finance Officer	RM

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

Name	Membership	Oct 14	Jan 15	April 15	May 15	July 15	Oct 15	Jan 16
Helen Nichols	Lay Member (Chair)	A	√					
Roger Pontefract	Lay Member	√	√					
Paul Ashby	Practice Manager	√	√					
Colette Riley	Practice Manager	√	N					
Jeff Simmonds	Lay Member and Governing Body Member	√	A					
Martin McDowell	Chief Finance Officer	√	√					
Debbie Fagan	Chief Nurse & Quality Officer	√	√					
David Smith	Deputy Chief Finance Officer	√	A					
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	√	N					
Ken Jones	Chief Accountant	√	√					
Debbie Fairclough	Head of Client Relations, CMCSU	A	A					
Roger Causer	Senior Local Counter Fraud Specialist, MIAA	A	N					
Wendy Currums	Local Counter Fraud Specialist, MIAA	√	√					
Adrian Poll	Audit Manager, MIAA	√	√					
Elizabeth Tay	Audit Manager, PricewaterhouseCoopers	A	√					
Mark Jones	Audit Director, PricewaterhouseCoopers	A	A					
Ian Roberts	Senior Manager, PricewaterhouseCoopers		√					

No	Item	Action
A15/01	**Apologies for absence** Apologies for absence were received from Jeff Simmonds, Mark Jones, David Smith and Debbie Fairclough.	
A15/02	**Declarations of interest** Declarations of interest were received from CCG officers who hold dual posts in both Southport and Formby CCG and South Sefton CCG.	
A15/03	**Advance notice of items of other business** There were no items of other business advised to the Chair.	
A15/04	**Minutes of the previous meeting** The Minutes of the previous meeting were approved as a true and accurate record and signed off by the Chair.	
A15/05	**Action points from previous meeting** A14/71 – *Appointment of Vice Chair* - to be carried forward to April. A14/73 – *Internal audit anti-fraud services report* – MMcD is in the process of setting up an IMT Steering Group, therefore this item has been carried forward to April. A14/75 – *Audit Committee Handbook* – a new issue of the Handbook is due for release; at that time copies will be ordered and distributed to Committee members. All other action points from the previous meeting were closed as appropriate.	MMcD MMcD KJ
A15/06	**Confirmation of Auditor appointment from 2015/16** The appointment of KPMG as auditors was noted by the Committee.	
A15/07	**Losses and special payments** The report notified the Committee of any subsequent losses and special payments since the last report. Action by the Committee The Committee noted the content of this report.	
A15/08	**Internal audit progress report** The progress report provided the Committee with an update in respect of the assurances, key issues and progress against the Internal Audit Plan for 2014/15. **<u>Data Quality and Performance Reporting</u>** HN asked what needed to be done to make it a higher level of assurance than significant. AP said a lot of work was being carried out and this was something that would be revisited on an on-going basis. HN asked if this was a maturity issue and AP confirmed it was. MMcD said that this should be communicated at locality level. As an example of work being reviewed, the CCG were looking to see if the data facilitators currently used could provide information that is more beneficial as our Integrated Performance Report matures. Action by the Committee The Committee noted the content of this report.	

No	Item	Action
A15/09	**Internal audit counter fraud progress report** WC updated the Committee on work progressed during the reporting period against the agreed 2014/15 anti-fraud work plan. HN and MMcD raised the question of the plan of action on counter fraud discussed early last year, as well as the response for the action of Counter Fraud Policy 2013/14 which both could recall completing. WC is to ask RC as to what the next steps are in respect of this report. HN asked about CHC and WC confirmed they were following on from internal audit review, particularly at patient level, to ensure there are no false claims. HN asked if the review was broader than patient level eg nursing homes. MMcD said high volume areas were mainly looked at where claims could "slip through the net", and CHC was a big part of this. WC assured the Committee that if any concerns were identified she would meet with MMcD to discuss and take forward if necessary. MMcD asked WC about the coverage of counter fraud training. WC confirmed all CCG staff have been trained, and it was a case of ensuring new starters were provided with training. MMcD said this should be noted to the Governing Body. Action by the Committee The Committee noted the content of the report.	WC
A15/10	**Self-assessment Checklist** DFr had observed two Audit Committee meetings and provided feedback based on a consolidated review. HN felt the assessment was slightly too positive and, as such, the Committee proceeded to review the checklist and the following changes were agreed: Under Behaviours: points 1, 5 and 6 were downgraded to a mark of 4. Under Processes: point 3 was downgraded to a mark of 4 and points 5, 6 and 10 were upgraded to a mark of 5. (The revised checklist will be sent to Committee members and officials after the meeting). It was identified and agreed that specific training would help Committee members gain a better understanding of NHS finance, and KJ is to look at the possibility of arranging a bespoke training workshop. Under Processes: point 13 – *Role in relation to whistle-blowing* - it was noted that this Policy is with the Quality Committee and it was agreed that the Policy would be brought to the next meeting. Action by the Committee 1. Training regarding NHS finance is to be arranged. 2. Whistle-blowing policy to be brought to next meeting. 3. CCG Risk Register and GB Assurance Framework to be submitted to the Audit Committee for review in October 2015.	RM KJ D Fagan

No	Item	Action
A15/11	**Scheme of Delegation progress update** This report detailed a small number of changes to the Scheme of Delegation (SoD) to ensure it continues to be operationally fit for purpose. Action by the Committee The Committee approved this report.	
A15/12	**2015/16 Committee Work Schedule** MMcD presented the Work Schedule which was approved by the Committee, subject to the following changes: 1. As well as receiving Finance & Resource Committee and Quality Committee minutes, minutes are also to be presented for the Service Redesign Committee and Approvals Committee. 2. The Counter Fraud Progress Report, presented today, is to be presented in October 2015 instead of July 2015. Action by the Committee 1. The Committee approved the work schedule for 2015/2016. 2. Changes are to be updated on the schedule.	RM
A15/13	**2015/16 Meeting Dates** MMcD presented the meeting dates to the Committee for 2015/16. It was agreed that due to the tightness of the schedule, the papers for the 20th May meeting would be received by the Committee on Monday, 18th May. Action by the Committee The Committee noted the meeting dates for 2015/2016.	
A15/14	**External Audit Plan** IR presented this report and gave an overview of the key points, in particular Appendix B, Risk and response, which highlighted the following risks. IR clarified that the risks identified were from a generic audit point of view and not ones specifically identified to the CCG. • Risk of management override of controls – significant; • Risk of fraud in revenue and expenditure recognition – significant; and • Medium-term financial sustainability – elevated. Action by the Committee The Committee approved this report.	

No	Item	Action
A15/15	**HMRC PAYE review** KJ gave the Committee a verbal update of the HMRC PAYE review. KJ confirmed letters had been issued to Governing Body members but some signed contracts were still outstanding, and some individuals wished to discuss the content of the contracts further. KJ said he had met with Hill Dickinson who confirmed the positions of GB members should be positions of appointment and superannuable. KJ has asked the CCGs' HR Department to seek clarity from the Pensions Agency as to the way forward on this. IR said PwC will provide advice on this particular issue. Once the contracts have been signed, key point changes need to be made by March payroll. MMcD described the principles that the CCG was seeking to adhere to in terms of remunerating its members. They were (in order of importance): • satisfy legal requirements; • not seek to unfairly disadvantage GB members in terms of fulfilling their roles; and • provide value for money for the CCG taking account of the first two principles. It was noted that the Governing Body rate is set and there may be a need for the Remuneration Committee to review these circumstances, with the aim of a consistent approach across the CCGs, in line with the principles outlined. Action by the Committee The Committee noted the verbal update and asked for further updates to be given to Finance & Resource Committee and future Audit Committees.	
A15/16	**Information Governance Toolkit** MMcD presented this report to the Committee. MMcD pointed out that the IG Toolkit needed to be signed off before the next Audit Committee meeting in April, and requested that both himself and HN be given delegated authority to sign this off, having had opportunity to review the CCG's proposed submission. Action by the Committee Delegated authority was given to MMcD and HN in order to sign off the IG Toolkit to meet the of March deadline.	
A15/17	**Minutes of other Committees to be formally received** The following Minutes were received by the Committee: a) Finance and Resource Committee Minutes - November 2014; b) Quality Committee Minutes - November 2014. Action by the Committee The above Minutes were noted.	

No	Item	Action
A15/18	**Any other business** HN raised the Conflicts of Interest Guidance management, recently published by NHS England for CCGs. MMcD noted that the Chief Officer and Chair of Audit Committee will have to provide assurance that the CCG has complied with this guidance. http://www.england.nhs.uk/wp-content/uploads/2014/12/man-confl-int-guid-1214.pdf	HN/ MMcD
	Date and time of next meeting Wednesday, 22nd April 2015 9.30am to 11.00am Family Life Centre, Southport	

NHS
Southport and Formby
Clinical Commissioning Group

Ainsdale and Birkdale Locality Meeting Minutes

Date: Thursday 22nd January 2015
Venue: The Family Surgery, 107 Liverpool Road, Southport PR8 4DB

Attendees		
Dr Kebsi Naidoo	(Chair) GP, Family Surgery	KN
Dr Gladys Gana	GP, Lincoln House Surgery	GG
Dr Ian Kilshaw	GP, The Grange Surgery	IK
Dr Sivaranjini Shyamsundar	GP, Lincoln House Surgery	SS
Dr Stuart Bennett	GP, Ainsdale Medical Centre	SB
Dr Paul Smith	GP, Ainsdale Village Surgery	PS
Rachael Ogden	Ainsdale Village Surgery	RO
Jane Uglow	Locality Development Manager, S&F CCG	JU
Kay Walsh	Medicines Management	KW
Melanie Wright	Locality Development Manager, S&F CCG	MW
Apologies		
Dr Lindsay McClelland	GP, Ainsdale Village Surgery	LMcC
Paul Ashby	Practice Manager, Ainsdale Medical Centre	PA
Natalie Dodsworth	Practice Manager, The Family Surgery	ND
Janice Lloyd	Practice Manager, Lincoln House Surgery	JL
Nina Price	Practice Manager, The Grange Surgery	NP
Karen Ridehalgh	Practice Manager, Ainsdale Village Surgery	KR
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr G Gana	Lincoln House Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Dr I Kilshaw	The Grange Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Dr K Naidoo	The Family Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Dr R Russell	Ainsdale Medical Centre	✓	✓	✓	✓	✓	A	✓	✓	✓	A		
Dr S Bennett	Ainsdale Medical Centre	A	A	A	A	A	✓	A	A	-	✓		
Dr P Smith	Ainsdale Village Surgery	✓	✓	✓	✓	✓	A	A	✓	-	✓		
Dr L McClelland	Ainsdale Village Surgery	A	A	A	A	A	✓	✓	A	✓	A		

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/01	**Apologies for absence** Apologies were noted. Please see attendance sheet.  201501 A&B Attendance Sheet.pd	
15/02	The Minutes of the previous meeting in December were agreed as an accurate record.  A&B Minutes - December 2014 (FIN/ The action tracker was discussed and noted.	
15/03	**15/3 Chair's Update** The CCG final budget is on track to meet its statutory obligations. *Local Quality Contract* - all practices are now clear on open/close times with reference to the Local Quality Scheme. Dr Naidoo advised there will be a review for the next contractual year and it is likely Frail Elderly will form a key part of this work. *PM Challenge Fund* - awaiting outcome to see if funding is secured. Dr Naidoo also reported on a recent discussion with Billie Dodd regarding *'Facing the Future'* a piece of work under way with West Lancs CCG in relation to Community Services for which there are a number of milestones the Trust must achieve which will influence the decision as to whether to go out to procurement for community services. The deadline is June 2015.	
15/04	**Quality and Patient Safety** Dr Naidoo referred to ongoing issues around raised potassium levels in blood tests: there are another 2 patients and that these should be itemised via NHS number and the details forwarded to Billie Dodd to keep track.	All Practices
15/05	**Performances and Finance** *Locality Emergency Admissions* Mrs Wright presented the Emergency Admissions figures which had been considered at the December locality meeting and sought clarification as to whether practices felt there was any value in 'drilling' down this information further to patient level. Practices did not feel this level of data would add value. Mrs Wright went on to ask whether there is any information/data that would be helpful to the practices that is not supplied at present. *Analysis of long term conditions* Mrs Wright presented disease prevalence data by practice, which is	

No	Item	Action
	produced by Public Health. It was noted that practice names are incorrect on this document, which raised questions as to accuracy of data. Mrs Wright agreed to feed this back to Public Health. *Financial Report* Local performances on Quality Premium – the likely total amount payable is £45,969 against a total possible of £612,925 for this contractual year . This is due to, *inter alia,* under performances for Merseycare and Emergency Admissions and the situation is worsening.	MW
15/06	**Medicines Management** *Peer Review of Antimicrobial Audits - Kay Walsh* The following audit reports were presented and peer reviewed: Family, Quarters 1 and 2; Ainsdale Village, Quarters 1 and 2; Lincoln Road, Quarters 1, 2 and 3; The Grange, Quarter 3; Ainsdale Medical, Quarters 1, 2 and 3. Practices discussed the outcomes of the peer review which was felt to be helpful. It was agreed that the remaining audit reports will be presented at the March meeting. Practices will be advised by their practice pharmacist of the dates for the Quarter 4 audit Discussion also took place relating to whether 3 days is still the recommended duration for uncomplicated UTI. Ms Walsh agreed to revert on this. Dr Siva advised that there is a manufacturer's problem with Trimethoprim in 100mg and 200mg dosage. Ms Walsh also agreed to look into this. Dr. Smith raised whether the addition of Script Switch messages could be an action from the peer review. KW to look into.	KW KW KW
15/07	**Any Other Business** *Pharmacy Opening Times* Dr Smith enquired as to where patients can go to obtain their prescriptions obtained during the extended working hours and whether the CCG have also commissioned this service. Mrs Uglow responded that the CCG does not commission these services, but NHS England does. *Electronic vs Paper Correspondence from hospital* Dr Smith referred to duplication of discharge information being received from hospital in both electronic and paper formats. Mrs Wright referred to previous discussions in this meeting and advised that the Trust will revert to purely electronic discharges upon confirmation from the CCG that they are agreeable. Mrs Wright agreed to chase progress on this. *Expensive scripts* Dr Gana raised the costs associated with Apomorphine Ms Walsh responded that this drug is on the high cost drug list and, as such, the financial risk is shared between all practices. Discussion also took place over scripts for dressings and who should prescribe. The meeting noted that the Medicines Management Operational Group are considering this question and a letter is being drafted, which will be circulated in due course.	MW KW

No	Item	Action
	Renavit Dr. Bennett queried whether this should be prescribed. KW advised that it is ACBS and is on the Pan Mersey Formulary for patients on dialysis. Noted that on Grey List KW to raise whether it should be removed from the Grey List	
15/08	**Date and Venue for Next Meeting** Thursday 26 February 2015 at 12.30pm at The Family Surgery.	

NHS
Southport and Formby
Clinical Commissioning Group

Formby Locality Meeting Minutes

Date: Thursday 11th December 2014 at 13.15 – 14.45

Venue: The Village Surgery, Formby

Attendees		
Dr Chris Bolton	(Chair) GP, The Village Surgery	CB
Pippa Rose	Practice Nurse Facilitator	PR
Dr Doug Callow	GP, Chapel Lane Surgery	DC
Dr Sarah Lindsay	GP, Freshfield Surgery	SL
Dr Deborah Sumner	GP, The Hollies Surgery	DS
Stewart Eden	Practice Manager, Chapel Lane Surgery	SE
Susanne Lynch	Medicines Management, S&F CCG	SLy
Moira McGuinness	Formby Locality Manager S&F CCG	MM
Colette Riley	Practice Manager, The Hollies	CR
Lisa Roberts	Practice Manager, Freshfield Surgery	LR
In Attendance		
Angela Parkinson	Locality Manager, South Sefton CCG	AP
Niall Leonard	GP, Roe Lane Surgery	NL
Apologies		
Sue Lowe	Practice Manager, The Village Surgery	
Yvonne Sturdy	Nurse Practitioner, The Village Surgery	YS
Minutes		
Anne Lucy	Locality Development Support, S&F CCG	AL

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr D Callow	Chapel Lane Surgery	✓	✓	✓	A	A	A	✓	✓	✓			
Dr T Quinlan	Chapel Lane Surgery	✓	L	A	✓	A	A	A	A	A			
Dr C Bolton	The Village Surgery	A	✓	✓	✓	✓	✓	A	✓	✓			
Dr J Reddington	The Village Surgery	A	A	A	A	A	A	A	A	A			
Dr S Johnson	The Village Surgery	A	A	A	A	A	A	A	A	A			
Dr L Grant	The Village Surgery	A	A	A	A	A	A	A	A	A			
Dr D Mortimer	The Village Surgery	✓	A	A	A	A	A	A	A	A			
Dr J Eldridge	The Hollies Surgery	✓	A	A	A	A	A	A	A	A			
Dr D Sumner	The Hollies Surgery	A	L	✓	A	A	✓	A	✓	✓			

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr T Brettel	The Village Surgery	A	A	A	A	A	A	A	A	A			
Dr S Lindsay	Freshfield Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓			

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/110	**Welcome, apologies and introductions** Apologies were noted. See attendance sheet below:  Attendance sheet.pdf	
14/111	**Minutes of the last meeting** The minutes from the previous meeting on 13 November were agreed as an accurate record.	
14/112	**Primary Care** Niall Leonard and Angela Parkinson led a group update / discussion on collaborative working, LQC, the PM's Challenge fund, and potential areas where collaborative / federated working might be feasible. This included Frail Elderly care, intermediate and hospice-type care, extended hours (1830 – 2000 on weekdays and 0800-1200 at weekends). The group discussed sharing good ideas / techniques across the CCG, payment and remuneration considerations. Opening times (in terms defined in the Local Quality contract) were discussed and clarified	
14/113	**Matters Arising** SL gave an update re the CIP (intelligence portal) Group discussed coding errors – these should be brought up as a quality issue and followed up to recoup erroneous charges (contributing to overspend in general). **Action: Group asked for miscoding to be followed up to attempt to recoup erroneous charges**	**DC**
14/114	**Care Home Antimicrobial Prescribing** A peer review had not been undertaken and this item was carried forward to the next locality meeting in January	
14/115	**Community Geriatrician** MM gave an overview of the community geriatrician model that is currently being discussed by the CCG and Trust. It will involve a 24 hour wrap around	

No	Item	Action
	team. MM will keep the group informed re progress. It is anticipated that an agreed model could be in place by March/ April 2015	
14/116	**Winter Pressure** Those practices wishing to participate are submitting plans and allocating additional winter sessions for December / January. **Action: MM to determine payment basis as it was believed that payment rates were different for South Sefton CCG practices**	**MM**
14/117	**Quality Premium Dashboard** Not discussed	
14/118	**Quality and Patient Safety** MM reported that some practices reported that they had patients discharged with outstanding tests. This could possibly result in overcharging. SL had brought sample discharge letters and passed them to DC (Quality Lead) for follow up. MM reminded practices to do the same	
14/119	**Locality Business** CR gave a summary from the meetings she attends as Board / Locality Practice manager  CCG FEEDBACK NOV 2014 for Dec 14 meet SE to circulate a summary of collaborative working model discussed at the last collaborative working group meeting	
14/120	**Pharmacy Update** SL gave a summary of highlights from the pharmacy report, noting that most practices were underspent. Budget figures will be emailed to practices (as access via CMiP had been problematic)  SFCCG Month 7 1415 Prescribing Budget.xl  Nov 14 Medicines Management Update	
14/121	**AOB** • MM had received a request that practice nurses should be included in flu clinic planning sessions so their shift / breaks could be planned in • The next PLT will be on 17 December at Formby Christian fellowship and will discuss voluntary, community, faith sector • SL noted that the prescriber quality scheme will move to the local quality contract. SL is in the process of rewriting this to lend a practice (rather than GP) focus. • MM advised that the care home project would be continuing until end	

No	Item	Action
	March 2015 • MM advised that the Alcohol Recovery Unit (ARU) would commence operations on Friday 12 December	
14/122	**Date and time of next meeting:** Thursday 15 January, Formby Village Surgery, 13:15 **<u>Confirmed dates for 2015 Locality Meetings</u>** Thursday 15th January Thursday 5th February Thursday 12th March Thursday 2nd April Thursday 7th May Thursday 4th June Thursday 9nd July Thursday 6th August Thursday 10rd September Thursday 1st October Thursday 12th November Thursday 3rd December	

NHS
Southport and Formby
Clinical Commissioning Group

Formby Locality Meeting Minutes

Date: Thursday 15th January 2015
Venue: Formby Village Surgery

Attendees		
Dr Chris Bolton	(Chair) GP, The Village Surgery	CB
Dr Sarah Lindsay	GP, Freshfield Surgery	SL
Stewart Eden	Practice Manager, Chapel Lane Surgery	SE
Yvonne Sturdy	Nurse Practitioner, The Village Surgery	YS
Sue Lowe	Practice Manager, The Village Surgery	SL
Susanne Lynch	Medicines Management, S&F CCG	SLy
Moira McGuinness	Formby Locality Manager S&F CCG	MM
Colette Riley	Practice Manager, The Hollies	CR
Lisa Roberts	Practice Manager, Freshfield Surgery	LR
In Attendance		
James Bradley	Finance, S&F CCG	
Apologies		
Dr Doug Callow	GP, Chapel Lane Surgery	DC
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr D Callow	Chapel Lane Surgery	✓	✓	✓	A	A	A	✓	✓	✓	A		
Dr T Quinlan	Chapel Lane Surgery	✓	L	A	✓	A	A	A	A	A	A		
Dr C Bolton	The Village Surgery	A	✓	✓	✓	✓	✓	A	✓	✓	✓		
Dr J Reddington	The Village Surgery	A	A	A	A	A	A	A	A	A	A		
Dr S Johnson	The Village Surgery	A	A	A	A	A	A	A	A	A	A		
Dr L Grant	The Village Surgery	A	A	A	A	A	A	A	A	A	A		
Dr D Mortimer	The Village Surgery	✓	A	A	A	A	A	A	A	A	A		
Dr J Eldridge	The Hollies Surgery	✓	A	A	A	A	A	A	A	A	A		
Dr D Sumner	The Hollies Surgery	A	L	✓	A	A	✓	A	✓	✓	A		
Dr T Brettel	Freshfield Surgery	A	A	A	A	A	A	A	A	A	A		
Dr S Lindsay	Freshfield Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/01	Welcome, apologies and introductions  Attendance sheet - completed.pdf	
15/02	**Minutes of the last meeting** The minutes from the last meeting on 11 December 2014 were agreed as an accurate record.  Formby Locality Minutes- December F **Rapid Access Clinic** Discussion took place over access to this clinic. Dr Bolton noted that it was a good idea in principle. Dr Bolton to contact Dr Kati Scholtz to discuss if useful in Formby.	
15/03	**Matters Arising:** • Antimicrobial Prescribing – Peer Review It was agreed to place this item on the agenda for the next meeting and that data for antimicrobials in care homes audit in quarter 1 and 2 needs to be brought to this meeting by all practices and present by a GP • MM to chase up passwords for CMIP.	Agenda MM
15/04	**Financial Allocation 2015 (James Bradley)** James Bradley provided an overview of the CCG's financial allocation for 2015/16. Discussion took place over erroneous coding/overcharging and whether monies can be recovered. JB advised that this can be pursued via the Commissioning Claims but can be difficult to prove; the only way to do this is to compare the SIP with discharge data. Timescales are limited to 6-8 weeks. CB invited JB to come in to look at data. JB would need to get report back on claims from CSU and map a timespan for opportunity to make claim.	
15/05	**Locality Dashboard** Discussion over whether Locality would like this data 'filed down' to NHS numbers. MM advised that PMO team are happy to do this but need to know what outcomes practices would put in place from the findings. Discussion took place over data presented; SL asking for the figures from **'Emergency Admissions for acute conditions that should not usually require hospital admission'** to be broken down to patients that attended A&E and were admitted and those that attended and discharged as need to understand what these figures mean. Could also further split the information to hours/out of hours attendances and age groups – to find out if something could be done differently. MM acknowledged that if this information is obtained would need to feedback on the results.	MM

No	Item	Action
15/06	**Quality and patient safety** **Dr Doug Callow – apologies.** CB raised an issue relating to Out of Hours provision. MM to contact Malcolm Cunningham who is lead on this. CR commented on problems with staffing on the CERT team before Christmas. SL also commented on a case where an attempt obtain community IV antibodies was difficult. MM is looking into this.	MM MM
15/07	**Locality Business** **Chair's Update** • Next year's Locality contract is on Frail Elderly and health checks for over 75s although it is not finalised yet. • Prime Minister's Challenge Fund bid is going in and all S&FCCG practices have signed up for £1.7m. This will look at having a base at the hospital – a discussion followed over the geographical area of this being at the hospital. MM noted that local areas could be discussed in the future **Governing Body** • Service redesign CR will share when has more information. **WCG** • Federation – discussion took place at WCG meeting.	
15/08	**Any Other Business** **Quality Report** Discussion took place over quality report. Ambulance times were discussed – a 4 hour wait for blue light. MM asked for SL and CR to send her details of these incidences.	SL/CR
15/09	**Date of next meeting:** **Thursday 5th February 2015 at 1.15pm** **Formby Village Surgery.**	

NHS
Southport and Formby
Clinical Commissioning Group

Central Locality Meeting Minutes

Date: Tuesday 25th November 2014 at 13.00 – 15.00

Venue: Kew Surgery

Attendees		
Dr Ian Hughes	GP, Cumberland House	IH
Dr Mark Bond	GP, Curzon Road	MB
Dr Halina Obuchowicz	GP, Kew Surgery	HO
Joanne Ball	Public Health Sefton	JB
Roy Boardman	Business Manager, St Marks Medical Centre	RB
Sharon Forrester	Locality Development Manager, S&F CCG	SF
Dawn Bradley-Jones	Practice Manager, Trinity Practice	DBJ
Sejal Patel	Medicines Management	SP
Alix Shore	Community Matron	AS
Kate Wood	Practice Manager, Kew Surgery	KW
In attendance		
Becky Williams	Chief Analyst, South Sefton CCG	BW
Minutes		
Sadie Rose	Administrator, S&F CCG	SR
Apologies		
Dr Graeme Allan	(Chair) GP, St Marks Medical Centre	GA
Dr Gajanana Kumble	GP, Trinity Practice	GK
Rachel Cummings	Practice Manager, Cumberland House	RC

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr M Bond	Curzon Road Medical Practice	✓	✓	✓	✓		✓	A	✓				
Dr A Farrell	Curzon Road Medical Practice	A	✓	A	A		A	A	A				
Dr G Hedley	St Marks Medical Centre	A	A	A	A		A	A	A				
Dr G Allen	St Marks Medical Centre	✓	✓	A	✓		A	✓	A				
Dr G Stubbens	St Marks Medical Centre	A	A	✓	A		A	A	A				
Dr I Hughes	Cumberland House	✓	✓	✓	✓		✓	✓	✓				
Dr H Obuchowicz	Kew Surgery	A	✓	✓	✓		A	✓	✓				
Dr W Coulter	Kew Surgery	✓	A	A	A		A	A	A				
Dr L Campbell	Trinity Practice	✓	✓	A	A		A	A	A				

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr G Kumble	Trinity Practice	A	A	A	A		✓	A	A				

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/81	**Welcome and Apologies** Apologies were noted.	
14/82	**Performance and Finance Update** Becky Williams attended the meeting to discuss the Quality Premium Report and the Locality Dashboard. <u>Quality Premium Report</u> The final 2013/14 data is yet to be confirmed by NHS England, however the CCG has received a copy of the data used by NHS England to measure performance, and indicative financial totals. Indicative data from NHS England for 2013/14 reveals that Southport & Formby CCG should receive a payment of £279,094 against a total possible payment (if all indicators were within tolerance) of £595,400. This is due to underperformance in a number of areas which were described in the April report to this committee. Based on local data performance for the indicators for 2014/15 (April 2014 – September 2014), Southport & Formby CCG should receive a payment in 2014/15 of £0 against a total possible payment (if all indicators were within tolerance) of £612,925. This is due to poor performance of the access to psychological therapies measure, underperformance on the emergency admissions composite measure, Merseycare's underperformance on the medication error reporting measure, underperformance on the medication error reporting measure, the local diabetes measure and underperformance on the ambulance measure, which would result in a 25% reduction to the overall possible payment, plus indicators for which performance is currently unknown due to annual reporting frequencies. However, taking a likely case scenario approach, the total amount payable under the likely case scenario is £321,786 against a total possible payment (if all indicators were within tolerance) of £612,925. This is an improving position from last month's estimate. BW explained that a number of the indicators are out of practice's control such as ambulance response rates; however the unplanned admissions data can be drilled down on further. BW explained that any information and intelligence from practices would help. **Action: Practices to check the patients that they are identifying through risk stratification tool are the same patients as those preventable admissions.**	ALL

No	Item	Action
	Action: BW to send a list of ambulatory sensitive conditions. <u>Primary Care Dashboard</u> A draft locality information pack/dashboard was circulated and BW explained how it consists of real data from June compared to the previous year and compares various elements at practice level (e.g. GP referrals and prescribing). This is currently a draft document and is awaiting further data from finance. The idea is for the dashboard to be sent out on a monthly basis. Any feedback on the dashboard is welcomed by BW.	BW
14/83	**Minutes from the previous meeting/Matters arising** The minutes from the previous meeting on 28 October were agreed as an accurate record.	
14/84	**Chair's Update** No chair's update due to apologies from Dr Allan.	
14/85	**Quality and Patient Safety Issues** <u>Rheumatology Referrals</u> An issue regarding rheumatology referrals was discussed. The issue involves practices receiving re-referral requests for diagnostics following a patient's discharge. Sharon Forrester asked the group if anyone had reported incidents of a similar nature, or whether this was just an isolated incident. Jan Leonard will be collecting evidence of this to take to the board. Practices to send any issues to Sharon. <u>Emergency Eye Clinic</u> Dr Obuchowicz raised an issue with the emergency eye clinic not seeing a patient and referring them to A&E. **Action: SF to find out who is responsible for commissioning ophthalmology** **Action: SF to find out the structure of the emergency eye clinic and emergency ENT pathway.**	SF SF
14/86	**Service Improvement/ redesign** <u>Locality Team</u> A discussion around the future structure of locality group meetings was discussed. SF spoke about ways of making locality meetings more clinical focused and how to best utilise these meetings. SF also spoke the dual role of locality managers and how to link the portfolio areas into the locality meetings to have more of an impact. SF spoke about the current work that is ongoing with the trust around redesigning cardiology. SF also spoke about ways in which data on heart failure can be drilled down on further to influence clinical practice.	

No	Item	Action

14/87	**Medicines Management Update**
	
	<u>Antimicrobial Audit</u>
	Sejal Patel provided the group with the results from the antimicrobial audit. The total number of items audited in May was 58, with 39.7% items being in line with the guidance. The total number of items audited in August was 52 and 48% of these were in line with the guidance. Common themes identified included:
	
	• Duration of UTI- 6/7 days for UTI (guidance is 3 days for uncomplicated UTI in women, 7 days for UTI in men)
	• Respiratory tract (bronchitis)- Amoxicillin prescribed for 7 days (should be 5)
	• Choice of antibiotics
	  - Cephalexin for UTI (in patients with normal renal function)
	  - Co-amoxiclav for UTI
	• Suboptimal strength
	  - 250mg amoxicillin for respiratory tract infections in adults
	
	Another audit it due to be conducted for November. SP drew the group's attention to the RCGP toolkit: 'target antibiotics' which is available online.
	Action: SP to send the link to SF to circulate.
	
	<u>Category M Drugs</u>
	SP circulated information following changes in category M drugs as of the 1st October. SP also circulated a list of alternatives that could make savings to compensate for the hit to practices prescribing budgets. These are only potential savings and are not going to be appropriate for all patients. Practices were advised to support their local pharmacist.
		SP/SF

14/88	**Connected Communities** Sharon Forrester provided an update on the connected community's project.  CONNECTED COMMUNITIES activit  as at 31 October.doc  Case Study - Mr Mrs L.docx  Case Study - MrsJ.docx	
14/89	**AOB** <u>Winter Pressure Monies</u> **Action: SF to send out an email to all practices with full details.**	SF
14/90	**Date and Time of Next Meeting** Tuesday 16th December 13:00-15:00 Kew Surgery	

NHS
Southport and Formby
Clinical Commissioning Group

Central Locality Meeting Minutes

Date: Tuesday 16th December 2014 at 13.00 – 15.00

Venue: Kew Surgery

Attendees		
Dr Ian Hughes	GP, Cumberland House	IH
Dr Halina Obuchowicz	GP, Kew Surgery	HO
Dr Graeme Allan	GP, St Marks Medical Centre	GA
Roy Boardman	Business Manager, St Marks Medical Centre	RB
Sharon Forrester	Locality Development Manager, S&F CCG	SF
Dawn Bradley-Jones	Practice Manager, Trinity Practice	DBJ
Sejal Patel	Medicines Management	SP
Alix Shore	Community Matron	AS
Rachel Cummings	Practice Manager, Cumberland House	RC
In attendance		
Angela Parkinson	Locality Manager, Litherland	AP
Niall Leonard		NL
Minutes		
Sarah Rycroft	Senior Administrator, SS/S&F CCG	SR

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr M Bond	Curzon Road Medical Practice	✓	✓	✓	✓		✓	A	✓	A			
Dr A Farrell	Curzon Road Medical Practice	A	✓	A	A		A	A	A	A			
Dr G Hedley	St Marks Medical Centre	A	A	A	A		A	A	A	A			
Dr G Allen	St Marks Medical Centre	✓	✓	A	✓		A	✓	A	✓			
Dr G Stubbens	St Marks Medical Centre	A	A	✓	A		A	A	A	A			
Dr I Hughes	Cumberland House	✓	✓	✓	✓		✓	✓	✓	✓			
Dr H Obuchowicz	Kew Surgery	A	✓	✓	✓		A	✓	✓	✓			
Dr W Coulter	Kew Surgery	✓	A	A	A		A	A	A	A			
Dr L Campbell	Trinity Practice	✓	✓	A	A		A	A	A	A			
Dr G Kumble	Trinity Practice	A	A	A	A		✓	A	A	A			

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/91	**Welcome and Apologies** Introductions and apologies were given	
14/92	**Minutes from the previous meeting/Matters arising** The minutes from the last meeting have now been amended re Medicines Management and are attached	 Central Loca Minutes- Nover
14/93	**Performance and Finance Update** • Winter Pressures Update – The group said that they had all received the email from Billie Dodd and all agreed that they were happy with it. • Locality Dashboard – AF Management and Heart Failure – SF confirmed that a pilot on heart failure will go ahead in the New Year. A CVD strategy Group commenced this month to look at AF & stroke management in more detail. SF agreed to bring more detail to the group to the January 2015's meeting.	SF
14/94	**Quality and Patient Safety Issues** • Ophthalmology – SF informed the group that the issue re Ophthalmology is being investigated with the Service Manager at the hospital • Cardiology – SF said that there is an issue re Cardiology at Southport as there are a backlog of approximately 200 patients that have been referred but still not seen by a consultant and follow up appointments there is a backlog of approximately 700 patients. The referral should be 2 weeks • Emergency admissions – SF circulated the Emergency admissions dashboard to the group and said that it is available to practices. Becky Williams has sent the ambulatory sensitive conditions to the group. SF said that she will send out the link to the Emergency admissions dashboard	SF SF SF
14/95	**Service Improvement/Redesign** Community Geriatrician Scheme and Locality Team Working Update items have been deferred to January 2015 meeting	SF
14/96	**Medicines Management Update** SP handed out budget information to each practice and asked them to look over this and discuss in January's meeting	ALL
14/97	**Primary Care** **Access – LQC** An email request to clarify what the definition of being open is for part 1 of the Local Quality Contract was recently circulated to Practice Managers, this was discussed regarding practices opening doors and being accessible	

No	Item	Action
	by phone between 8 – 6.30. Dr Mark Bond had subsequently forwarded an email to Practice Managers with the intention of adding the item to the LMC agenda 16.12.14. **Local Quality Contract Year 1/Year 2** Practices were asked to consider what had worked well in year one, and what year two could look like. A suggested model that CCG are considering is a scheme focusing on patients aged 75 and over with long term conditions which would place the resources with the cohort of patients with complex needs. **PMCF** Nationally there is £100m available through the Prime Ministers Challenge Fund for practices who wish to combine practice populations to cover 30,000 patients, and develop schemes and bids to improve access. Bids need to be submitted by 16th January. Some initial thoughts included: • 6.30pm – 8.00pm access M-F – routine bookable appointments • access Saturday and Sunday – routine bookable appointments • Community/Practice location (dependent upon geography of practice buy in) • Alternative provider ie GTD/UC24 etc. who already have clinical networks/ management structure/ governance arrangements/Indemnity cover/CQC registration/IG Toolkit • Alternative provider to run the service, locate workforce etc. GP and nursing staff required, ability to instigate investigations and close episodes • Opportunity for local clinicians to be involved • Appointments bookable (to include online booking) • Out of hours provider / A+E to have access to routine bookable appointments • Skype appointments/ email? available as an alternative to face to face • Identify local pharmacy with opening arrangements • Data sharing agreements (read and add to) in place between practices/provider • Mobile app technology for remote monitoring (in and out of hours ?) • Wrap around services extended to cover extended hours (frail/elderly) • iMerseyside support to provider (as currently only operates to 6.30). • Locality model (if enough buy in from practices), locality location for delivery, operate/manage locally (without using GTD/UC24) • If successful contract would be with NHS England - would need agreement on who would hold the contract on behalf of practices involved Practices were asked to consider whether this is something that needs to be developed/pursued. Feedback to AP.	
14/98	**AOB**	

No	Item	Action
	• RC queried hospital charges • Individual funding requests were queried as to correct information on the website	
14/99	**Date and Time of Next Meeting** Tuesday 28th January 13:00-15:00 Kew Surgery	

NHS
Southport and Formby
Clinical Commissioning Group

Central Locality Meeting Minutes

Date: Tuesday 27th January 2015

Venue: Kew Surgery, 85 Town Lane, Southport PR8 5PH

Attendees		
Dr Ian Hughes	GP, Cumberland House	IH
Dr Mark Bond	GP, Curzon Road Surgery	MB
Dr Graeme Allan	(Chair), GP, St Marks Medical Centre	GA
Dr Kati Scholtz	CCG Board Member	KS
Dr Wendy Coulter	GP, Kew Surgery	WC
Sharon Forrester	Locality Development Manager, S&F CCG	SF
Kathy Rimmer	District Nurses, Curzon Road	AS
Rachel Cummings	Practice Manager, Cumberland House	RC
Apologies		
Dr Halina Obuchowicz	GP, Kew Surgery	HO
Roy Boardman	Business Manager, St Marks Medical Centre	RB
Dawn Bradley-Jones	Practice Manager, Trinity Practice	DBJ
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr M Bond	Curzon Road Medical Practice	✓	✓	✓	✓		✓	A	✓	A	✓		
Dr A Farrell	Curzon Road Medical Practice	A	✓	A	A		A	A	A	A	A		
Dr G Hedley	St Marks Medical Centre	A	A	A	A		A	A	A	A	A		
Dr G Allen	St Marks Medical Centre	✓	✓	A	✓		A	✓	A	✓	✓		
Dr G Stubbens	St Marks Medical Centre	A	A	✓	A		A	A	A	A	A		
Dr I Hughes	Cumberland House	✓	✓	✓	✓		✓	✓	✓	✓	✓		
Dr H Obuchowicz	Kew Surgery	A	✓	✓	✓		A	✓	✓	✓	A		
Dr W Coulter	Kew Surgery	✓	A	A	A		A	A	A	A	✓		
Dr L Campbell	Trinity Practice	✓	✓	A	A		A	A	A	A	A		
Dr G Kumble	Trinity Practice	A	A	A	A		✓	A	A	A	A		

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/01	**Welcome, Apologies & Introductions** Apologies were noted.  201501 Central Locality Attendance s	
15/02	**Minutes of previous Meeting/Action Tracker** The minutes of the previous meeting were agreed as an accurate record except for an amendment to No. 14/93 - SF commented that it was not agreed that the AF Management and Stroke pilot be presented to LMC in February. The Action Tracker was updated.	 Central Loca Minutes- DECEI
15/03	**Matters Arising** *GP Locality Leads Meeting* GA advised that the PM Challenge Fund was the main topic during this meeting in terms of discussions over how it might work and who might volunteer. *St Marks & Trinity GP representation & Chair Replacement* GA advised that he will be retiring as Chair at end of March 2015 and will organise GP representation for St Marks and Trinity. However a new Chair will need to be organised. It was agreed to put this on the agenda for March. *Governing Body Update* Co-commissioning - KS advised that at Board Development Meeting last week 3 options were looked at: i) To stay the same ii) Taking part in co-commissioning; having much bigger say although would not be responsible for individual GP management. iii) Co-commissioning done by CCG. S&F CCG went for Option 2. Discussion took place over this and how it would work. KS also noted that if Option 1 agreed can change to Option 2 or 3 at any point in tax year however if choose Options 2 or 3 would have to wait to change until following tax year. *PM Challenge Fund* 19/20 practices have signed up for this. Negotiations are taking place regarding running clinic at the Medical Outpatients. Minutiae of how this will work has not been done yet. GA advised we will hear about bid by 23 February 2015. The fund is for a year from April 2015. Some GPs have committed workforce to the Fund and surgeries will have to delegate / take responsibility for certain clinics (after 6:30pm and weekends AMs). A&E will also be able to book these appointments. Discussion followed over responsibility of each surgery to staff this and how quickly it will need to be implemented.	SF – agenda item March

No	Item	Action
	GP in Casualty Early indications show the GPs are not dealing with a lot of GP problems and there are also shifts that need filling if anybody would like to volunteer. Discussion took place over how this is working and results. *IAPT services* Wirral and Cheshire Partnership now been awarded the new contract. IH asked what will happen to existing patients; KS advised that this will be discussed at Board tomorrow. GA raised question that original specification for IAPT included cancer patients and we have a contractual obligation to provide psychological therapies to cancer patients. The final spec does not include them. KS to look into this. *Breast Clinic Services* No new information as yet. Original agreement is that existing patients will be followed up at S&O. However KS mentioned a patient for whom the letter asks the GP to ensure a follow up is done. KS has raised this with Doug Callow. Concerns were raised regarding the follow ups for existing patients being done by the clinicians at SDGH - KS to raise with JL. *Respiratory* KS is Respiratory lead – KS to ensure they have received e-mail from Sefton Community Respiratory Team. A service pack will be sent out in next 3 weeks to summarise all services available, for example oxygen, end of life care. This will also be available on the intranet. This led to a discussion regarding patients coming out of hospital without a Shared Care Agreement such as Clexane injections. SF and KS to flag up with Meds Management Team.	KS KS ALL SF + KS
15/04	**Quality & Patient Safety** *Rapid Access Chest Pain Clinic and Cardiology ICO* The locality discussed issues relating to the Rapid Access Chest Pain Clinic and Cardiology Service at Southport & Ormskirk Hospital NHS Trust. Southport & Formby is leading the programme of work around this area and will regularly update/involve localities in development.	KS
15/05	**Performances and Finance** *Quality Premium Report* SF summarised the Quality report. *Central LTC Analysis* Discussion took place over high A&E admissions and suggestion that a piece of work needs to be done in primary care about what actions should be taken before a patient is referred. Further discussion took place about conditions that should not be referred; Group all thought these conditions could not be dealt with by GP. It was felt that the information was unclear. *Education for Practices:* SF discussed the 9 care processes for diabetes; there will be practice visits by Diabetes lead.	

No	Item	Action
	Locality Dashboard – AF and HF SF presented data on the Cardiovascular Programme dashboard for 2014/2015 and for Heart Failure.  Copy of Cardiovascular.xlsx  Copy of SF - Heart Failure and Atrial Fibr Discussion took place over how we can influence this and over 'drilling down' patient data to try to understand why patients are being admitted and a possible peer review of this. SF to ask Data Analyst to contact practices with patient details. Practices agreed this was a good idea but no time to do it. If no capacity SF will take this back to PMO.	SF
15/06	**Service Improvement/Redesign** *Community Geriatrician Scheme Update* KS has no further information at present. *Connected Communities* SF informed Group that this is doing really well; over the 2 localities there have been over 100 referrals. There has been really good outcomes and patient feedback. There is a further piece of work that is needed to see if patients have still accessed services/GPs/hospital. The funding will finish at the end of June; SF to write a summary and Connected Communities are to write an evaluation report for March/April following which SF to take to SMT for more funding.	
15/07	**Medicines Management** Nothing raised.	
15/08	**Any Other Business** • Discussion took place over receiving payment for meetings attended. • Anticoagulant referrals: MB raised issue over where to send referrals to for Anti-coagulants. IH discussed similar problems he had and advised can make direct referral o Community Anti-coagulant clinic but if patient needs to see haematologist first this takes longer. The Consultant will be attending the next PLT at UHA in February for further clarification.	
15/09	**Date and Venue for next meeting:** Tuesday 24th February 2015 at 1:00pm to 3:00pm Kew Surgery	

NHS
Southport and Formby
Clinical Commissioning Group

North Locality Meeting Minutes

Date: Thursday 18 December 2014 at 13.00

Venue: Marshside/Corner Surgery

Attendees

Dr Ian Scott	(Chair) GP, Churchtown Medical Centre	IS
Jane Ayres	Medicines Management	JA
Lydia Hale	Practice Manager, Roe Lane Surgery	LH
Carol Mackenzie	Practice Manager, The Corner Surgery	CM
Nicole Marshall	Practice Manager, Marshside Surgery	NM
Sarah McGrath	Locality Development Manager, S&F CCG	SMc
Anne Lucy	Locality Development Support, S&F CCG	AL
Sam Muir	Practice Manager, Norwood Surgery	SM
Dr Kati Scholtz	GP, Norwood Surgery	KS
Hilal Mulla	GP, Corner Surgery	HM
Dr Rory Kidd	GP, Churchtown Medical Centre	RK
Dr Niall Leonard	GP, Roe Lane Surgery	NL
Angela Parkinson	Locality Development Manager, SS CCG	AP

Apologies

Rachel McKnight	MerseyCare	RMc
Lyn Roberts	Practice Manager, Churchtown Medical Centre	LR
Val Sheard	Health Promotion Specialist, Public Health	VS
Rob Caudwell	GP, Marshside Surgery	RC
Dr Kati Scholtz	GP, Norwood Surgery	KS

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr K Scholtz	Norwood Surgery	✓	✓	✓	✓	✓	A	A	A	✓			
Dr A Al-Dahiri	Norwood Surgery	✓	A	A	A	A	✓	A	A	A			
Dr S Tobin	Norwood Surgery	A	A	A	A	A	A	A	A	A			
Dr D Unwin	Norwood Surgery	A	A	A	A	A	A	A	A	A			
Dr A Zubairu	Norwood Surgery	A	A	A	A	A	A	✓	✓	A			
Dr N Leonard	Roe Lane Surgery	A	✓	A	✓	A	✓	✓	A	L			
Dr A Trevor	Roe Lane Surgery	✓	A	✓	A	A	A	A	A	A			
Dr J Fox	Roe Lane Surgery	A	A	A	A	✓	A	A	A	A			
Dr J Canavan	Roe Lane Surgery								✓	A			

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr H Mulla	The Corner Surgery	✓	A	✓	A	✓	A	✓	A	✓			
Dr S Woodcock	The Corner Surgery	A	A	A	A	A	✓	A	A	A			
Dr M Moriarty	The Corner Surgery	A	✓	A	✓	A	A	A	✓	A			
Dr R Caudwell	Marshside Practice	✓	✓	✓	A	✓	A	✓	✓	A			
Dr M McCormack	Churchtown Medical Centre	A	A	A	A	A	A	A	A	A			
Dr R Kidd	Churchtown Medical Centre	A	A	A	A	A	✓	✓	A	✓			
Dr I Scott	Churchtown Medical Centre	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Dr P Giannelli	Churchtown Medical Centre	A	A	A	A	✓	A	A	A	A			

✓ Present
A Apologies
L Late or left early

No	Item	Action
14/109	**Welcome and apologies** Apologies were noted. See attendance sheet below: 201412 Attendance.pdf	
14/110	**Minutes of the last meeting** The minutes from the previous meeting on 20 November 2014 were agreed as an accurate record. KS asked whether the group had further discussed ideas for the format / progress of the locality meetings. Suggestions should be directed to Rob Caudwell to take to the GP Chairs' meetings with Fiona Clark	
14/111	**Quality and patient survey** SM noted that engagement around changes in breast services would take place in the new year LH noted that Brian Kelly will be the new community matron for the locality (taking over Janet McAlpine's caseload) KS asked whether community matrons / district nurses attended nursing homes. KS to email Debbie Curran for clarification	
14/112	**Medicines Management - antimicrobial audit** JA gave a summary of the findings of a recent antimicrobial audit. Prescribing levels were found to be low and appropriate for the weeks audited. Guidelines were generally followed and there were no concerns	

No	Item	Action
	around acid suppression medication. JA will supplement the report by presenting a report comparing results from other CCGs' audits next month. Patient expectation seems to be a major factor in the level of prescribing Antimicrobial Audit in Care Homes.docx	
14/113	**Service Improvement/ redesign** KS outlined the proposed model re community geriatrician care. The model is still under discussion / development and detailed costings have yet to be produced. The precise requirements are still to be finalised. The model will include elements of consultant support to community practices (seeing patients in outpatient clinic same or next day); and the extension of aspects of the nursing home projects. Education towards geriatrician related qualification would be anticipated so that the community would continue to benefit from expertise developed within the model. An administrator would be appointed to manage appoinrments, consultations and consultant availability. The model is to be presented for discussion at the Wider Constituent group meeting in January The model was well received and a number of queries were noted. These covered equality of treatment, provision of MDTs. These would be included in further discussions to define requirments precisely	
14/114	**Locality business** KS had attended a recent telehealth workshop. She encouraged colleagues to allow due consideration for the benefits that telehealth could offer.	
14/115	**Transforming Primary Care** NL reiterated the definition of opening hours, extended opening hours and the services that should be expected to be provided during these periods. MIAA are additionally auditing practice opening hours. NL outlined a potential Local Quality Scheme for 2015 – a payment (based on an eligibility register) per patient for frail elderly care. This would enable the appropriate care to be given across the CCG for registered frail elderly patients. It was felt that this approach could redress areas where resource was insufficient. NL outlined a proposal to bid for funding to support additional hours (from the Prime Minister's Challenge fund). These could be delivered in one location (per locality) to support patients from a number of practices who would not normally be able to attend during normal opening hours. The service could be provided by CCG GPs or external GPs. The group was asked to consider whether to bid. The group considered that it could bid. AP noted that outline bids for a 12 month pilot would need to be submitted by 16 January 2015.	

No	Item	Action
14/116	**Any other business** HM asked whether all practices were using the dementia toolkit AL noted that as part of her falls prevention research she had consulted David Unwin. (Norwood) who had suggested considering meds reviews as a way of reducing falls risk in the elderly and had copied other locality GPs into his responses. AL asked practices to consider and suggest practical measures that might reduce the number of falls in the over 65s	
14/117	**Date of Next Meeting:** Thursday 29 January 2015, 13.00- 14.30, Marshside/Corner Surgery	

NHS
Southport and Formby
Clinical Commissioning Group

North Locality Meeting Minutes

Date: Thursday 29th January 2015 at 13.00

Venue: Marshside/Corner Surgery

Attendees		
Dr Ian Scott	(Chair) GP, Churchtown Medical Centre	IS
Jane Ayres	Medicines Management	JA
Rob Caudwell	GP, Marshside Surgery	RC
Carol Mackenzie	Practice Manager, The Corner Surgery	CM
Nicole Marshall	Practice Manager, Marshside Surgery	NM
Sarah McGrath	Locality Development Manager, S&F CCG	SMc
Dr Kati Scholtz	GP, Norwood Surgery	KS
Dr Hilal Mulla	GP, Corner Surgery	HM
Rachel McKnight	MerseyCare	RMc
Dr Rory Kidd	GP, Churchtown Medical Centre	RK
Dr Niall Leonard	GP, Roe Lane Surgery	NL
Sharon Johnson	Informatics Merseyside	SJ
In Attendance		
Jan Campbell	Sefton CVS	JC
Apologies		
Lyn Roberts	Practice Manager, Churchtown Medical Centre	LR
Lydia Hale	Practice Manager, Roe Lane Surgery	LH
Sam Muir	Practice Manager, Norwood Surgery	SM
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr K Scholtz	Norwood Surgery	✓	✓	✓	✓	✓	A	A	A	✓	✓		
Dr A Al-Dahiri	Norwood Surgery	✓	A	A	A	A	✓	A	A	A	A		
Dr S Tobin	Norwood Surgery	A	A	A	A	A	A	A	A	A	A		
Dr D Unwin	Norwood Surgery	A	A	A	A	A	A	A	A	A	A		
Dr A Zubairu	Norwood Surgery	A	A	A	A	A	A	✓	✓	A	A		
Dr N Leonard	Roe Lane Surgery	A	✓	A	✓	A	✓	✓	A	L	✓		
Dr A Trevor	Roe Lane Surgery	✓	A	✓	A	A	A	A	A	A	A		

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr J Fox	Roe Lane Surgery	A	A	A	A	✓	A	A	A	A	A		
Dr J Canavan	Roe Lane Surgery								✓	A	A		
Dr H Mulla	The Corner Surgery	✓	A	✓	A	✓	A	✓	A	✓	✓		
Dr S Woodcock	The Corner Surgery	A	A	A	A	A	✓	A	A	A	A		
Dr M Moriarty	The Corner Surgery	A	✓	A	✓	A	A	A	✓	A	A		
Dr R Caudwell	Marshside Practice	✓	✓	✓	A	✓	A	✓	✓	A	✓		
Dr M McCormack	Churchtown Medical Centre	A	A	A	A	A	A	A	A	A	A		
Dr R Kidd	Churchtown Medical Centre	A	A	A	A	A	✓	✓	A	✓	✓		
Dr I Scott	Churchtown Medical Centre	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Dr P Giannelli	Churchtown Medical Centre	A	A	A	A	✓	A	A	A	A	A		

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/01	**Welcome and apologies** Apologies were noted. See attendance sheet below: 201501 North Locality Attendance s	
15/02	**Minutes of the last meeting** It was acknowledged that Dr Rory Kidd did attend the last meeting on 18 December 2014 and the minutes from the previous meeting were amended to reflect this. It was agreed that the minutes were then an accurate record. 14/111 Regarding Community Matron and whether this service included residential NH – SMc has looked at the spec and it was agreed that they do technically fit the category but this needed to be made more exlicit in future service specifications	201412 Nor Locality Minutes
15/03	**VCF Direct** Jan Campbell presented Sefton Council for Voluntary Services' new database: VCF Direct. Sefton CVS have approximately 1200 organisations that are listed in their directory; of these most offer many different services and the CCG commissioned Sefton CVS to put this information on-line in an searchable database which they are in the process of completing. So far, of 600 organisations surveyed there are over 4000 services accessible to the community. At present there is a 'signposting' service available over the telephone and a referral process is also being esbtablished. JC asked for feedback on how to make this information more useful/accessible. NL felt signposting service would be of most interest to GPs rather than GPs looking at a directory. KS also felt it would be a good service but would be preferable to take GPs out of the equation and invest in the signposting services that the patients can access. JC advised they will be developing credit card/leaflets with their contact details on.	
15/04	**Quality and Patient Safety** *Breast Clinic*	

No	Item	Action
	KS advised that practices need to be aware that breast consultants have been requesting GPs to refer existing patients to other trusts RC advised that he has discussed this practice with Rob Gillies and this will not be happening in future. SMc advised that Clatterbridge will be undertaking reviews for existing patients. SMc raised issue that some GPs are referring to both services at UHA and RLUH. KS asked for clarification of which surgeries are doing this. SMc to look into this.	SMc
15/05	**Practice Peer discussion – Long Term Condition Prevalence** The Group discussed the data presented. RC noted that it would be helpful to know what is normal/average and if the figures are a significant deterioration. SMc to ask for further clarification and for confidence intervals to be added to the graphs.	SMc
15/06	**Medicines Management Update** JA presented the budget figures to the Group.	
15/07	**Community Geriaritrician Scheme Update** KS advised that scheme is going ahead, costings are being done and it is likely to begin in April.	
15/08	**Prime Minister's Challenge Fund** The bid went in last Friday; result will be known mid/end February. Discussion took place over the bid and actions needed if successful. The funding is for one year. Hoping for more information for next meeting.	
15/09	**Primary Care Infrastructure Bids** NL advised that the monies are available however the bids are due in on 16/02/2015. Discussion took place over what can be applied for and NL asked Locality Group if there is agreement for a resource based bid to be made (for example for intermediate care beds, community diagnostics services, CVS, mental health services), in the community, for the community – NL to do proposal for this.	NL
15/10	**Locality Business** *Co-commissioning* – KS advised that S&F CCG had voted for Option 2. *Governing Body* – Discussion took place at GB regarding locality specific perfomance data (presented as a dashboard) and how this information is used most effectively by localities *Community Respiratory Team* – Discussion took place over the present arrangements and all agreed that improvements were indicated	
15/11	**Any other business** Nil	
15/12	**For information: Quality Premium Report**	
15/13	**Date of Next Meeting:** Thursday 26 February 2015, 13.00- 14.30, Marshside/Corner Surgery	