NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public Agenda

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

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

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

The Governing Body

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

In Attendance

Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC

No	Item	Lead	Report	Receive/ Approve	Time
Governance					
GB15/85	Apologies for Absence	Chair	-	R	3 mins
GB15/86	Declarations of Interest	Chair	Verbal	R	1 mins
GB15/87	Hospitality Register	Chair	✓	R	1 mins
GB15/88	Minutes of Previous Meeting	Chair	✓	A	5 mins
GB15/89	Action Points from Previous Meeting	Chair	✓	A	5 mins
GB15/90	Business Update	Chair	Verbal	R	5 mins
GB15/91	Chief Officer Report	FLC	✓	R	10 mins
GB15/92	GP Pressures and Supporting Practices	All	Verbal	R	5 mins
GB15/93	Annual Report and Audit Opinion 2014/15	MMcD	Verbal	A	10 mins
GB15/94	Q4 Corporate Risk Register and GB Assurance Framework	FLC	R	R	10 mins
GB15/95	CCG Corporate Objectives 2015/16	FLC	R	A	10 mins

No	Item	Lead	Report	Receive/ Approve	Time
Service Improvement/Strategic Delivery					
GB15/96	Strategic Blueprints	KMcC	R	A	10 mins
GB15/97	Shaping Sefton Update	FLC	R	R	10 mins
Finance and Quality Performance					
GB15/98	Integrated Performance Report	KMcC/ MMcD/ DF	✔	R	10 mins
GB15/99	Overview, Quality and Performance – Southport & Ormskirk Hospitals NHS Trust	FLC/ DF/ KMcC	✔	R	10 mins
GB15/100	Revised Budgets for 2015/16 and Transformation Fund	MMcD	✔	A	10 mins
For Information					
GB15/101	Key Issues reports from committees of Governing Body: a) Finance & Resource Committee b) Quality Committee c) Service Improvement Redesign Committee		 ✔ ✔ ✔	 R R R	5 mins
GB15/102	Finance & Resource Committee Minutes	-	✔	R	5 mins
GB15/103	Quality Committee Minutes	-	✔	R	
GB15/104	Service Improvement & Redesign Committee Minutes	-	✔	R	
GB15/105	Locality Meetings: a) Ainsdale & Birkdale (South) Locality b) Formby Locality c) Central Locality d) North	 - -	 ✔ ✔	 R R	
Closing Business					
GB15/106	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				5 mins
GB15/107	Date of Next Meeting Wednesday 29th July 2015 at 15.00 hrs, Family Life Centre, Southport				
Estimated meeting close					1515 hrs

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

NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Attendance Tracker

Membership	Designation	Jan 2014	Mar 2014	May 2014	Jul 2014	Sep 2014	Nov 2014	Jan 2015	Mar 2015	May 2015	Jul 2015	Sep 2015	Nov 2015
Rob Caudwell	Chair & GP Clinical Director	A	✓	✓	✓	✓	A	✓	✓				
Niall Leonard	Clinical Vice Chair & Governing Body Member	✓	✓	✓	✓	A	✓	L	✓				
Helen Nichols	Vice Chair & Lay Member - Governance	✓	✓	A	✓	✓	✓	✓	✓				
Graeme Allen	GP Clinical Director & Governing Body Member	✓	A	Resigned									
Paul Ashby	Practice Manager			✓	✓	✓	✓	✓	A				
Roy Boardman	Practice Manager	✓	✓	Resigned									
Doug Callow	GP Clinical Director & Governing Body Member			✓	✓	✓	✓	A	A				
Margaret Carney	Chief Executive, Sefton MBC *(co-opted member)*	A	A	A	A	A	A	A	A				
Pete Chamberlain	GP Clinical Director & Governing Body Member								L				
Hannah Chellaswamy	Deputy Director of Public Health, Sefton MBC	✓	A	✓	A	✓	✓	✓	A				
Fiona Clark	Chief Officer, Southport & Formby CCG	✓	✓	✓	✓	✓	✓	✓	✓				
Martin Evans	GP Clinical Director & Governing Body Member	✓	✓	✓	A	✓	✓	✓	✓				
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	✓	✓	✓	✓	✓	✓				
Liam Grant	GP Clinical Director & Governing Body Member	✓	A	Resigned									
Maureen Kelly	Chair, Healthwatch Sefton *(co-opted member)*	A	A	A	✓	✓	✓	A	✓				
Karen Leverett	Practice Manager	✓	A	Resigned									
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓				
Peter Morgan	Deputy Chief Executive, Sefton MBC *(co-opted member)*	A	✓	A	✓	✓	A	✓	✓				
Hilal Mulla	GP Clinical Director & Governing Body Member	✓	✓	✓	✓	✓	✓	✓	✓				
Roger Pontefract	Lay Member, Patient & Public Involvement	✓	A	✓	✓	✓	✓	A	A				
Colette Riley	Practice Manager & Governing Body Member			✓	✓	✓	✓	✓	✓				
Kati Scholtz	GP Clinical Director & Governing Body Member			✓	✓	✓	✓	✓	A				
Jeffrey Simmonds	Secondary Care Doctor	✓	✓	✓	✓	✓	A	A	✓				

✓ Present
A Apologies
L Late

Attendance Tracker

NHS
Southport and Formby
Clinical Commissioning Group

Hospitality Register
April 2015

Recipient	Nature of Gift / Hospitality	Date Received	Approximate Value	Sponsored By
-	-	-	-	-

No hospitality received.

Governing Body Meeting in Public
Draft Minutes

Date: Wednesday 25th March 2015, 1300 hrs to 1600 hrs
Venue: Family Life Centre, Ash Street, Southport, Merseyside, PR8 6JH

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

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

The Governing Body		
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Dr Niall Leonard	Clinical Vice Chair and Clinical Director	NL
Paul Ashby	Practice Manager and Governing Body Member	PA
Dr Doug Callow	GP Clinical Director and Governing Body Member	DC
Hannah Chellaswamy	Deputy Director of Public Health, SMBC	HC
Fiona Clark	Chief Officer	FLC
Dr Martin Evans	GP Clinical Director and Governing Body Member	ME
Debbie Fagan	Chief Nurse	DF
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Martin McDowell	Chief Finance Officer	MMcD
Peter Morgan	Deputy Chief Executive, Sefton MBC *(co-opted member on behalf of M Carney)*	PM
Dr Hilal Mulla	GP Clinical Director and Governing Body Member	HM
Helen Nichols	Vice Chair and Lay Member for Governance	HN
Roger Pontefract	Lay Member for Patient & Public Engagement	RP
Colette Riley	Practice Manager and Governing Body Member	CR
Dr Kati Scholtz	GP Clinical Director and Governing Body Member	KS
Dr Jeff Simmonds	Secondary Care Doctor and Governing Body Member	JS
In Attendance		
Billie Dodd	Head of CCG Development *for Item 15/52*	BD
Jan Leonard	Chief Redesign & Commissioning Officer *for Items 15/50 & 15/51*	JL
Karl McCluskey	Chief Strategy & Outcomes Officer *for Items 15/56 and 15/58*	KMcC
Melanie Wright	Lead for Intermediate Care *for Item 15/53*	MW

Questions from members of the Public

Q: Ken Lowe – when will it be clear what the budget will be for voluntary services?
A: To be discussed in Part 2 and the CCG should be able to confirm figures at the start of next week.

Presentation on "Mental Health Transformation" by Dr Hilal Mulla

FLC updated the membership with feedback in relation to that morning's Mersey Care Board meeting. There was a need to examine the acute 'psychosis' side in more detail. There was also a need to understand what was required weighed against the funding available.

A presentation by the mental health task force is going to next Health and Wellbeing Board meeting.

There is a need to bridge the transition gap between Alder Hey and Mersey Care in relation to younger people as it is acknowledged there are some gaps.

FLC expressed thanks to Hilal and the team in identifying the issues and information with which to move forward.

No	Item	Action
GB15/41	**Apologies for Absence** were received from Paul Ashby, Dr Doug Callow, Hannah Chellaswamy, Roger Pontefract and Dr Kati Scholtz.	
GB15/42	**Declarations of Interest** All members holding dual roles across both South Sefton CCG and Southport & Formby CCG declared their interest. There were no other declarations made in respect of items of business on the agenda.	
GB15/43	**Hospitality Register** The Governing Body received the Hospitality Register. There were no further additions.	
GB15/44	**Minutes of Previous Meeting** The minutes were accepted as a true and accurate record of the previous meeting.	
GB15/45	**Action Points from Previous Meeting** *15/4 – Review of Case for Change* – coming back to the Governing Body in due course. *15/8ab – Integrated Performance Report* – remove from tracker. *15/8c – Stroke Service Review* – remove from tracker. *15/8d - S&O Mortality Rates* – remove from tracker. *15/8e - Mental Health Issues* – page 378 of meeting pack shows improved performance for January showing upward trajectory. Remove from tracker. *15/9b - Corporate Risk Register* – remove from tracker. 15/12a - Strategic Plan – remove from tracker. 15/13a – Out of Hours Pharmacy - remove from tracker. *15/15 – Re-procurement of NHS 111 North West Service* - on agenda. Remove from tracker *15/17 – Emerging Issues* – GB members have been attending locality meetings to strengthen links. Remove from tracker. *15/18 - Key Issues to be updated to CCG website* – remove from tracker.	
GB15/46	**Business Update** A new Improving Access to Psychological Therapies (IAPT) service is to be launched across South Sefton CCG and Southport & Formby CCG on 1st April 2015. GP practices have been informed and Dr Caudwell is advised that there is an expectation of a smooth transition for our patient population. The CCG has been authorised by NHSE to participate in joint commissioning without taking fully responsibility. Hopefully this can be used to address some of the pressures across the system. The CCG is currently experiencing huge pressures across A&E and primary care. A lot of work is being done on mental and community health. Dr Caudwell thanked the membership for all the help and support received in his first 12 months as Chair.	
GB15/47	**Chief Officer Report** *Shaping Sefton* – a successful event was held on 12th February in conjunction with the King's Fund. A transformational board was now being developed to drive the agenda. On behalf of Governing Body, FLC thanked Peter Morgan of Sefton Council for his contribution and congratulated him on his impending retirement at the end March. *Procurement* – the NHS 111 Service has been awarded the contract to partner FCMS and Urgent Care 24 and the contract will transfer over in October/November. *Commissioning Support Unit* – it has been confirmed the North West Commissioning Support Unit (NWCSU) did not get on the Lead Provider Framework. NHS England has set up a transformation board, chaired by Simon Banks, Chief Officer of Halton CCG. Mrs Clark will be leading a group from the Merseyside CCG network to determine future requirements.	

No	Item	Action
	Continuing Health Care (CHC) - issues have been added to the risk register as key areas of risk. As a result of weekly meetings, we are now implementing work plans and actions. *Informatics Mersey Partnership Board* – Mrs Clark will be chairing the board meetings for the next 6 months.	
GB15/48	**GP Pressures and Supporting Practices** *Prime Minister's Challenge Fund* – the fund will have a big impact on primary care if the bid is successful. The impact of GPs retiring could have a negative impact and primary care should be a priority for the CCG going forward. The outcome will be known on or around 27th March.	
GB15/49	**NHS Southport & Formby CCG Constitution** The members received the updated Constitution that had been amended to include the relevant provisions to enable the establishment of joint commissioning between the CCG and NHS England. NL noted the reference to Sussex Road needed to be removed. **Actions:** **The Governing Body approved the changes to the Constitution once the amendment in relation to Sussex Road had been made.**	TJ
GB15/50	**NHS Southport & Formby and NHS England Joint Committee – Terms of Reference** NHS England guidance has changed slightly, as there is now a stipulation included regarding chairing meetings. As a result of this change, Helen Nichols would not be able to chair the joint committee as she is also Audit Committee chair. Approval was therefore sought based on that amendment which will be resolved at the first meeting of the joint committee. **Action:** **The GB approved the Joint Committee Terms of Reference.**	
GB15/51	**Breast Care Services Engagement and Equality Report and Recommendations** JL updated the Governing Body on the results of a recent engagement exercise. Key issues identified were: • Patients disappointment at sudden closure of service; • Lack of communication; • Real concerns about future care and follow up; • Engagement exercise under an equality impact assessment; • Concerns around travelling. The next steps are to review an evidence-based breast care pathway, recognising the strong public views. A report will come back to the Governing Body with final pathway in conjunction with West Lancashire CCG in due course. JL has made contact with the Cheshire & Mersey Cancer Network to establish the best way of communicating to patients so they can add their feedback and help shape commissioning on that process. A meeting has been arranged for Mrs Clark to meet with breast surgeons at Southport & Ormskirk Hospital NHS Trust on 21st April 2015.	

No	Item	Action
GB15/52	**Care Closer to Home Strategy 2013 – 2018 (refreshed in 2015)** The original programme was developed in 2012/13 and it was felt timely to refresh the strategy as a result of joint working with Southport & Ormskirk Hospital NHS Trust and West Lancashire CCG. The update has focussed on bringing together collective thinking which has an emphasis on unplanned, intermediate, primary care, etc. The governance structure and some of the project management arrangements were currently being revised to support this, in line with the Shaping Sefton initiative. Mrs Nichols was aware that a decision regarding the future of procurement of community services may be required and asked how the strategy and this process would be reconciled to each other given that resources are limited? Mrs Clark confirmed the Care Closer to Home Strategy would stand regardless of the provider of services and confirmed it fitted with the CCG's strategic plan. The CCG was working jointly with West Lancashire CCG and Southport & Ormskirk Hospital NHS Trust, as an integrated care organisation, to see how those services could be provided. **Action: The GB approved the refreshed Care Closer to Home strategy.**	
GB15/53	**Sefton Joint Intermediate Care Strategy** The strategy has been developed in conjunction with Southport & Formby CCG and South Sefton CCG and the Local Authority. The strategy is aligned to the Sefton Health & Wellbeing Board's vision of aligned care. The strategy is also aligned with the CCG's priorities in relation to the frail and elderly, virtual ward, etc. Dr Caudwell thanked Mrs Wright for all her hard work. **Action: The GB approved the Sefton Joint Intermediate Care Strategy.**	
GB15/54	**Draft CCG Quality Strategy** DF advised that the strategy was still in draft form as it had only been presented to the previous week's Quality Committee. She confirmed the strategy was aligned to the CCG strategic plan and reflected local priorities, national drivers and priorities out of the National Priority Board. As result of joint co-commissioning arrangements with NHS England, Mrs Clark was now accountable for quality improvement, but not responsible for practitioner performance. As a result some of the work traditionally dealt with by NHS England may come through to the Governing Body. Lyn Cooke to add to CCG website as a stand-alone document. **Action: the GB approved the draft CCG Quality Strategy.**	LC
GB15/55	**Safeguarding Strategy** The CCG had commissioned the peer review as part of its development. The strategy was presented to the Quality Committee prior to Christmas, however, had been re-presented to the Quality Committee as a result of changes to the Care Act. The Quality Committee had challenged the Safeguarding Service as to whether the strategy could be more CCG focussed and more aligned to the Health & Wellbeing Board. A local implementation plan is to be developed. **Action: The Governing Body approved the strategy.**	

No	Item	Action
GB15/56	**2015/16 Planning Submission** This submission reflects last year's agreement to develop and re-visit its strategic plan, as well as the need to conform to a national reporting plan. Final plans need to be reviewed by 14th May. One of challenges has been shift from data that was used in the 2014/15 plan to something different this year (ie from MARS (Monthly Activity Returns) to SUS (Secondary Uses Service)). This is more comprehensive and drills down to episode level enabling us to translate activity/level of service. Regarding non elective growth, Southport & Formby showed a marked increase in growth from October onwards; however the older population in the Southport & Formby area was higher than the national average, making up 30-40% of non-elective admissions. FLC believed we had a very robust plan which responded to recent demands and achievable given financial constraints this year. **Actions:** **(i) The Governing Body supported the refresh and final submission;** **(ii) Noted the detail contained in the national planning guidance and the implications for the review of existing two year operational and five year operational plans;** **(iii) Approved the submission of 2015/16 plans in relation to NEL activity at 0% and the re-profiled plan for future years;** **(iv) Approved the submission of plans to achieve the various national performance measures including RTT, A&E, Mental Health, HCAI, Cancer and Primary Care; and** **(v) Approved 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 be met in line with the revised planning timetable.**	RC/ FLC/ MMcD/ KMcC
GB15/57	**Home Oxygen Assessment Service Contract** The Home Oxygen Assessment Service has been put to tender through a robust and EU compliant process. Liverpool Community Health NHS Trust was the most economically advantageous bid submitted. The Governing Body is asked to approve the award of 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. **Action: The Governing Body approved the award of the Home Oxygen Assessment Service Contract to Liverpool Community Health NHS Trust.**	
GB15/58	**Integrated Performance Report** KMcC presented highlights from his full report. *Quality* - Miss Fagan gave an update on the quality section of the report. A single item Quality Surveillance Group (QSG) on cancer had been held last month producing many recommendations from NHS England which Dr Allen had confirmed the CCG was already complying with. Feedback will go through to the Quality Committee. There has been an increased trend in reporting pressure ulcers and as a result the Trust is reviewing their processes. *Finance* - projected deficit has reduced by £250K, however, there is still overspend which gives cause for concern. Page 369 shows actions that have been put in place throughout year mainly through deferred items. The CCG remains on target to deliver financial duties for financial year. **Action: the GB received the report.**	
GB15/59	**Emerging Issues** It was agreed this item would be taken off the agenda as the item 'GP Pressures and Supporting Practices' had been added.	

No	Item	Action
GB15/60	**Key Issues reports from committees of Governing Body**: a) *Finance & Resource Committee* – MMcD due to set up a QIPP group from April onwards specifically to look at where we are able to reduce costs within the CCG for next year. b) *Quality Committee* – specific concerns around S&O safeguarding performances. As a result a Contract query has been issued through normal routes with Southport & Ormskirk Hospital NHS Trust. There are also concerns in relation to the timeliness and quality of responses to complaints – to be brought in house. c) *Service Improvement Redesign Committee* – Bal Duper has been invited to discuss the community triage service. Respiratory Support – JK discussing with Kati Scholtz, the ongoing respiratory lead. NL needs to follow this up with KS. Potentially very valuable – to be brought back to May meeting just to be sure. d) Audit Committee – received.	NL/KS
GB15/61	**Finance & Resource Committee Minutes** were received by the Governing Body.	
GB15/62	**Quality Committee Minutes** were received by the Governing Body.	
GB15/63	**Service Improvement & Redesign Committee Minutes** were received by the Governing Body.	
GB15/64	**Audit Committee Minutes** were received by the Governing Body.	
GB15/65	**Locality Meeting Minutes:** a) Ainsdale & Birkdale (South) Locality b) Formby Locality c) Central Locality d) North were received by the Governing Body.	
GB15/66	**Any Other Business** *Quality Accounts* – the CCG has received a request from Cllr Catie Page to support them in their work, Miss Fagan will lead on this. *Section 75* – MMcD asked the Governing Body to approve delegated authority to the Chief Officer to £8.5m for Southport & Formby CCG. **Action: Approved.**	
GB15/67	**Date of Next Meeting** Wednesday 27th May 2015 at 13.00 hrs, Family Life Centre, Southport	

NHS
Southport and Formby
Clinical Commissioning Group

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

No	Item	Action
15/4 (14/125)	***Review of Case for Change*** – the paper is currently being revised and will be brought back to the Governing Body for review.	KMcC
GB15/49	**NHS Southport & Formby CCG Constitution** NHS England guidance has changed slightly, as there is now a stipulation included regarding chairing meetings. As a result of this change, Helen Nichols would not be able to chair the joint committee as she is also Audit Committee chair. Approval is therefore sought based on that amendment which will be resolved at the first meeting of the joint committee. NL noted the reference to Sussex Road needed to come out of the paper. **Actions:** **(i) the Governing Body approved the changes to the Constitution once the change in relation to Sussex Road had been removed;** **(ii) a paper would also need to be presented to the Wider Forum for ratification.**	TJ TJ
GB15/54	**Draft CCG Quality Strategy** Lyn Cooke to add the strategy to the CCG website as a stand-alone document.	LC
GB15/56	**2015/16 Planning Submission** The Governing Body approved 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.	RC/ FLC/ MMcD/ KMcC
GB15/60	**Key Issues reports from committees of Governing Body:** c) Service Improvement Redesign Committee – Respiratory Support – JK discussing with Koti Scholtz, the ongoing respiratory lead. NL needs to follow this up with KS. Potentially very valuable – to be brought back to May meeting just to be sure.	NL/KS
GB15/66	**Any Other Business** Section 75 – MMcD asked the Governing Body to approve delegated authority to the Chief Officer to £8.5m for Southport & Formby CCG. **Action: Approved.**	FLC

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/91	**Author of the Paper:** Fiona Clark Chief Officer Email: fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: May 2015	

Title: Chief Officer Report

Summary/Key Issues:

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

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

	Links to Corporate Objectives (x those that apply)
x	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.

Chief Officer Report

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

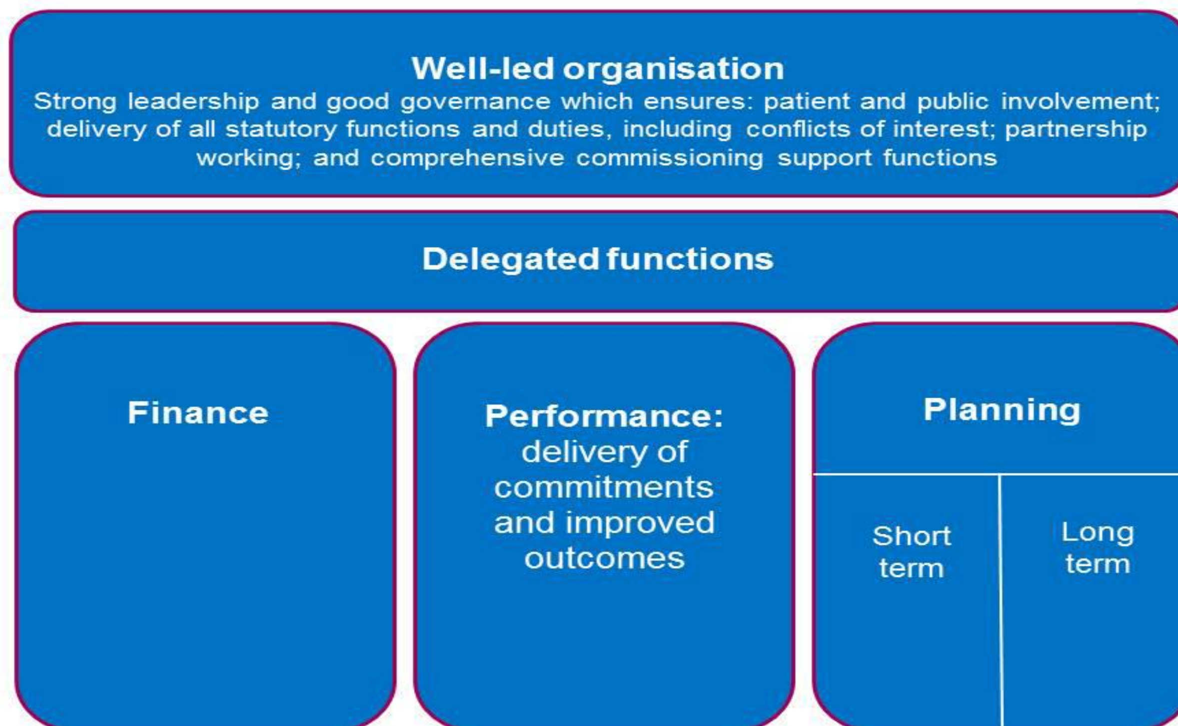
Report to the Governing Body
May 2015

1. CCG Assurance Framework

1.1 Much has changed since CCGs became statutory organisations on the 1st April 2012 and went through the authorisation process, giving rise to the need for a fresh approach to assurance.

1.2 A new assurance framework is therefore required to address these changes. This will strengthen the focus on a CCG's track record and ongoing performance in delivering improvements for patients. It will continue to assess a CCG's capability as well as ensuring its fitness to take on additional roles and responsibilities. To this end NHS England has undertaken a consultation process beginning in January 2015 to produce a new CCG scorecard. This will complement the existing CCG Delivery Dashboard which NHS England uses to undertake the quarterly assurance process.

1.3 This new framework also acknowledges that CCGs have different starting positions, with different populations and challenges, requiring different leadership responses. Some are operating in an extremely difficult environment, within challenged health economies or with legacy financial issues. Assurance covers the overall delivery of a CCG, and will take place continuously throughout the year, rather than as a one-off inspection. This framework describes a continuous assurance process that aims to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively to commission safe, high-quality and sustainable services within their resources, delivering on their statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients.



Chief Officer Report

1.4 There will be a risk based approach adopted by NHS England which differentiates high performing CCGs, those whose performance gives cause for concern, and those in between. NHS England intends to publish the CCG scorecard which will inform several of these components on *MyNHS,* through the NHS Choices website. Our performance and delivery commitments will be described in relation to five population groups, the generally well, people with long term conditions, people with mental health problems or learning disabilities, children and young people, and the frail elderly, with an additional focus on planning. The outcome measures in the scorecard will be derived from, and assessed in line with, the NHS Outcomes Framework.

1.5 Other intelligence will be used in the assurance process including the annual CCG 360 survey, as well as local partners and other organisations such as the Health & Wellbeing Board, the Care Quality Commission, NHS Trust Development Authority and Monitor and local Health Watch.

1.6 For co-commissioning functions and for out-of-hours services, CCGs will be required to prepare a quarterly self-certification of compliance against five key areas: governance and the management of potential conflicts of interest, procurement, expiry of contracts, availability of services, and outcomes. For delegated arrangements and out-of-hours services, the self-certification will be required to be signed off by the CCG governing body.

1.7 For joint commissioning arrangements the self–certification will be signed off by the joint committee of the CCGs or of the CCG and NHS England. The process will reflect the flexibility of NHS England to respond differently in different circumstances. A national moderation process will take place to provide confidence that the framework has been applied consistently across all CCGs, and that issues are being handled and escalated using the same approach.

1.8 The conclusion to this process will mean that CCGs are assessed as being in one of four assurance categories, which have been named to make them consistent with those used elsewhere in the NHS, such as the Care Quality Commission, and in other sectors, and to make them more meaningful to patients and the public. The categories are:

- assured as outstanding;
- assured as good;
- limited assurance, requires improvement; and
- not assured.

1.9 The action or intervention from NHS England will be dependent on the outcome and categorisation. This could range from light touch to further assessment and intervention. A new category of special measures has been developed. Alongside the four assurance categories NHS England may apply a new special measures regime designed to address persistent and chronic performance challenges, financial challenges and / or governance difficulties due to the CCG's lack of capability and capacity to provide leadership to deliver sustained improvement. The application of special measures will usually result from issues that have persisted over a period of two quarters, unless action is required sooner, such as when financial problems are identified. It is most likely to be applied to those CCGs in the 'limited assurance' and 'not assured' categories. A CCG placed in special measures will be required to agree with NHS England, and to deliver, a sustainable improvement plan, with the assistance of a range of intensive support options. This could include, for example, support from a well-performing CCG, which could act as a 'buddy' for the CCG in special measures.

1.10 The CCG should have made significant progress in its recovery plan in a maximum of 12 months and, following a review, should exit special measures at this point, if not sooner, even though there may be ongoing deliverables to be achieved as part of the improvement plan.

1.11 At the end of the year all this information will be consolidated into a statutory assurance report to be published by NHS England. CCGs will also be expected to publish their individual assurance reports.

2. CCG 360 Stakeholder Survey 2015

2.1 The CCG has recently received the results of the 2015 survey. These are currently being considered and any necessary actions as a result formulated into the CCG Organisational Development plan for 2015/16.

2.2 In the main the survey provided positive assurance to the CCG. However, there are a number of areas for improvement in line with national benchmarking. Further updates will be provided to the Governing Body and discussed with the CCG membership to then provide a comprehensive action plan for the July Governing Body meeting. The survey will be published on the CCG website.

3. Planning 15/16 Update

3.1 The CCG concluded its planning submission on 14th May to NHSE. This submission was based upon out turn 2014/15 and as such represents a 0% plan for 2015/16. NHSE have discussed with all CCGs jointly, in the days leading up to the submission, and impressed the need for CCGs to commission realistic levels of activity, being mindful that the evident national increase in NEL a is c2.5-3.5%.

3.2 The CCG has also agreed its quality premium categories and submitted confirmation of these as part of the planning submission. These have been clinically agreed within the CCGs and all Localities have contributed to the discussion on quality premium selection. It will be important, going forward that the CCG closely monitors provider performance against plans and addresses any over performance issues on a monthly basis through contract management.

4. Transforming Care for People with Learning Disabilities - Next Steps

4.1 This document has been produced jointly by the following organisations:

- Association of Directors of Adult Social Services (ADASS)
- Care Quality Commission (CQC)
- Department of Health
- Health Education England (HEE)
- Local Government Association (LGA)
- NHS England

4.2 NHS England commissioned Sir Stephen Bubb will produce a report on how to accelerate the transformation that we, people with learning disabilities and their families are looking for.

4.3 Following Sir Stephen's report, NHS England, the Department of Health, the Local Government Association, the Association of Directors of Adult Social Care, the Care Quality Commission and Health Education England are confirming commitment to strengthen the Transforming Care delivery programme by creating a new delivery board, bringing together the senior responsible owners from all the organisations.

4.4 The work to be taken forward through this programme will be wide-ranging and over the coming months it will continue to be co-designed and co-produced in partnership with people with learning disabilities and/or autism, their families, clinicians, commissioners, providers, other national organisations in the health and care system (such as Skills for Care, Skills for Health, Public Health England) and other stakeholders.

4.5 The paper, sets out some early actions to be taken in 2015 following Sir Stephen Bubb's report, and some of the issues required to engage further with stakeholders, as we work together to transform care. The areas covered in the report are:

- Empowering people and families;
- Getting the right care in the right place;
- Regulation and inspection;
- Workforce development.

4.6 The Governing Body will receive an update on further action required by the CCG to meet the requirements and expectations as laid down under each of the headings, in due course.

5. North West Coast Academic Health Science Network (NWCAHSN)

5.1 The NWCAHSN has produced its Business Plan for 2015/16, whilst describing its values and recognising its achievement in 2014/15 it identifies a number of safety and clinical areas as priorities for 2015/16, namely:

- Leadership;
- Paediatric/adult transition;
- Hydration;
- Sepsis;
- Technology for safety;
- Support to avoid frail elderly admissions;
- Good practice care homes programme;
- Health and wellbeing of staff;
- Measurement;
- Medicine optimisation alongside stroke;
- Mental health;
- Musculoskeletal innovation;
- Reduced alcohol-related A&E attendances.

The business plan also has cross-cutting themes and core platforms to support these priority areas which have been identified to maximise the impact of work currently in progress and to take account of other local and national drivers.

6. Care Quality Commission Inspection of GP Practices

6.1 The Care Quality Commission has published a report following inspection of Hightown Surgery which has been rated overall as inadequate. The practice, run by SSP Health Ltd, has been placed into special measures and the CCG is working closely with NHS England to support the practice to deliver an action plan to address the areas of concern.

6.2 The practice will be re-inspected by the CQC in six months to ensure that improvements have been made.

7. Locality development

7.1 We are now focusing on the localities as a key area organisational development in 2015/16. This work includes, providing more useful information for localities to help them commission more effectively, supporting the development of clearer locality priorities to help further shape local services providing additional support to locality lead GPs and managers through the development of a "locality team" improving the links between localities and the Governing Body to improve communications and to enable localities to more directly influencing decision-making.

8. Continuing Health Care (General Update)

8.1 The CCG/CSU Continuing Health Care Steering Group continues to meet and the meeting schedule has moved to monthly. The improvement plan has been rationalised due to the position of NWCSU with regard to the Lead Provider Framework (LPF). The CCG is meeting on 20 May 2015 to discuss with NHSE available support in order to go to the LPF for this service.

9. Continuing Health Care (Retrospective Cases)

9.1 The CCG commissions the CSU to provide the management of Retrospective CHC Cases. Currently the CCG is underperforming against the monthly trajectory that has been set by NHSE for the closedown of such cases. Performance management of CSU is in place and the CCG is due to attend a series of meetings being held by both CSU and NHSE in order to support improved performance.

10. Southport & Ormskirk Hospitals NHS Trust Chief Inspector of Hospitals Visit

10.1 A Quality Summit was held on 7 May 2015 at which the outcome of the Chief Inspector of Hospitals Visit was formally announced. This report was published by the Care Quality Commission on 13 May 2015.

Overall judgement = Requires Improvement

The judgements for the five domains are as follows:

- Safe = Requires Improvement (for acute hospital sites and community)
- Effective = Requires Improvement (for acute and community services)
- Caring = Good (for acute and community services)
- Responsive = Requires Improvement (for acute and community services)
- Well-led = Requires Improvement (for acute and community services)

10.2 Checks on specific services were undertaken and the outcome was as follows:

- Community Health Services for Adults = Requires Improvement
- Community Health Services for Children, Young People & Families = Requires Improvement

10.3 The Trust is required to develop appropriate action plans and submit them to the CQC. At the time of writing this paper, the CCG are in discussion with NHSE regarding the need to hold a Single Item Quality Surveillance Group Meeting. Further information on the outcome of the inspection is detailed in a further paper to be discussed as an agenda item for this meeting.

11. Named GP Safeguarding Children

11.1 The CCG have successfully recruited to the post of Named GP Safeguarding Children. Dr Wendy Hewitt commenced in post on 27th April 2015.

12. North West Commissioning Support Unit Update

12.1 The CCG has been working collaboratively with neighbouring Merseyside CCGs and colleagues from NHS England to agree a collective approach to the future procurement of commissioning support services (CSS.) This follows the announcement that the North West Commissioning Support Unit (NWCSU) was not accepted on to the national Lead Provider Framework (LPF). It is likely that the CCG will be required to use the LPF to secure much of its future commissioning support and meetings are taking place to determine the exact details. NHSE is assisting CCGs with the process and it is proposed that the new arrangements will be put in place in the autumn.

12.2 In the meantime we are working with NWCSU to transfer a small number of service lines in-house as per our agreed intentions from December 2014 and we will sign a new SLA with the CSU commencing in June 2015 to secure their services until the new organisational arrangements for commissioning support services are established.

13. Health Education North West- e-WIN Newsletter

13.1 The innovative work the CCG has been developing regarding student placements has been published in in the latest edition of the e-WIN Newsletter. A link to this can be found below and this good news story has also been publicised in the CCG weekly newsletter.

http://www.ewin.nhs.uk/resources/5627/developing-student-placements-within-a-clinical-commissioning-group-ccg

14. MIAA Safeguarding Review

14.1 MIAA is currently undertaking a Safeguarding Review in the CCG. The outcome of the review will be reported to both the Quality Committee and the Governing Body once completed.

15. Provider Quality Accounts

15.1 The CCG have been presented with relevant provider Quality Accounts. The CCG has worked collaboratively with partners and will be returning a joint response for publication in the Provider Quality Accounts. The CCG is also in the process of supporting both the Health Overview & Scrutiny Committee and the Children's Overview & Scrutiny Committee in their review of the Quality Accounts.

16. Nursing & Midwifery Council - The Code: Professional Standards of Practice and Behaviours of Nurses and Midwives (2015) (the Code)

16.1 The Nursing & Midwifery Council have published a revised 'Code' which presents the professional standards that nurses and midwives must uphold in order to be registered to practice in the United Kingdom. Failure to comply with the code may bring a nurse or midwife's fitness to practice into question. The values and principles set out within the code are not negotiable or discretionary. The code is effective from 31st March 2015 and structured around the following 4 themes:

- Prioritising people;
- Practising effectively;
- Preserving safety;
- Promoting professionalism and trust.

16.2 The standards have been expanded to include:

- A professional duty of candour;
- A requirement to offer help if an emergency arises outside a nurse or midwife's normal area of practice;
- Ensuring the fundamentals of care are delivered effectively during all stages of life;
- New standards on dealing with complaints;
- Use of all forms of communication, including social media;
- More detail about raising concerns and whistleblowing;
- Guidance on effective record keeping;
- Greater clarity on delegation and decision-making;
- Guidance on prescribing and medicines management.

16.3 Understanding and reflecting on the code will be central to compulsory revalidation for nurses and midwives planned for 2015 onwards. The code will be a useful point of reference for embedding professional values and principles in appraisal.

16.4 The Chief Nurse has requested that the Corporate Governance Support Group review and consider what amendments may be necessary to both relevant CCG policies and the CCG raisal documentation so it reflects the NMC Code (2015).

17. Nurse Revalidation

17.1 Nurse revalidation is a process that all registered nurses and midwives will need to engage with to demonstrate that they practice safely and effectively throughout their career. It will be a continual process not a point in time activity or assessment and will be about promoting good practice across the whole population of nurses and midwives All nurses and midwives are currently required to renew their registration every 3 years and the intention is that revalidation will strengthen this renewal process.

17.2 New requirements will focus on:

- Up-to-date practice and professional development;
- Reflection on the professional standards or practice and behaviour as set out in the NMC Code (2015);
- Engagement in professional discussions with other registered nurses and midwives.

17.3 The NMC is currently piloting the proposals for revalidation with a range of organisations and practice settings across the United Kingdom. The proposals are as follows:

STEP 1: Nurses and midwives need to meet a range of validation requirements designed to show that they are keeping up-to-date and actively maintaining their fitness to practise with evidence being kept in a portfolio. Examples of such requirements include:

- Practising a minimum number of hours;
- Undertaking continuing professional development (CPD);
- Obtaining feedback about own practice;
- Reflecting on the Code, CPD and feedback about own practice – discussing these with another NMC registrant;
- Providing a health and character declaration;
- Having appropriate cover under an indemnity arrangement.

STEP 2: Nurses and midwives need to demonstrate to a third party that they have met their revalidation requirements. This is called obtaining confirmation.

STEP 3: Every three years all nurses and midwives will apply for revalidation. They will need to declare to the NMC that they have met the requirements and obtained confirmation. Verification checks will be undertaken by the NMC.

17.4 The Chief Nurse and Deputy Chief Nurse have been liaising with the CCG HR support from CSU to ensure that plans are in place as appropriate within the organisation. There is still some uncertainty regarding the arrangements which will include what responsibility, if any, the CCG Chief Nurse and Deputy Chief Nurse will have in relation to the revalidation of Practice Nurses. The NMC will finalise the proposals in October 2015.

18. Freedom to Speak Up Review (Robert Francis February 2015)

18.1 The 'Freedom to Speak Up Review' by Robert Francis was published in February 2015. The aim of the review was to provide advice and recommendations to ensure that NHS staff in England feel it is safe to raise concerns, confident that they will be listened to and the concerns will be acted upon.

18.2 The Chief Nurse has requested that the Corporate Governance Support Group reviews and considers what amendments may be necessary to relevant CCG policies. The CCG Programme Manager for Quality & Safety will also be reviewing the recommendations and how they sit alongside the CCG Francis Action Plan. The Government's expected annual Francis response is still being awaited nationally – this was expected November 2014.

18.3 The Chief Nurse and the Chief Delivery & Integration Officer will be considering what impact the recommendations may have on the CCG Organisational Development Plan.

19. Sign Up to Safety Pledge

19.1 The Quality Committee have approved the CCG signing up to the 'Sign Up To Safety' Pledge. The areas the CCG has made pledges against are as follows:

- Health Care Acquired Infections;
- Pressure Ulcers;
- Catheters in Nursing Homes.

19.2 Progress against these pledges will be monitored by the CCG Programme Manager for Quality & Safety. The CCG commitment to the pledges will be uploaded onto the website.

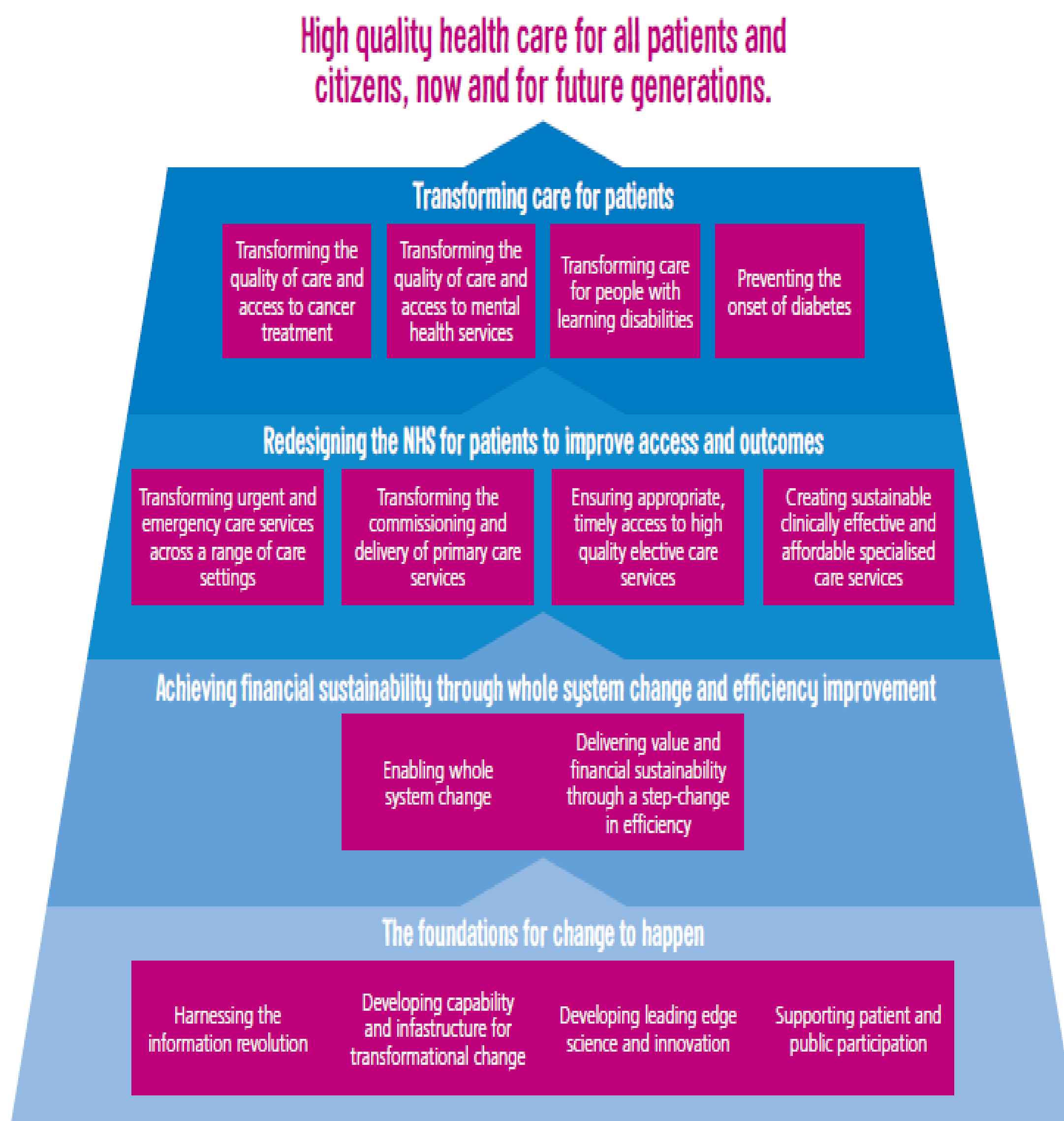
20. CCG Constitutional Change

20.1 The Chief Officer received a letter from NHS England on 1st May 2015, to inform the CCG that they have decided to replace the June and November windows and that future applications for constitutional change can be made at whatever point during the year fits the CCG's business needs.

20.2 There would be one exception, which is that any changes related to CCG boundaries or populations would still need to be submitted during the summer, so that allocations can be adjusted for the following financial year. The existing guidance, 'Procedures for CCG constitution change, merger or dissolution', published in May 2013 otherwise remains in place.

21. NHS Business Plan 2015-2016

21.1 NHS England has published the business plan for 2015/16. Its priorities are highlighted in the below:



22. Recommendations

22.1 The Governing Body is asked to receive this report.

Fiona Clark
Chief Officer
May 2015

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/	**Author of the Paper:** Judy Graves Governance Facilitator, NWCSU Email: judy.graves@nhs.net Tel: 0151 295 8908
Report date: May 2015	

Title: Quarter 4 2014/15 Risk Assurance Framework & Corporate Risk Register Update

Summary/Key Issues:
To provide members with an update on the organisations final Q4 position against the Governing Body Assurance Framework (GBAF), Corporate Risk Register (CRR) and the support provided.

GBAF
Southport & Formby CCG have a total of 14 risks recorded on the Governing Body Assurance Framework (GBAF) against the 7 corporate objectives for 2014/15:

Risk Rating:
- 1 has increased
- 4 have decreased (improved)
- 9 have remained static

Of which
- 0 are Extreme risks
- 9 are High risks
- 4 are Moderate risks
- 1 is Low risk

Assurance Rating:
- 2 risks improved assurance ratings
- 1 risk had a worsening assurance rating

CRR
There are 22 operational risks recorded on the Southport & Formby CCG Corporate Risk Register (CRR) for quarter 4 (March) 2014/15:
- 21 risks continue from February 2015:
  - 1 has increased
  - 18 have stayed the same
  - 2 have reduced
- 0 risks removed
- 1 new risk

Of which:
- 3 are Extreme
- 13 are High
- 4 are Medium
- 2 are Low

CRR & GBAF

Recommendation		
The Governing Body is asked to: • Receive and note the report and appendices presented • Note the work undertaken and progress made on assurance and scrutiny, making comment for any further developments. • Review Q4 (March) 2015 GBAF positions, specifically the 'GIC' and 'GIA': the Governing Body need to be assured where there are any incidences of an absence of 'Gaps in Control' and/or 'Gaps in Assurance'. Consider/comment/approve accordingly • Review Q4 (Mar) 2015 CRR positions. Consider/comment /approve accordingly.	Receive	X
	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

Report to the Governing Body
May 2015

1.0 BACKGROUND

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

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

It is the responsibility of the Governing Body to ensure a robust system and process is in place and that risks are being consistently identified and managed.

The risk review cycle includes:

- Identification of new risks relating to the work of the CCG;
- Closing of risks that are no longer relevant (or being managed to the extent that the risk is tolerable), and;
- Review and assess all open risks and action plans to ensure that they reflect the current status of the risk.
- Manage the risks to ensure they do not impede the delivery of team or organisational objectives.

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

The framework records the links between strategic objectives, key risks and key controls. It also indicates the sources of evidence or assurance, which support the controls, and identifies any gaps.
It is reviewed at business meetings of the Senior Management Team and Quality Committee on a quarterly basis and overseen by the Audit Committee. The Corporate

Governance Group reviews and scrutinises it before submission to the Quality Committee to ensure the risk scores and assurances are accurate and robust.

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

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

Corporate Risk Register (CRR)

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

All new and updated risks are recorded on the CRR on a monthly basis, where they are then reviewed by the Senior Management Team and subsequently the CCG's Corporate Governance Support Group as a first line of assurance. The CRR is then submitted to the Quality Committee which has delegated responsibility for receiving, reviewing and scrutinising the CRR.

2.0 Q4 PROGRESS

- Work continues with the SMT and Corporate Governance Support Group to ensure robust assurance processes are in place, continued and reviewed
- 1:1 meetings held with risk leads to discuss and review CRR and GBAF updates
- Monthly and quarterly reports completed and submitted for SMT, Corporate Governance Sub-Group and Quality Committee including highlights for review and scrutiny
- Assurance schedule continues to be reviewed. Draft now compiled for 2015/16.
- SMT reminded of the importance of ensuring all respond accordingly on any changes in risk so as to ensure compliance with the organisations Risk Management Strategy
- GBAF 'Gaps in Control' and 'Gaps in Assurance' reviewed to ensure appropriate

3.0 SOUTHPORT & FORMBY CCG POSITION STATEMENTS (Q4 March 2015)

3.1 Governing Body Assurance Framework *(Appendix B and C)*

Southport & Formby CCG have a total of 14 risks recorded on the Governing Body Assurance Framework (GBAF) against the 7 corporate objectives for 2014/15:

Risk Rating:

- 1 has increased in risk: 3.1
- 4 have decreased (improved): 1.1, 1.2, 1.3, 1.4
- 9 have remained static

Of which

- 0 Extreme risks
- 9 High risks: 1.4, 1.5, 1.6, 2.1, 3.1, 5.1, 6.1, 6.2, 6.3.
- 4 Moderate risks: 1.1, 1.2, 1.3, 4.1
- 1 Low risk: 7.1

Assurance Rating:

- 2 risks improved assurance ratings: 1.1, 1.2,
- 1 risk had a worsening assurance rating: 3.1
- 11 remained the same

GBAF	Southport & Formby CCG
1.1 Non Delivery of financial targets due to failure to control CCG expenditure budgets	Risk rating **reduced** from 3x4 (12) to 1x4 (4) Assurance rating **improved** from reasonable to significant. Management plan in place which continues to work well. Budget training now delivered to 95%. Remaining 5% being carried out on a rolling programme.
1.2 Non-delivery of financial targets due to over-performance/in-effective demand management of activity levels within acute and community provider contracts	Risk rating **reduced** from 3x4 (12) to 1x4 (4) Assurance rating **improved** from reasonable to significant. Management plan being tracked and on target. Monitored by F & R Committee.
1.3 Failure of providers to deliver CQUIN targets leading to slow change /transformation of services	Risk rating 3x3 (9) **reduced** to 2x3 (6) Assurance **remains** significant Review of Quality team and CSU support completed. Function will become in-house from 1st April. Transition plan in place.

GBAF	Southport & Formby CCG
1.4 Exceed trajectories for HCAI impacting on patient safety & non-achievement of quality premium ***in accordance with national set objectives e.g. CCG/ provider/CDiff trajectory/ zero tolerance for RSA** ***note: risk reworded**	Risk rating 3x4 (12) **reduced** to 3x3 (9) Assurance **remains** reasonable Quality team continue to liaise with local authority to develop joint KPI's/Quality indicators for Care Homes. Plans in place for a joint Local Quality Surveillance Group for Care Homes and domiciliary providers across Sefton with GP clinical leads. RCA CDIFF tool developed.
3.1 Delays in implementing Care Closer to Home will impact on demand in the Integrated Care Organisation which will draw out requirement to delivery savings.	Risk rating 2x3 (6) **increased** to 3x3 (9) Assurance has **decreased** from Reasonable to Limited Additional allocation requirements/pressures have been specified.

3.2 **Corporate Risk Register *(Appendix D)***

There are 22 operational risks recorded on the Southport & Formby CCG Corporate Risk Register (CRR) for quarter 4 (March) 2014/15:

- 21 risks continue from February 2015:
  - 1 has increased: QUA011
  - 18 have stayed the same
  - 2 have reduced: FIN003, QUA009
- 0 risks removed
- 1 new risk: STA004

Of which:

- 3 are Extreme: BUO001,QUA011, STA004
- 13 are High: FIN003; QUA002, 4, 6, 8, 12, 14, 15; REP001, 3, 4, 5; STA001.
- 4 are Medium: QUA003; REP002; STA002, 3.
- 2 are Low: QUA001, 9

CRR Risk	Southport & Formby CCG
BUO001 18 week & cancer pathways may not be met due to non-delivery of target by provider	Risk remained static from Q3 +2 (February) 2015 with a rating of 4x4 **(16)**: **Extreme** Cancer 62 day target currently not achieving. Failure is in relation to complex pathways and multiple providers. Issues with Southport & Ormskirk data and validity of. Evidence indicates that it is a software issue which is double counting patients. As a consequence RTT figures have been showing a breech since October 2014. Trust was issued a contract query in February 2015. Will be managed through the contract meetings. Diagnostic waiting time target failure for Endoscopy. However is dependent on recruitment of 3 Consultants and 1 Specialist Registrar. Recruitment is ongoing and being supported by HR. Business cases are in place for each post.
FIN003 Changes in patient flow causes financial issues, due to increases in activity overall and the financial implications on the 14/15 Financial performance of the CCG. Predominant risk areas are: CHC and Urgent Care which have both seen significant growth in demand.	3x4 **(12) reduced** to 2x4 **(8)** Additional control actions now completed including action plan, data quality review and benchmarking review.
QUA009 Risk that patients could be harmed or receive inadequate care due to failure of GP's to deliver against Primary Care Quality Contract 14/15	2x3 **(6) reduced** to 1x3 **(3)** Some practices had difficulty accessing Dashboard through CMIP. Plan put in place to address, issues now resolved.

CRR Risk	Southport & Formby CCG
QUA011 Risk that patients could be harmed or receive inadequate care due to failure to deliver against National Key Performance Indicator for IAPT (Improving Access to Psychological Therapies)	4x3 **(12) increased** to 5x3 **(15): Extreme** IAPT performance against revised 3.75% remains challenging with CCG not likely to achieve yearend target.
STA004: NEW RISK Risk that patients could be harmed or receive inadequate care due to poor practice and/or lack of compliance with standards at provider trust.	Initial risk rating 4x4 **(16): Extreme** Ongoing challenges for short and long-term delivery. - Analysis carried out on some specialities - Joint Governing Body Development sessions establish with first meeting held. - Links established with supporting authorities

4.0 CONCLUSION

Southport & Formby CCG's 2014/15 Governing Body Assurance Framework and Corporate Risk Register documents highlights the key objective and operational risks as at the end of Q4 (March) 2015, with the majority of risks remaining static in terms of score. Additional controls have been identified where possible, with descriptions of action plans and work programmes intended to close identified gaps. SMT, Corporate Governance Support Group and Quality Committee will continue to monitor and assure risk scores and that progress against mitigating actions by Lead Officers will be robustly managed in line with the CCG's Risk Management Strategy.

Judy Graves
NWSCU

Recommendations

As identified on page 2:

The Governing Body is asked to:

- Receive and note the report and appendices presented
- Note the work undertaken and progress made on assurance and scrutiny, making comment for any further developments.
- Review Q4 (March) 2015 GBAF positions, specifically the 'GIC' and 'GIA': the Governing Body need to be assured where there are any incidences of an absence of 'Gaps in Control' and/or 'Gaps in Assurance'. Consider/comment/approve accordingly
- Review Q4 (Mar) 2015 CRR positions. Consider/comment /approve accordingly.

Appendices

A. Risk Matrix (end of report)
B. GBAF Q4 2014/15 Summary (separate document)
C. Governing Body Assurance Framework Q4 2014/15 (separate document)
D. Corporate Risk Register Q4 2014/15 (separate document)

Appendix A

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

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

Significant risk

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

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

Southport & Formby CCG Assurance Framework 2014/15
Assurance Rating Summary Quarter 4

Key:
▼ L – Assurance rating reduced from previous Quarter
► M – Maintained assurance rating from previous Quarter
▲ H - Higher assurance rating than previous Quarter
N/A – Not applicable – assurance not expected
Blank – No comparable rating

Southport and Formby
Clinical Commissioning Group

Risk No	Risk Description	Risk Rating (L & C)	Accountable Lead	Assurance Rating Q1	Q2	Q3	Q4	Assurance Rating Key
Unique Identifier	Strategic risk transposed from Assurance Framework document	Risk rating based on agreed risk matrix	Identified lead on behalf of the CCG who is referred to as the 'Risk Owner' on the Assurance Framework document	These columns will state either 'Limited' 'Reasonable' or 'Significant' assurance has been awarded dependent on the weight of assurance provided				This column will have ▼or ►or ▲ inserted here to demonstrate any changes since last review
Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance								
1.1	Non Delivery of financial targets due to failure to control CCG expenditure budgets	~~3x4~~ 1x4	Martin McDowell	R	R	R	S	▲
1.2	Non-delivery of financial targets due to over-performance/in-effective demand management of activity levels within acute and community provider contracts	~~3x4~~ 1x4	Martin McDowell	R	R	R	S	▲
1.3	Failure of providers to deliver CQUIN targets leading to slow change / transformation of services	~~3x4~~ 2x3	Debbie Fagan	S	S	S	S	►
1.4	Exceed trajectories for HCAI impacting on patient safety & non-achievement of quality premium	~~3x4~~ 3x3	Debbie Fagan	R	R	R	R	►
1.5	Lack of capacity and capability of CSU to deliver sufficient support in a responsive manner within resource envelope. In particular organisational change due to merger, specifically: CHC BI delivery	3x4	Tracy Jeffes	S	S	S	S	►
1.6	Non-delivery of 2014/15 QIPP Plan which supports transformational change	3x4	Karl McCluskey	R	R	R	R	►
Corporate Objective 2: Sustain reduction in non- elective admissions in 2014- 2015								
2.1	Potential for any reduction in non-elective admissions to be offset by increased demand	4x3	Karl McCluskey	R	L	L	L	►
Corporate Objective 3: Implementation of 2014-15 phase of Care Closer to Home								
3.1	Delays in implementing Care Closer to Home will impact on demand in the Integrated Care Organisation which will draw out requirement to deliver savings.	2x3	Billie Dodd	R	R	R	R	►

Risk No	Risk Description	Risk Rating (L & C)	Accountable Lead	Assurance Rating				Assurance Rating Key
Corporate Objective 4: **Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership and partners**								
4.1	Review and re-specification of community services may not deliver particular preferences of individual GP's	**2x3**	Billie Dodd	**L**	**R**	**R**	**R**	►
Corporate Objective 5: **Implementation of 2014-15 phase of Primary Care quality strategy / transformation**								
5.1	Lack of capacity amongst clinical colleagues to deliver transformation	**3x3**	Jan Leonard	**R**	**R**	**R**	**R**	►
Corporate Objective 6: **Agreed three year integration plan with Sefton Metropolitan Borough Council and implementation of year one (14/15) to include an intermediate care strategy**								
6.1	Inability to deliver system wide change due to failure to shift resource from one part of the health and social care system to another	**3x3**	Tracy Jeffes	**L**	**L**	**R**	**R**	►
6.2	Potential of changes to social care funding to have an adverse impact on NHS services	**3x3**	Tracy Jeffes	**L**	**L**	**L**	**L**	►
6.3	Capacity across CCG and council to deliver a robust and co-ordinated one year and three year plan	**3x3**	Tracy Jeffes	**R**	**R**	**R**	**R**	►
Corporate Objective 7: **Review the population health needs for all mental health services to inform enhanced delivery**								
7.1	Completion of full scale review across children and adults in year	**1x2**	Karl McCluskey	**S**	**S**	**S**	**S**	►

NHS
Southport and Formby
Clinical Commissioning Group

Southport and Formby CCG Assurance Framework – Quarter 4 2014-15: January – March 2015

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Martin McDowell							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.1 Non Delivery of financial targets due to failure to control CCG expenditure budgets	~~3x4~~ 1x4	Internal and External Audit Plan in place to review systems of internal control Robust financial management process in place to ensure reserves and contingency are utilised in an appropriate manner Internal budgetary management process in place to support and challenge budget holder to deliver within agreed limit	Financial Plan for 2014/15 signed off by Governing Body (May 2014). Monthly Finance performance reports presented to Finance & Resource Committee with reporting to Governing Body by exception report. Monthly reporting to NHS England as part of the collective NHS Financial position. Reported to the Governing Body via Finance & Resource committee minutes. Budget holder training: ongoing rolling programme.	**Significant** **Reasonable** Robust processes in place and continue to be managed. Includes Management Action Plan: monitored on a monthly basis to Finance & Resource committee. **Limited**	~~(GIA) Additional budget holder training required:~~ completed	~~Not required at this stage.~~ Training now held. Delivered to 95%. Final sessions being carried out for the final 5%. Training will be carried out on a rolling programme.	~~March 2015~~
Progress Reports	Q1	**On target - Robust processes in place and being managed.**				**Assurance Rating**	**Reasonable**
	Q2	**On target - Robust processes in place and continue to be managed.**					**Reasonable**
	Q3	**Management Action Plan in place to deliver against financial targets. Monitored on a monthly basis to Finance & Resource committee.**					**Reasonable**
	Q4	**Management Action Plan in place to deliver against financial targets and continues to be monitored on a monthly basis.**					**Significant**

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance

Governing Body Reports

Lead Officer/Risk Owner: Martin McDowell

Principal Risks	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
1.2 **Non-delivery of financial targets due to over-performance/in-effective demand management of activity levels within acute and community provider contracts**	~~3x4~~ 1x4	Provider contracts agreed and signed with specified activity levels and associated costs Robust financial planning and control process in place Internal and External Audit Plan in place to review systems of internal control Contingencies and reserves held to cover overspends during the year.	Agreed provider contracts signed for 2014/15, with robust contract management arrangements in place to maintain/deliver activity and associated costs within agreed limits Monthly provider contract review meetings in place to verify performance and quality (including CQUIN) Revised Financial Plan for 2014/15 signed off by Governing Body (May 2014). Monthly Finance performance reports presented to Finance & Resource Committee with reporting to Governing Body by exception report. Monthly reporting to NHS England as part of the collective NHS Financial position. Internal budgetary management process in place to support and challenge budget holder to deliver within agreed limit	**Significant** Better information provided at practice level. Targets met and all being managed. **Reasonable** Management plan developed and on track to manage financial position to ensure stay on target and mitigate over performance for 14/15. Currently identified schemes to reduce demand in Urgent Care as part of Strategic Plan. **Limited**	~~(GIA) Better information required at practice level to encourage ownership of management/info improved control of referrals etc.~~	~~Currently working through.~~ In place.	~~March 2015.~~

Progress Reports			Assurance Rating
	Q1	**Likely over-performance offset by adequate reserves held at Q1**	**Reasonable**
	Q2	**Management plan developed to manage financial position to ensure stay on target and mitigate over performance for 14/15.**	**Reasonable**
	Q3	**Management plan being tracked and on target. Monitored by F&R committee.**	**Reasonable**
	Q4	**Management plan being tracked and on target. Monitored by F&R committee.**	**Significant**

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.3 Failure of providers to deliver CQUIN targets leading to slow change /transformation of services	~~3 x 3~~ 2 x 3	Regular reporting to Quality Committee. Formal exception reporting to Quality Committee from GP Clinical Lead for Quality and CQUIN. Contract meetings scheduled is in place to review and verify performance and activity on provider contracts including CQUIN Discussion re providers as part of QSG (NHS England) work plan	Bi-monthly performance reports from Quality Committee received by Governing Body. Quality reporting standing agenda item for Governing Body, including Quality Contract updates. Chief Nurse leads on Quality to ensure that quality is maintained via established resources and is a Governing Body member. Chief Nurse member of Finance & Resource Committee. Senior Finance Team member attached to the Quality Committee to ensure risk is minimised Chief Nurse / member of CCG Quality Team, in attendance at provider quality meetings. Clinical Director for Quality/GP Clinical Leads for Quality in place with managerial support from the CCG Quality Team. Reports to the SMT on the Quality Team following review of function, roles, capacity and support. With further report in October. Transition plan in place.	**Significant** Regular provider performance reviewed at scheduled Quality Contract meetings. Transition plan in place for the in-housing of quality services **Reasonable** **Limited**	~~(GIA & GIC) Review of function, roles and capacity of Quality Team needed:~~ completed ~~(GIA) Review of quality support from CSU needed:~~ completed	~~Report being presented to SMT at end of September 2014 following completion of review.~~ ~~Report being presented to SMT at end of September 2014.~~ Workforce paper submitted to SMT as per required timelines in October 2014 and as part of wider corporate review. Quality function currently provided from CSU. Will now become an in-house service from 1st April. - Transition plan in place regarding Transition risks - Meeting held with CSU to discuss transfer for 1st April	~~Chief Officer and Chief Nurse – September 2014~~ ~~Chief Nurse September 2014~~ ~~March 2015~~ April 2015

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
Progress Reports	Q1	Regular provider performance reviewed at scheduled Quality Contract meetings.				Assurance Rating	Significant
	Q2	Provider performance continues to be reviewed. Workforce paper for Quality Team undertaken					Significant
	Q3	Workforce paper submitted as part of wider corporate review. Outcome by end of Q4					Significant
	Q4	Transition discussed at SMT and Governing Body. Governing Body agree proposal take bring in-house.					Significant

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance

Governing Body Reports

Lead Officer/Risk Owner: Debbie Fagan

Principal Risks	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
HCAIs **1.4 Exceed trajectories for HCAI impacting on patient safety & non-achievement of quality premium in accordance with national set objectives e.g. CCG/ provider/CDiff trajectory/ zero tolerance for RSA**	~~3 x 4~~ 3 x 3	Regular reporting to Quality Committee on HCAIs CPQG reporting CDIFF Steering Group established (progress reports to Quality Committee) Local Health Economy Steering Group (workshop planning meeting held March 2014, Workshop held April 2014, Steering Group meetings held July and September, October 2014, February 2015. HCAIs standing agenda item CCG action plan presented to Quality Committee and shared with NHSE: updates received. Process in place for CCG review of CDIF route cause analysis reports. CDIFF appeals process in place and operational. Initial meeting September 2014. Meetings held regularly. Final meeting for 14/15 due to be held 12/03/15.	Minutes and key actions of Quality Committee meetings reported to Governing Body. Provider performance re HCAI discussed at Quality Committee for purposes of assurance. Key risks identified within quality contract meetings. Local system in place and operational for MRSA post infection reviews Common RCA CDIFF tool developed and includes evaluation regarding effectiveness from Higher Education.	**Significant** **Reasonable** Held Health Economy Workshop for CDIFF: outcomes being taken forward and developed. Regular steering group meetings in place and RCA tool for CDIFF developed. Inaugural Local Health Economy Steering Group meetings held July, September and October 2014, telecom February, with next meeting April 2015. Continue to liaise with Public Health to develop CCG process for review of provider CDIFF RCA's/CCG CDIFF management of provider CDIFF 'Appeals process. Appeals process has commenced and working well. **Limited**	~~(GIC) To review the role of the Sefton Health Economy Steering group i.e. key risks to be filtered through this group.~~ ~~(GIC) Workshop identified the absence of a common RCA tool for CDIFF across the health economy:~~ completed with draft finalised. (GIC) Lack of integrated working around quality indicators within care homes.	Review to be held in April 2015 ~~Common RCA CDIFF tool developed and includes evaluation regarding effectiveness from Higher Education. Currently being revised, due for completion January 2015.~~ Meeting held with Sefton Council Director of Adult Services to discuss integrated working around quality indicators with Care Homes which will include IPC/HCAI's. Was agreed to focus on Care Homes in relation to Joint Quality Indicators. Progress to be discussed at next meeting due December 2014. Quality team	Chief Nurse ~~July 2014~~ April 2015 ~~January 2015~~

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Debbie Fagan							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
					(GIA) Local Health Economy Steering Group meetings to be scheduled for 2015.	continue to liaise with local authority to develop joint KPI's/Quality indicators for Care Homes. Plans in place for a joint Local Quality Surveillance Group for Care Homes and domiciliary providers across Sefton with GP clinical leads. Next meeting due to be held April 2015.	~~January~~ April 2015

Progress Reports			Assurance Rating	
	Q1	**Held Health Economy Workshop for CDIFF. Date set for inaugural meeting of the steering group for July 2014. Liaising with Public Health to develop CCG process for review of provider CDIF RCA's/CCG CDIFF management of provider CDIFF 'Appeals process.**		**Reasonable**
	Q2	**Workshop outcomes being taken forward and developed. Inaugural Local Health Economy Steering Group meeting held July with a further meeting held September 2014. Common RCA CDIFF tool being developed.**		**Reasonable**
	Q3	**RCA CDIFF tool in final stages of completion. Final changes due January 2015. To be launched at HCAI Steering Group in early 2015.**		**Reasonable**
	Q4	**RCA CDIFF tool developed. Quality team continue to liaise with local authority to develop joint KPI's/Quality indicators for Care Homes and plans in place for a joint Local Quality Surveillance Group for care homes and domiciliary providers.**		**Reasonable**

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
1.5 **Lack of capacity and capability of CSU to deliver sufficient support in a responsive manner in key risk areas which have been identified as CHC BI delivery, Customer Solutions and CMCSU merger with GMCSU**	**3 x 4**	Re-negotiation of SLA in process Contract/Performance Monitoring Group meet monthly and development of more robust KPI's with new service specifications Exception reporting on performance and delivery at SMT.	Monthly meeting of Performance Monitoring Group Head of Client Operations – CSU to attend weekly SMT meetings to support Specific assurances obtained CSU to ensure continuation of locally based delivery despite CSU merger Reports to Finance & Resource Committee on six monthly basis SLA to 2014/15 in place Plan in place CHC.	**Significant** MIAA report (December 2013) offered significant assurance of CCG's performance management of CMCSU. SLA renegotiation. Key CCG and CSU leads agreed new service specifications and KPIs around all service areas. **Reasonable** Governing Body receives minutes of Finance & Resource Committee **Limited**	(GIA) Strategic annual review of CSU service delivery by commissioning support requirements. ~~(GIC) Specific work and forward plan for future management of CHC to be developed:~~ Completed. (GIA) CMIP roll out plan to be updated and to include dates for availability for practice level information and additional planning to involve locality manager ~~(GIA) CHC information varying on monthly basis~~		September 2014 ~~September 2014~~ October 2014 ~~August 2014~~

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks ***Risk Owner***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
					(GIC) Financial information received and negotiations now focus on SLA for April 2015 and beyond.	Current SLA extended to end ~~March~~ April 2015. CSU notified of CCG commissioning intentions for 15/16. ~~Process in place to consider implications of commissioning intentions. To work through solutions for affected service lines.~~	~~February 2015~~
					(GIA) Failure of NWCSU to be accepted onto LPF increases the risk of maintaining stability of commissioning support service into 15/16.	SLA rolled forward to end April to enable implementation of bringing in-house agreed service lines. However working with neighbouring CCG's on a collaborative approach for support services for the future.	April 2015

Progress Reports	Quarter	Report	Assurance Rating	Rating
Progress Reports	Q1	**SLA renegotiation. Key CCG and CSU leads agreed new service specifications and initial KPIs around all service areas pending price discussions**	**Assurance Rating**	**Significant**
	Q2	**Current SLA rolled forward to April 2015. Review of all service lines underway.**		**Significant**
	Q3	**Creation of NWCSU now completed.**		**Significant**
	Q4	**SLA rolled forward to end of April 2015 to enable implementation of bringing in-house agreed service lines. Working with neighbouring CCG's on a collaborative approach for support services for the future.**		**Significant**

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
QIPP **1.6** **Non-delivery of 2014/15 QIPP Plan which supports transformational change**	**3x4**	QIPP targets identified within the 2014/15 financial plan QIPP plans in place to deliver required financial cost reductions	QIPP financial savings targets and plans signed off by the Governing Body (May 2014) Monthly financial performance reports (including QIPP targets and associated savings) presented to Finance and Resource Committee and reviewed by the Governing Body Board Development session held on strategic approach to QIPP.	**Significant** **Reasonable** QIPP plans and associated finance cost reductions identified within CCG strategic financial plan and approved by governing body in May 2014 **Limited**	(GIA) Current QIPP in reserves (£257,000). ~~(GIC) Board development session to be held on developing a strategic approach to QIPP:~~ completed.	~~Month 7 review and augmentation of approach to QIPP in year to be undertaken jointly with finance. Working to identify QIPP contributions in year. To be reported to next Finance & Resource Committee in January 2015.~~ Completed. Re-profiled QIPP plan to be presented to March Governing Body. Document identifies a number of approaches to manage gap and schemes. For example outpatient news follow-up and conversion of elective activity - currently pursuing with clinical members of the Governing Body. ~~Development session planned for 18th December. Findings to be pulled together for January 2015.~~ Reworked financial plan to be presented to March Governing Body.	~~January 2015~~ March 2015 ~~January 2015~~ March 2015

Corporate Objective 1: Improved quality of commissioned services, whilst achieving financial balance				Governing Body Reports			
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
Progress Reports	Q1	QIPP plans and associated finance cost reductions identified within CCG strategic financial plan and approved by governing body in May 2014				Assurance Rating	Reasonable
	Q2	Initial review of project structure and requirements set out. These are to be agreed in Q3. Further potential QIPP areas being considered in conjunction with Finance for targeting					Reasonable
	Q3	QIPP areas being considered. Board development session being held on 18th December to look at developing a strategic approach to QIPP.					Reasonable
	Q4	Revised strategic and financial plan.					Reasonable

Corporate Objective 2: Sustain reduction in non- elective admissions in 2014- 2015

Governing Body Reports

Lead Officer/Risk Owner: Karl McCluskey

Principal Risks	Risk Status (L x C)	Key Controls	Assurances on Controls	Key Positive Assurance (**External / Independent)	Gaps in Control or Assurance (GIA) or (GIC)	Corrective Action	Responsibility Target Date
2.1 Potential for any reduction in non-elective admissions to be offset by increased demand	**4x3**	Weekly and monthly non-elective performance reviewed by PMO / SMT Bi-monthly performance reports to Governing Body	Exception reporting to Governing Body bi-monthly Exception issues raised and alerted through SMT to be addressed via Head of CCG Development. Integrated Performance Report Report presented and approved by both Governing Bodies in September 2014. Minutes of meetings Aintree Contract Query Notice being managed through Collaborative Commissioning Forum includes reporting process.	**Significant** **Reasonable** Annual profile and changes in non-elective activity across five years agreed and developed with governing body and reflected in CCG two year operational plan and five year strategic plan. **Limited** Report submitted to the Collaborative Commissioning Forum. Feedback being a clearer understanding of the pathway.		Review of non-elective unplanned activity and variance to plan completed. However further clarity has been requested. Still a view that due to change in activity counting. CSU carrying out analysis of emergency activity with common data set. Report to be submitted to next Collaborative Commissioning Forum: completed	~~January~~ April 2015 ~~January 2015~~

Progress Reports	Q1	**Annual profile and changes in non-elective activity across five years agreed and developed with governing body and reflected in CCG two year operational plan and five year strategic plan.**	Assurance Rating	**Reasonable**
	Q2	**New Integrated Performance Report taken to both Governing Body meetings in September in 2014 and approved. Revised Clinical Pathway for emergencies agreed with Aintree for implementation in September. CCG's working with Trust to understand non-elective impact and consequences.**		**Limited**
	Q3	**Assessment concluded. Aintree now issued with Contract Query Notice on heightened level of activity associated with revised clinical pathway. Being managed through the Collaborative Commissioning Forum (CCF).**		**Limited**
	Q4	**Analysis of emergency activity being carried out as a result of the Contract Query Notice.**		**Limited**

Corporate Objective 3: Implementation of 2014-15 phase of Care Closer to Home				Governing Body Reports			
Lead Officer/Risk Owner: Billie Dodd							
Principal Risks ***Risk Owner:***	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
3.1 Delays in implementing Care Closer to Home will impact on demand in the Integrated Care Organisation which will draw out requirement to deliver savings.	~~2x3~~ 3x3	Strategic Partnership Board monitoring progress of implementation Monitoring activity rates via CSU information portals and contract meeting Central funding received in 2014 by SFCCG should mitigate pressures in Acute sector over Winter period. Plan for funding completed and submitted 30th July 2014. Allocation received and apportioned.	Exception reporting via Chief Officer report to Governing Body Contract motoring via F&R Committee Care Closer to Home Programme Board ~~Group~~ Operational Resilience Network: commenced September 2014 and is ongoing. Minutes of meetings feed into Strategic Partnership Board. Regular reporting to NHS E against funding spend and performance which continues to be monitored on an ongoing basis.	**Significant** **Reasonable** Monthly minutes of F&R committee are reported to Governing Body and Chief Officers report is submitted to the Governing Body (standing agenda Items) Minutes of meetings feed into Strategic Partnership Board Regular reporting to NHS E against spend and performance. **Limited** Additional allocation requirements have been specified.	~~(GIA) Reporting process needed against apportioned funding allocations~~: completed ~~(GIA) Need to ensure internal systems are central, accessible and fit for purpose~~: completed	Allocation received and apportioned. Regular reporting to NHS E against spend and performance. Monitored on an ongoing basis. Additional allocation requirements have been specified. ~~Systems being looked at to ensure~~ are central and accessible, are working well and are monitored. ~~need to be able to provide data at short notice.~~	~~January 2015~~ ~~December 2014~~
Progress Reports	Q1	**Governing Body receives update on F&R Committee via receipt of minutes and Chief Officers report.**				**Assurance Rating**	**Reasonable**
	Q2	**System-wide Resilience plan agreed and submitted.**					**Reasonable**
	Q3	**Funding allocated and distributed to providers. Ongoing monitoring of performance and spend.**					**Reasonable**
	Q4	Resilience plan delivered. Performance of A&E remains core.					**Limited**

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Corporate Objective 4: Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership and partners				Governing Body Reports			
Lead Officer/Risk Owner: Billie Dodd							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
4.1 **Review and re-specification of community services may not deliver particular preferences of individual GP's**	**2x3**	Wider group engagement event held in July 2014. Lead GP focus from CCG chair and Vice Clinical chair 'Facing the future' work with West Lancs. Specify Service	Care closer to Home board Strategic partnership board Primary care Quality board Operational Resilience Network: commenced September 2014 and to be held on a monthly basis. Minutes of meetings feed into Strategic Partnership Board. Updates to the Governing Body via the Chief Officers report	**Significant** **Reasonable** Event strengthened links with GP's and established valuable data which will be used to build on and take forward for future commissioned services. Further event being ~~to be~~ held in ~~January~~ April 2015 and will include a discussion regarding the Senior Medical Model in the community (will involve local GP's and local Geriatricians) Wider Group meeting held in October, where GP's agreed Nursing Home Pilot rollout across Southport & Formby. **Limited**	(GIC) Further stakeholder event needs to be held: need to identify and support the engagement of wider stakeholders to work collaboratively for a 'whole' service. ~~(GIA) need to ensure updates are fed through to the Governing Body via the Chief Officers report:~~ in place. (GIC) Nursing Home Pilot to be rolled out across Southport & Formby.	Wider Group Engagement event held in July 2015. Involved must/should/could/ would with GP's. Has provided a list of areas that will be used to inform future service specifications. Further 'Wider' event being held in April 2015 which will include a progress update. ~~Further stakeholder event due to be held early 2015.~~ Nursing Homes now Geriatrician model. S&F service specific milestones ~~to be agreed by Chair in December 2015~~ in the process of being finalised. Draft to be ready by end of March 2014.	~~January 2015~~ April 2015 ~~January 2015~~ March 2015
Progress	**Q1**	**Planning work being carried out for a Wider Group Engagement event to be held July 2014.**					**Limited**

Corporate Objective 4: Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership and partners				Governing Body Reports			
Lead Officer/Risk Owner: Billie Dodd							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
Reports	Q2	**Wider Group Event successful and has enabled valuable data to be gained: further work underway on taking the work forward and building on.**				Assurance Rating	**Reasonable**
	Q3	**'Facing the Future' work with West Lancs continues and development of localised milestones and agreement at October Wider Group. To develop Nursing Home Services across Southport & Formby. Milestones being agreed with Chair in December**					**Reasonable**
	Q4	March milestones being measured. Progress being presented to Governing Body with decision to be made on future approach. Draft plan to then be presented to Service Improvement and Redesign followed by F&R in May 2015. Project target date is June 2014.					**Reasonable**

Corporate Objective 5: Implementation of 2014-15 phase of Primary Care quality strategy / transformation				Governing Body Reports			
Lead Officer/Risk Owner: Jan Leonard							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
5.1 **Lack of capacity amongst clinical colleagues to deliver transformation**	**3x3**	Development of Local Quality Contract Primary Care Clinical Lead identified in new GB Documented and robust PDR process for Governing Body members and locality lead roles Locality and practice lead roles clarified Primary Care Quality Board established November 2013 – led by clinician. Board continue to meet regularly. - Operational until Q3 2014/15 - Replaced by Service Improvement and Redesign Committee, established Q3 2014/15. Consultation completed. Contract finalised and all practices signed up.	Monitoring of uptake and performance of LQC, reported via Primary Care Quality Board Regular updates to Senior Leadership Team on LQC Minutes of Locality Meetings received by Governing Body Primary Care Quality Board disbanded and now feeds through/replaced by Service Improvement and Redesign Committee: is already established with 2 meetings held to date. Governing Body oversight of PDR process for members/clinical and locality leads via exception reporting	**Significant** **Reasonable** Consultation now completed and contract finalised. All practices now signed up to contact. Local quality contract on-going. **Limited**	(GIC) Review of access component of LQC to be carried out.	Primary Care Quality Board disbanded and replaced by Service Improvement and Redesign Committee. 2 meetings already held. MIAA carrying out external review on the access component of LQC (Local Quality Contract).	January 2015
Progress Reports	**Q1**	**Contract is ready pending completion of consultation.**				Assurance Rating	**Reasonable**
	Q2	**Practices signed up to contract. Delivery of Quality Contract to commence 1st October 2014.**					**Reasonable**
	Q3	**Contract continues to be monitored. Service Improvement and Redesign Committee established with regular meetings being held.**					**Reasonable**
	Q4						

Corporate Objective 6: Agreed three year integration plan with Sefton Metropolitan Borough Council and implementation of year one (14/15) to include an intermediate care strategy				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks *Risk Owner*	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
6.1 Inability to deliver system wide change due to failure to shift resource from one part of the health and social care system to another	3x3	Regular joint meetings with Sefton Council to develop Integration Plans. Range of task and finish groups established to develop plans for 14/15 and longer term, reporting to HWBB RIG (Resource and Integration Group) and PIG (Programme Integration Group) Provider forum established to explore system-wide change. Key officers assigned from Sefton Council and CCG to develop intermediate care strategy	Documented Evidence of reports and minutes from meetings Development of s256 agreements for 14/15 Task and Finish Groups key areas developed at workshop held in May 2014: developing short and long term plans. BCF3 submission highlights -4 3 main schemes to aim to reduce non-elective activity through development of enhanced community provision. BCF 3 has now been approved following removal of remaining conditions.	**Significant** **Reasonable** NHS E approved BCF plans December 2014 **Limited** Workshop completed key work streams to progress integration agenda. Key work streams have begun to develop plans further.	(GIC) BCF3 submission highlights key risks in relation to achieving the plan.	Health and Wellbeing Board working to explore and mitigate risks where possible. Further work completed on BCF risks, mitigations and assurances from NHS E. Next step is implementation and monitoring of BCF schemes and ongoing report to PIG. 'Shaping Sefton' plan to formalise revised governance arrangement for integrated working. Development of section 75 agreement with local authority drawing to a conclusion.	~~January 2015~~ ~~February 2015~~ April 2015 March 2015
Progress Reports	Q1	**Workshop held in May to agree key areas for Task and Finish Groups to develop integrated working. Programme Integration Group supportive of approach and groups developing short term and longer term plans**				**Assurance Rating**	**Limited**
	Q2	**BCF3 submission highlighted potential areas for system change.**					**Limited**
	Q3	**BCF3 now approved without conditions and moved to full implementation.**					**Reasonable**
	Q4	**Section 75 being finalised and governance arrangements reviewed to support implementation in 15/16. 1 scheme in BCF being 'Integrated Wellness Service'.**					**Reasonable**

Corporate Objective 6: Agreed three year integration plan with Sefton Metropolitan Borough Council and implementation of year one (14/15) to include an intermediate care strategy				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks *Risk Owner*	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
6.2 Impact of reductions in social care funding on health services	3x3	Integrated working through HWBB sub-structure to develop system-wide approaches. Care Closer to Home and Virtual Ward as key programmes to facilitate operational Clear outcomes for s256 agreements and development of future section 75.	Documents and minutes from meetings. BCF3 enabled the further development of joint plans.	**Significant** **Reasonable** **Limited** HWBB supportive of wider –system approach and groups developing short term and longer term plans. BCF3 submission brought together the work from these groups for key schemes which will be performance managed as part of the BCF3 process.	(GIC) Impact of Council spending plans on Health Services has not yet been fully determined. (GIA) Need for clear measures and processes across system to identity impact	Meetings to be held between Senior Council and Senior CCG Officers to explore impact and identify any mitigations 'Shaping Sefton' plan to formalise revised governance arrangement for integrated working	~~January 2015~~ April 2015
Progress Reports	Q1	**HWBB supportive of wider –system approach and groups developing short term and longer term plans**				**Assurance Rating**	**Limited**
	Q2	**BCF3 submission highlighted plans for protection of Social Services however risks remain.**					**Limited**
	Q3	**BCF3 now approved but impact of reductions in resources requires further assessment.**					**Limited**
	Q4	**'Shaping Sefton' plan to formalise revised governance arrangement for integrated working**					**Limited**

Corporate Objective 6: Agreed three year integration plan with Sefton Metropolitan Borough Council and implementation of year one (14/15) to include an intermediate care strategy				Governing Body Reports			
Lead Officer/Risk Owner: Tracy Jeffes							
Principal Risks *Risk Owner*	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
6.3 Capacity across CCG and council to deliver a robust and co-ordinated one year and three year plan	**3x3**	Programme and integration group of Health and Well Being Board to sponsor and co-ordinate plans Integration post to co-ordinate and lead the work.	Programme group has already supported the development of the plans. Job description in place for integration post	**Significant** **Reasonable** Plans supported. Integration post to co-ordinate and lead the work. **Limited**	(GIC) Recruitment to commence: post not yet advertised, further review of job description required.	Delay due to council reorganisation.	~~January~~ April 2015
Progress Reports	Q1	**Resources and job outline for role to develop integrated working in place. Functional working group plans received by the HWB programme group.**				**Assurance Rating**	**Reasonable**
	Q2	**Post not advertised, further review of job description required.**					**Reasonable**
	Q3	**Review of requirements pending Council changes.**					**Reasonable**
	Q4	**Council restructuring still progressing.**					**Reasonable**

Corporate Objective 7: Review the population health needs for all mental health services to inform enhanced delivery				Governing Body Reports			
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
7.1 Completion of full scale review across children and adults in year	**1x2**	Additional project resource appointed in quarter 1 Additional clinical leadership appointed quarter 1 Joint mental health task group with Sefton Council in place	Regular progress reporting to Governing Body Progress management and assessment to be undertaken via service improvement and redesign committee from September 2014. Minutes of meetings	**Significant** Detailed demographic and population health needs analysis undertaken as part of 5 year strategic plan and 2014/15 refresh of JSNA with the Local Authority. Improving Access to Psychological Therapies (IAPT) awarded to alternative r provider. To commence April 2015. **Reasonable** **Limited**	~~(GIC) Assessment of resource to support breadth and depth of project required:~~ completed.	Review of resources and development of business case completed. Now identifying priority areas for focus and development from the results of the review. First draft ~~expected~~ completed ~~January 2015~~ with final document to be presented to Governing Body in March 2015. Mental Health review and full paper being presented to part 2 Governing Body in March 2015: next steps will be	~~January 2015~~ March 2015

Corporate Objective 7: Review the population health needs for all mental health services to inform enhanced delivery				Governing Body Reports			
Lead Officer/Risk Owner: Karl McCluskey							
Principal Risks	**Risk Status (L x C)**	**Key Controls**	**Assurances on Controls**	**Key Positive Assurance (**External / Independent)**	**Gaps in Control or Assurance (GIA) or (GIC)**	**Corrective Action**	**Responsibility Target Date**
						identified following Governing Body meeting. Overview of findings being presented to Merseycare Trust in March 2015. Previous reporting issues regarding prevalence rates. Now received a revised report however now have a revised national target. Being monitored with a view to achieving target in Q4. IAPT target likely to be achieved.	March 2015 April 2015

Progress Reports	Quarter	Progress	Assurance Rating	
Progress Reports	**Q1**	**Detailed demographic and population health needs analysis undertaken as part of 5 year strategic plan and 2014/15 refresh of JSNA with the Local Authority.**	**Assurance Rating**	**Significant**
	Q2	**Review and assessment of Dementia incidents and diagnosis rates completed in September. Formal review of IAPT performance against access target of 15% initiated. Formal updated received at Governing Body November 2014.**		**Significant**
	Q3	**Governing Body to be updated and advised on IAPT reporting error and revised performance and national target for Q4**		**Significant**
	Q4	**Mental Health review and full paper being presented to part 2 Governing Body in March 2015.**		**Significant**

GUIDANCE

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

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

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

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

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

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

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

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

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

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

Assurance Rating

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

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

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

Examples of what constitutes differing levels of assurance:

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

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

Key Positive assurance

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Risk Grading Matrix

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

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

↓ Significant risk

Significant Risk

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

SOUTHPORT & FORMBY CCG - CORPORATE RISK REGISTER

Quarter 4 (March) 2014/15

Last Saved: 23/12/2014

By User: Judy.Graves

▼ Risk reduced
► Risk unchanged
▲ Risk increased

ID	Date Added	Principal Risk	2014/15 Strategic Objective	Domain Type2	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Due	Progress against action Plan	Q1	Q1+1 (Jul 2014)	Q1+2 (Aug 2014)	Q2 (Sept 2014)	Q2+1 (Oct 2014)	Q2+2 (Nov 2014)	Q3	Q3+1	Q3+2	L	C	Q4	Change Since Last Update
Business Objective																										
BUO001	Prior Q3 2013/14	18 week & cancer pathways may not be met due to non delivery of target by provider	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Business Objective	Chief Strategy & Outcomes Officer (Karl McCluskey)	Monthly contract meetings, Clinical Quality and performance meetings, clinical lead for contracts and for quality, additional funding for RTT, worked closely with providers on cancer pathway. Set up clinical meetings with cancer leads and manager. Managerial lead for cancer has action plan in place. Weekly and monthly monitoring through SMT and contractual performance. RCA for any 62 day breaches RTT plans with Aintree and Southport & Ormskirk agreed and weekly review of performance is in place. Reporting system developed that provides earlier notification of waiting time concerns. Is reviewed on a weekly basis and reported to SMT and SLT (Senior Leadership Team). Integrated Performance Report developed and presented to Governing Body.	3	3	9	Suspension of Breast Service in Southport & Ormskirk NHS Trust: closed to new referrals from 1st September: consequence being a higher level of breaches materialising however should resolve as activity being managed. S&O to complete validation of data. New Patient Admin System to be fully embedded and tested to ensure data reliable. Diagnostic Waiting Time Target failure: Endoscopy	TBC March 2015 March 2015	TBC April 2015 March 2015	Cancer 2 week: Continue to monitor the 2 week wait cancer performance. Systems in place are fit for purpose as the year end target is delivered. Achieving all 2 week targets. ~~Only 1 area slightly low: first appointment breast system - 92.64% against a target of 93%.~~ Cancer 31 day: achieving: achieving. Cancer 62 day: currently not achieving screening services - first definitive treatment and first referral to treatment. Failure relations to complex pathways and multiple providers. Other local providers contacted and they have put on additional capacity to meet demand. Will be monitoring and working with providers to identify issues. Longer term we are working With local providers to develop a new pathway and make a sustainable service locally. The overall 18 week target was delivered and Southport & Ormskirk trust made significant progress against clearing the backlog of patients waiting 18 weeks continues to be monitored and ongoing. Reporting system now developed and continues to be completed and reviewed on weekly basis and reported to SMT and SLT. Feedback received from SMT and SLT who have commented that they are now able to see in context compared to other performance and quality components. RTT (Referral to Treatment Time) plans with Aintree and Southport & Ormskirk agreed and weekly review of performance is in place: continues. Southport & Ormskirk having issues with data and validity of. Evidence indicates that it is a programme issue with the new software, likely cause being multiple counting of the same patient depending on stage of care. Subsequently showing a breech however it is not believed that this is the case. No back-up system is in place. S & O are trying to do patient by patient validation. Is an 18 week issues however do not believe treatment is actually being affected. S&O are currently unable to advise how long the validation process might take. Ongoing validation of waiting list to ensure chronological treatment of patients. Error has been identified as double counting of patients. As a consequence RTT figures are showing a breech. In February the Trust were issued with a contract query due to failure to deliver since October. Will be managed via contract meetings. Integrated Performance reporting system developed. First report presented to SS & SF Governing Bodies in September 2014. Positive feedback and well received. Members considered provided a more rounded picture and joined up quality and performance issues. Will take time for the new Patient Admin System (PAS) to be established: testing and refining data, system and process ongoing. Diagnostics waiting time target failed in November as a result of a sickness absence in Echo Cardiology. Resolved in December. This was followed by failed target for non-elective which impacted in December (separate issue). An exception report was received from Aintree in relation to performance and included the areas that had failed (cardiology, MRI and Endoscopy). Aintree have already implemented action plans for all failed areas. Latest update is Echo Cardiology is achieving from January and MRI recovery already achieved. Endoscopy is dependant on recruitment of 3 Consultants and 1 Specialist Registrar. Recruitment is ongoing and being supported by HR. Business cases are in place for each post. Note: S&O elected not to undertake additional activity as consider currently not in position to take on.	3x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	4x4	4	4	16	►
Finance																										
FIN001	Removed and placed on Horizon scan																									
FIN002	Moved to Horizon scan																									
FIN003	Revised Q1 2014/15	Changes in patient flow causes financial issues, due to increases in activity overall and the financial implications on the 14/15 Financial performance of the CCG. Predominant risk areas are: CHC and Urgent Care which have both seen significant growth in demand.	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Financial	Chief Financial Officer (Martin McDowell)	-Monthly contracting meetings with main acute providers - Information shared with GP leads - Practice level reporting of financial information - Monthly monitoring of financial position -Action plan developed to mitigate in short term. - task force with weekly steering group established - Benchmarking review carried out by MIAA	4	2	8	~~Completion of action plan by March 2015 to mitigate short term financial pressure.~~ Completed. ~~Review of CSU team case management and data quality to better inform cause of increase in demand:~~ completed ~~Benchmarking exercise to be completed by MIAA:~~ completed. Awaiting MIAA benchmarking results.	~~March 2015~~ ~~March 2015~~ ~~March 2015~~ March 2015	~~April 2015~~ ~~April 2015~~ ~~April 2015~~ April 2015	CCG monitoring performance accordingly. CCG has built impact of changes into contract, not reflected in plans. Reported in financial position. Action plan that will mitigate in short term i.e. 14/15. now developed: will manage financial overspend. Has been presented to Governing Body. Governing Body agreed action plan and are aware of situation. Confident that will meet all action plan requirements by the end of the financial year (March 15). Delivery of action plan to be monitored. Robust contract management in place. CHC task force set up with a weekly steering group led by Helen Nicholls with COO of CSU and Chief Nurse, DoF along with wider team commenced December 2014 in order to improve processes around CHC case management and data quality National Benchmarking presented to F&R Committee in January 2015. MIAA commissioned to undertake further benchmarking. Results expected by end of March. Note: As discussed at SMT 25/11/14, risk has been reviewed and will be used as overall financial risk.	3x2	4x4	4x4	4x4	3x4	3x4	3x4	3x4	3x4	2	4	8	▼
FIN004	Moved to Horizon scan																									
FIN005	Moved to Horizon scan																									
FIN006	Moved to Horizon scan																									
FIN007	Removed																									
Quality																										

SOUTHPORT & FORMBY CCG - CORPORATE RISK REGISTER

Quarter 4 (March) 2014/15

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▼ Risk reduced
► Risk unchanged
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ID	Date Added	Principal Risk	2014/15 Strategic Objective	Domain Type2	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Due	Progress against action Plan	Q1	Q1+1 (Jul 2014)	Q1+2 (Aug 2014)	Q2 (Sept 2014)	Q2+1 (Oct 2014)	Q2+2 (Nov 2014)	Q3	Q3+1	Q3+2	L	C	Q4	Change Since Last Update
QUA001	Prior Q3 2013/14	Lack of existing capacity of Hosted Safeguarding Children and Vulnerable Adults Service could impact on CCGs ability to discharge its statutory functions	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Nurse (Debbie Fagan)	Hosted service arrangements in place across Merseyside, hosted by Halton CCG. Arrangements include discussion at CCG Network. Regular 1:1 scheduled between the Chief Nurse and Safeguarding Leads within the service. Updates presented to and discussed by the Safeguarding Steering Group Regular report to the quality Committee from the Safeguarding service. Commissioned 'CQC style' peer review of CCG Safeguarding arrangements. Children's: all positions filled. New Head posts for Adults and Children.	3	3	9	**Children's:** **Adults:** HR process to conclude: 30 day consultation regarding re-designed structure.	April 2015	April 2015	Children's team now at full strength: person previously off sick is now off of phased return and working their full hours and all posts filled. Formal staff consultation regarding structure now concluded. Interviews for Head of Safeguarding (Children) scheduled to take place. Restructuring has taken place following staff consultation and recruitment. New post for Looked After Children advertised. Children's element will have reached full establishment once post appointed to. Heads of both Adult's and Children's Safeguarding now recruited to. Adult's team: work and team supported whilst a member of the team was on planned sick leave: has now returned and normal service level resumed. Review of Adult service carried out. Has resulted in vacancy from redundancy being withdrawn until review finalised. Revised structure for Safeguarding Adults being discussed at Steering Group meeting on 17th November 2014 with a paper to then be presented to the CCG Network in December 2014. Financial viability discussions taking place for proposed statutory changes in view of the Care Act. Steering Group held in November and costings now being worked with finance. Next Safeguarding steering group January 2015. HR process has commenced (30 day consultation) for re-designed structure. Once HR process completed then recruitment can take place (restructure to align with children's and to take into account new Care Act). HR issues being managed by Halton CCG. Update provided to the Safeguarding Steering Group meeting held on 11/8/14. - Dates to be set by CCG CO for rest of year. Further update to next Steering Group meeting on 17th November 2014. Meetings also scheduled for 15/16.	3x3	3x3	3x3	3x3	3x3	3x3	3x3	1x3	1x3	1	3	3	►
QUA002	Prior Q3 2013/14	Need for clarity of roles and responsibilities between Safeguarding Hosted Service, CSU CHC team and LCH Provider Safeguarding Team to enable CCG to discharge their safeguarding function. Need for further clarity between health and social care commissioning / safeguarding for vulnerable adults.	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Nurse (Debbie Fagan)	Regular 1:1 meetings between safeguarding adults lead in hosted service and CHC locality lead. Identified a single point of contact system for Safeguarding Adults between the Safeguarding Service and hosted service. Draft Standard Operating procedure developed and includes recommendations re review.	4	5	20	Awaiting feedback from Quality Committee on draft SOP To obtain the recommendations from Liverpool Community Health's internal Safeguarding review that explored the role of the Safeguarding Adults team. Part 1 received: Awaiting part II which looks at progress against ongoing recommendations.	~~February~~ April 2015 March 2015	~~February~~ April 2015 March 2015	SOP updated following recommendations from safeguarding 'CQC style' peer review. Draft SOP sent to CCG Peer Reviewer for consideration Item on agenda for December 2014 Quality Committee. LCH internal review requested by Chief Nurse. Discussed at Contract meeting. Received LCH Safeguarding Review part 1 , waiting part 2: Chief Nurse has contacted the Deputy Director of Nursing chasing part 2. Awaiting 2nd peer review recommendations. Meeting between Chief Nurse and Deputy Director of Nursing to discuss 2nd peer review recommendations to be re-arranged once the new Nursing Director in post: expected to be arranged for January 2015. Safeguarding meeting to be arranged with new Interim Nursing Director regarding part 2 of the recommendations. Single point of contact in place and safeguarding service can mobilise teams and communicate with the LA. Contacted on 2/2/15 for confirmation of meeting and again 10/02/15 to confirm date with interim Nursing Director but no date set as yet. Plan for SOP review as part of meeting with LCH's review. Still waiting information from LCH in order to finalise SOP. CCG Network Steering Group updated at a meeting on 23rd February. Mitigating actions put in place.	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2	4	8	►
QUA003	Prior Q3 2013/14	That local residents may experience a fragmentation / less local co-ordination and responsiveness of complaints and patient information services at a local level due to NHS England's national procurement and separate management of these processes.	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Delivery and Integration Officer (Tracy Jeffes)	Regular feedback from CSU / PALs regarding management of local queries. CSU temporary management and coordination of local primary care complaints. EPEG receive a monthly overview from NHS England	3	3	9	Liaison with NHS E Merseyside Team regarding co-ordination of arrangements in the future. Further clarity is required on current and future arrangements in light of the organisational changes in NHS England.	March 2015	April 2015	NHS E now managing own complaints. Seek assurances from NHS England on current and future plans. Ongoing: NHS England re co-commissioning with CCG's - environmental factor to understand the plans and how co-commissioning might affect this risk: on-going discussions regarding plans for co-commissioning with NHS England. Includes discussion regarding the complaints process: ongoing EPEG is now receiving a monthly report on Primary Care complaints in addition to PALs reports. Healthwatch to report to EPEG on national findings regarding patient experience of complaints management: ongoing	2x3	2x3	2x3	2x3	2x3	2x3	2x3	2x3	2x3	2	3	6	►
QUA004	Prior Q3 2013/14	Impact of lab results on patient safety (tests at Aintree) being sent to GP practices where they are not registered. Current IT system only allows GPs to reject results	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Nurse (Debbie Fagan)	-Raised as an issue at the Quality Committee and Contract meetings. -Steering Group established - Terms of Reference revised	4	3	12	Discussed at LCL Incident Meeting on 3 July 2014. I-Merseyside team to send information to NHSE(M). NHSE(M) to liaise with HSCSC due to national issue and feedback. Note: not LCL issue	TBA: national issue	TBA: national issue	3 GP Clinical Quality Lead has set up a Task and Finish Group with the lead for Lab Services . Progress reports to be received by the Quality Committee. National problem - been referred back to system provider & risk will remain the same until further developments. Further meeting held on 31/7 to discuss. IMerseyside confirmed they have sent information again to HSCIC (Health & Social Care Information Centre). Chief Nurse liaised with I-Merseyside in September 2014. No update yet received form HSCSC/National Level: still waiting update. Chief Nurse requested I-Merseyside chase in October. Response not yet received. Chief Nurse has contacted I-Merseyside for a response. Update received from iMerseyside on the 19/12/14 with 2 options presented by HSCIC. NHS England leading on this and to consider which option is most appropriate. Contacted NHS E for update. Steering group revised terms of reference to manage clinical, technical and primary care issues as a result of incident. Still awaiting option from NHSE and group will follow up to NHSE. No update from NHSE. Contacted Kate Warriner & Michelle Creed on 10/02/15 who have responded that it is an ICE issue as such but a risk associated to rejection of pathology reports in GP clinical systems for patients not registered. Chief Nurse is chased and is awaiting a response on the NHSE action.	4x3	4x3	4x3	4x3	4x3	4x3	4x3	3x3	3x3	3	3	9	►
QUA005	Removed																									

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Last Saved: 23/12/2014

By User: Judy.Graves

SOUTHPORT & FORMBY CCG - CORPORATE RISK REGISTER

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

ID	Date Added	Principal Risk	2014/15 Strategic Objective	Domain Type2	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Due	Progress against action Plan	Q1	Q1+1 (Jul 2014)	Q1+2 (Aug 2014)	Q2 (Sept 2014)	Q2+1 (Oct 2014)	Q2+2 (Nov 2014)	Q3	Q3+1	Q3+2	L	C	Q4	Change Since Last Update
QUA006	Q3 2013/14	Providers RAG rating in relation to robust Safeguarding systems and processes presents lack of assurance for CCG based upon validation of information presented by the Trust. Risk increased due to interface issues with reporting system between CSU and Safeguarding Hosted Service.	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality and Financial	Chief Nurse (Debbie Fagan)	Assurance process paper presented to LSCB on processes in place. RAG rating monitored via Quality Contract meetings. Reported to Quality Committee and escalated to Governing Body as required. Chief Nurse informed NHS England (M) and safeguarding will be included in the quality review process with the Trust. Monitored through quality contract meetings with CSU Agenda item for discussion at provider Quality Contract meetings. Safeguarding performance discussed at Quality Committee. Process developed between CSU and Safeguarding service to further develop information flow across the two services. Quality 'Walk Around' carried out with feedback and outcomes reported to Executive Nurse, contract meetings, Quality Committee. Contract reviewed to ensure in line with KPI's	4	4	16	Ongoing liaison between Safeguarding Service and provider. Safeguarding Hosted Service have offered additional support to trusts as a critical friend. Safeguarding performance discussed at each provider quality contract meeting. Chief Nurse has confirmed that provider Safeguarding performance across the system would be an agenda item for discussion at next Quality Surveillance: Deferred to November meeting by NHS England. Deferred as a agenda item. Chief Nurse to follow up. 10/02/15 No confirmation for QSG agenda.	Ongoing TBC	TBC	Following update given at Safeguarding Service at March Quality Committee and discussion at March Governing Body - letter drafted and to be sent to all providers from CCG Chief Officer: confirmed as sent 11th April 2014. Upwards improvement reported from safeguarding service with regards the majority of provider process, although not enough to improve provider RAG rating in Q4. Chief Nurse and Safeguarding Service have met with Aintree and S&O in Q1 to discuss progress/support. Alder Hey Safeguarding performance discussed at the quality review meeting, held in June 2014. Another meeting-held early October. S&O Safeguarding Quality 'Walk Around' Audit held. Feedback to Executive Nurse. Outcome reported to CCG Quality Committee in September including Trust performance: showing positive improvement. Formal feedback given to Trusts at October Contract Meeting. Provider performance will continue to be monitored through the contracting process. Chief Nurse and Safeguarding Nurse met with Aintree to discuss performance of safeguarding services re revalidate of Q1 performance at same time as Q2. Contract variation to be put in place for Q3 in line with expected KPI's. Safeguarding Service have met with Liverpool Women's Hospital Director of Nursing in June 2014 with an update to the Chief Nurses for Liverpool CCG and the Sefton CCG's to be discussed at the next Quality Committee (Q2). LWH information not validated by Safeguarding Service in time for September Quality Committee. Mitigating action: CCG to present at LWH CQPG where this will be discussed and fed back to QC in November 2014. Teams will be in attendance for Q2 provider performance report update. Chief Nurse presented paper to Sefton LSCB (Local Safeguarding Children's Board) on the assurance processes that the CCG has in place and Q4 2013/14 provider performance: Provider performance data presented in September 2014. Q2 performance data from Safeguarding due: as per reporting schedule. Provider Performance showing an upward trajectory in relation to improvement on training of staff and safeguarding awareness. S&O served with contract query in February, as necessary level of assurance not provided. Safeguarding service reported latest assurance report in Jan 2015. Feedback has been given at appropriate contract meeting. Safeguarding Services due to report Q3 performance at March 2015 Quality Committee. Chief Nurse is awaiting confirmation from LCH on when they will be able to share their 2nd Safeguarding Review so as to enable the CCG to review alongside SOP for Safeguarding Adults in order to ensure no duplication in commissioning in the new system.	4x4	4x4	4x4	3x4	3x4	3x4	3x4	3x4	2x4	2	4	8	▶
QUA007	Removed																									
QUA008	Q1 2014/15	Lab results not being communicated to GP practices (from the Lab provider) due to IT system/technical issues that may have an impact on patient safety:	Objective 2 - Sustain reduction in non- elective admissions in 2014- 2015	Quality	Chief Nurse (Debbie Fagan)	Raised as an issue at the Quality Committee and Contract meetings. Director of Public Health notified. CCG comms notified. GP clinical lead identified within CCG Steering group set-up with reps from lab provider, local CCGs, I-Merseyside, Aintree Hospitals, NHS England and St Helens and Knowsley Informatics. Remains agenda item for discussion at Aintree CQPG and Aintree Collaborative forum. Task and Finish Group established. Group receive progress and lessons learnt are discussed.	4	5	20	GP Clinical Lead to meet with Acute Trust Provider Lab Team. Action plans sent out to 3 affected CCGs. Prioritisation of impact of results determines action plans. I Merseyside identify outstanding results. RCA to be completed: Level 1 Priority Patients Completed. Prioritised notification to GP's based on risk. Four technical issues identified: 1. Macroprolachin 2. Clinisys (NT-proBNP & other analyses) 3. EPOC/EMIS 4. Clinisys Corrupt Characters/EMIS Web ~~RCA Investigation outcome to be presented to next Task and Finish Group. Deferred to March 2015.~~ Meeting held 02/03/15. ~~NHS England (M) arranging meeting to discuss lessons learnt from RCA's. Need to confirm position with NHS E. NHSE didn't attend meeting.~~ Decision to commission external review in relation to lessons learnt discussed and agreed. Further discussed 24/3/15. Full agreement needed on the proposal for an external review to look at 'Lesson's Learnt'. ~~To be put on next lablinks meeting agenda for March 2015:~~ on LCL agenda 02/03/15	~~March 2015~~ ~~TBA~~ March 2015 ~~March 2015~~	~~March 2015~~ ~~TBA~~ March 2015 ~~March 2015~~	GP clinical lead identified within CCG, to support quality team. Steering group set-up with reps from lab provider, local CCGs, I-Merseyside, Aintree Hospitals, NHS England and St Helens and Knowsley Informatics. - Confirmation received at Steering Group meeting that, regarding the high risk/priority patients GP's had been notified of, the GP Clinical Lead had written to all practices informing them of the issues and the system for prioritisation of notification between the lab and GP practices: CCG has received information from LCL regarding number of patients and GP practices they belonged to as part of assurance that practices have been notified. Followed-up with GP practices: - Outstanding results to be identified, Priority results to be notified to practices in 5 days, second cohort in 2 weeks and all results within one month. - Extra-ordinary meeting held by NHS England in July: Task & Finish group last met 31/7. Plans in place to follow-up potential patient safety issue with practices in November 2014: letters sent to practices in November. To date no feedback received on whether an patient harmed as a consequence. - Next Task & Finish Group scheduled for September 2014 where progress and lessons learnt from provider RCA's to be discussed. ~~Waiting next meeting date for the Task and Finish Group.~~ Further meetings being held. ~~in December.~~ - Lessons Learnt event held and Chaired by NHS England in October 2014. CCG represented by Clinical Lead for Quality. Some suggestions made. Taking Lessons Learnt through to sub meetings of LCL Steering Group: ~~waiting next meeting date for the~~ Task and Finish Group held 2/3/15. Will be presented to Quality Committee once formal feedback through. - Remedial software introduced to capture any further incidents by the provider. LCL have reported issue nationally to MHRA. - CCG quality team undertaken risk assessment of each individual risk to demonstrate how actions that have been undertaken have mitigated ongoing risks in each of the identified 4 areas. CCG quality team continue to monitor. - Initial agreement made in August 2014 to commission external review. Being led by Knowsley CCG Chief Officer and the Trust. To be discussed further at a meeting of Aintree Collaborative Commissioning Forum 27th March 2015: need agreement of all CCG's (Liverpool, Knowsley and Sefton CCG's) in order to take forward. Review to look at Lesson's Learnt in relation to the incident investigation process. Meeting held. technical aspects of 3 incidents closed. However still open as clinical risk is still present. 4th incident is ongoing with majority of practices addressed with no errors at majority of practices. TOR of group revised to address and provide actions to resolve from a clinical risk perspective. Next meeting January 2015. Action chased up with CEO at Knowsley in January 2015. Software now working to prevent repeat of incident. Steering group revised terms of reference to manage clinical, technical and primary care issues as a result of incident. Still awaiting option from NHSE and group will follow up to NHSE. ~~Needs to be on next lablinks meeting agenda for March 2015.~~ On LCL agenda 2/3/15. Incident's were discussed further regarding progress. LCL looking to confirm close down on outstanding patient query's. Note: Identified that SF has minimal patient flow: risk reduced however continues to be monitored.	3x5	3x5	3x5	2x5	2x5	2x5	2x5	2x5	2x5	2	5	10	▶
QUA009	July 2014 (Q1+1)	Risk that patients could be harmed or receive inadequate care due to failure of GP's to deliver against Primary Care Quality Contract 14/15	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality (also Finance and Performance)	Chief Strategy & Outcomes Officer (Karl McCluskey)	Regular practice and GP visits Primary Care dashboard Updates to SMT - Dashboard in place and available for locality use	3	5	15	Locality level to test and assess practice performance.	February 2015	March 2015	Local Quality Contract 14/15: Primary Care dashboard which triangulates practice performance, quality and finance: will measure against other practices and highlight areas of differences and underpin Primary Care Contract with formal assessments now completed. Process for Primary Care Dashboard roll out and application at locality level presented to SMT on 3rd November 2014: Completed and available for locality use. Some practices had ~~having~~ difficulty accessing Dashboard through CMIP. Plan put in place to address: issues resolved. Latest version presented to Service Improvement and Re-design Committee in February 2015. Note: - Original consequence was rated as 5, now rated as 3 in view of shared risk between NHSE and CCG. - risk reduced due to 15/16 work being removed to Horizon Scan: 14/15 contract in place and well managed.	N/A	3x5	3x5	3x3	3x3	3x3	1x3	1x3	2x3	1	3	3	▼

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▼ Risk reduced
► Risk unchanged
▲ Risk increased

ID	Date Added	Principal Risk	2014/15 Strategic Objective	Domain Type2	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Due	Progress against action Plan	Q1	Q1+1 (Jul 2014)	Q1+2 (Aug 2014)	Q2 (Sept 2014)	Q2+1 (Oct 2014)	Q2+2 (Nov 2014)	Q3	Q3+1	Q3+2	L	C	Q4	Change Since Last Update
QUA010	Horizon Scan																									
QUA011	Q3+1 January 2015	Risk that patients could be harmed or receive inadequate care due to failure to deliver against National Key Performance Indicator for IAPT (Improving Access to Psychological Therapies)	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Strategy & Outcomes Officer (Karl McCluskey) and (Chief Redesign & Commissioning Officer) Jan Leonard	- Investigation completed: established that provider had made a local interpretation of target resulted in an over inflation of position. Situation has been notified to NHS England - Remedial action plan in place - Performance and contractual meetings and reporting process in place - paper presented to Governing Body November 2014 - Contract awarded to another provider effective April 2015.	4	3	12	- Continue to monitor position until end of financial year.	Mar-15	Mar-15	- Financial consequence as a result of over inflated position. Allowance made of £116,000. Continues to be monitored. IAPT performance against revised 3.75% remains challenging with CCG unlikely to achieve yearend target. Quality Committee April 2015: felt that there is a problem hitting the target but that there are low waiting times and the new guidance stipulates that people can self-refer also. They considered that Either the risk needs re wording to say the risk is around not going to hit target which would be extreme or the risk should be low based on the low waiting times and self-referral ability mitigating the risk	x	x	x	x	x	x	x	4x3	4x3	5	3	15	▲
QUA012	Q3+1 January 2015	Capacity constraints with Cardiology Services at Southport & Ormskirk Trust	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Redesign & Commissioning Officer (Jan Leonard)		4	3	12	'Action plan to be put in place including where other support might be gained and costings	Feb-15	Mar-15	- Meetings held with Liverpool Heart and Chest to discuss the possibility of them being able to provide support t the Trust. They have indicated that support would be available. - Liverpool Heart & Chest to work up costings and options with Southport & Ormskirk. Initial cohort of patients have all had their records been assessed and outpatients appointments arranged according to clinical priority. CCG are working with LHCH to develop a plan for the next stage of development.	x	x	x	x	x	x	x	4x3	4x3	4	3	12	►
QUA013	Horizon Scan																									
QUA014	Q3+2 February 2015	Risk to sustainability for commissioning support services due to unsuccessful application of NWCSU to be accepted onto LPF	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Chief Delivery and Integration Officer (Tracy Jeffes)	- Merseyside CCG Network exploring alternative support options - sub group meetings established	4	3	12	Review opportunities presented by LPF ~~Sub-group of Merseyside CCG Network to be developed:~~ developed.	March 2015 March 2015	April 2015 April 2015	- Discussion with Merseyside CCG Network regarding collaborative approaches to explore alternative support options - New sub-group ~~being~~ developed to look at proposals. Proposals in development. - NWCSU have identified sustainability partner to assist in maintenance of current service provision.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4x3	4	3	12	►
QUA015	Q3+2 February 2015	High volume of over 60 minute AMB turnaround times result in patients not receiving appropriate care	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Quality	Head of Primary Care & Contracting (Malcolm Cunningham)	- Regular feedback to monthly contract meetings - Regular communication with Blackpool CCG (lead commissioner)	3	3	9	Review to be completed on what can be done to improve turnaround times. Findings from review to be presented at next contract meeting.	March 2015 March 2015	April 2015 April 2015	- Work ongoing to review what can be done to improve turnaround times: rolling programme. Findings to be presented to next contract meeting. Long turnaround relates to physical capacity issue and lack of available beds.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3x3	3	3	9	►

Reputation / Adverse Publicity

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▼ Risk reduced
► Risk unchanged
▲ Risk increased

ID	Date Added	Principal Risk	2014/15 Strategic Objective	Domain Type2	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Due	Progress against action Plan	Q1	Q1+1 (Jul 2014)	Q1+2 (Aug 2014)	Q2 (Sept 2014)	Q2+1 (Oct 2014)	Q2+2 (Nov 2014)	Q3	Q3+1	Q3+2	L	C	Q4	Change Since Last Update
REP001	Prior Q3 2013/14	Unresolved restitution CHC cases may lead to reputational damage to CCG (to be read in conjunction with Risk 2 above)	Objective 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Reputational/ Adverse publicity	Chief Nurse (Debbie Fagan)	Commissioned Service from NWCSU; Standing Agenda Item on Quality Committee; Reports to the Governing Body; Updates received from CHC Team. Regular meetings between Chief Officer, Chief Nurse, Chief Finance Office regarding CHC progress. Letters reviewed by Chief Nurse before sign off by Chief Officer. Regular meetings held with CSU Complaints Team to keep track of complaints. Information feeds through to EPEG and Quality Committee.	4	3	12	Linked to restitution and comes through HOCO report. Review Restitution progress. Letter from Chief Nurse to complete all restitution cases by March 2017. Plans in place to performance manage via contracts.	March 2015	March 2015	Chief Nurse met with COO (NWCSU) & Yvonne Lockheed (March 2014). Change of Leadership within Locality Team. ~~Monthly meetings between Chief Nurse & CMCSU Team scheduled to discuss operational models~~ Discussed complaints management linked to restitution & CHC in general - NWCSU to review how complaints are logged, categorised and managed. CCG has requested more detailed information regarding activity in relation to restitution/closedown. NWCSU will clarify more detail in standard letters (e.g. timeframes) to manage patient/family applicant expectations: Completed. Chief Nurse checks each complaint letter before going to the Chief Officer for sign-off. ~~Plans for Integrated Model to be delivered locally in Q1/Q2 of 2014/15: integration workshops held with CCG /CSU/Local authority in June and July 2014. Integration Workshop held July 2014.~~ Note: Original restitution risk has been split from other CHC risks: REP 001 & REP 003 - green strikethrough font is split from original risk and into new risk - grey stays with main risk (1) - blue font: newly updated this month. - black = same for both Meeting held in December with CSU. CSU have undertaken a procurement process to commission support to undertake this function. Restitution forms part of the CCG / CSU /CHC steering group. this has been established in December and is meeting weekly to address operational issues. Plan received however further information on restitution cases still required. Requested further information from CSU by 02/02/15. Steering Group updated on operational issues and restitution cases at a meeting on 23rd February 2015. Quality Team presented with an update position on 02/02/15. Assurance given to be on track on meeting trajectories. Performance of CSU in relation to restitution discussed formally at SLA meeting.	4x3	4x3	4x3	4x3	3x3	3x3	3x3	3x3	3x3	3	3	9	►
REP002	Prior Q3 2013/14	Ineffective engagement and communications will impact on the ability to meet statutory duties and possible damage to CCG reputation	All	Adverse Publicity /Reputation	Chief Delivery and Integration Officer (Tracy Jeffes)	Integrated Communications and Engagement Strategy in place including annual action plans; Governance structure identified including Quality Committee, EPEG, Locality Groups	3	4	12	KPIs and dedicated resource for communications and engagement to be defined with NWCSU including annual review of communications and engagement strategy.	February 2015	March 2015	Systematic process for engagement and consultation defined, with clear reporting channels from locality level to committee structure (Community Champion, Locality Groups, EPEG, Quality Committee) Plan in place for Strategic Communications to come 'in-house': now in-house. In-housing of services is enabling additional capacity to be available in CCG. Respecification of comms and engagement service with NWCSU. Review of service being carried out. Benchmarking of comms and engagement capacity across Merseyside completed. Proposals for future capacity developed for discussion with SMT. Will form part of discussion for CSU commissioning intentions for 15/16: meetings ongoing through January and February 2015. Funded some additional engagement capacity. Being delivered through CSU to help manage high volume of engagement activity through December to March 2015.	3x3	3x3	3x3	3x3	3x3	3x3	3x3	2x3	2x3	2	3	6	►
REP003	Oct 2014 Split out from REP001	Local CHC process being fit for purpose to manage local demands Further work to be carried out on the definition of the risk, which will then have an impact on the controls and rating. To be carried out following a meeting with the CSU service being held in December 2014.	Objective 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Reputational/ Adverse publicity	Chief Nurse (Debbie Fagan)	Commissioned Service from NWCSU; Standing Agenda Item on Quality Committee; Reports to the Governing Body; Updates received from CHC Team. Regular meetings between Chief Officer, Chief Nurse, Chief Finance Office regarding CHC progress. Regular meetings held with CSU Complaints Team to keep track of complaints. Information feeds through to EPEG and Quality Committee. MIAA review	4	3	12	Steering group to address all identified issues as per external review. Review of risk to be carried out following CSU service meeting in December 2015. External review of high cost cases commenced with data provided by CSU. Steering group to address all issues	March 2015	March 2015	~~Chief Nurse met with COO (CMCSU) & Yvonne Lockhead (March 2014). Change of Leadership within Locality Team.~~ Monthly meetings between Chief Nurse & NWCSU team scheduled to discuss operational models Discussed complaints management linked to restitution & CHC in general - NWCSU to review how complaints are logged, categorised and managed. ~~CCG has requested more detailed information regarding activity in relation to restitution/closedown. CMCSU will clarify more detail in standard letters (e.g. timeframes) to manage patient/family applicant expectations.~~ Plans for Integrated Model to be delivered locally in Q1/Q2 of 2014/15: integration workshops held with CCG /CSU/Local authority in June and July 2014. Integration Workshop held July 2014. MIAA review of CCG CHC process undertaken. Initial draft report presented to Chief Nurse in October 2014 for comment: draft report is showing significant assurance. Will be shared with Quality Committee once final formal report is received from MIAA. Note: Original restitution risk has been split from other CHC risks: REP 001 & REP 003 - green font is split from original risk - strikethrough has put kept with the main risk (1) - blue font: newly updated this month. External review of high cost cases commenced with data provided by CSU. Steering group to address all issues. Weekly meetings of CSU /CCG now ongoing with work plans for service improvement. New CHC specification being redrafted for completion 02/02/15. New plan in place and new specification to be presented on 16/02/15 to Steering Group. Project plan developed and exception reporting developed. Option paper for reviews presented for discussion within CCG. Assurance to complete CHC reviews backlog by March 2015. CSU continue to report weekly. CSU option paper regarding Reviews for Funded Nursing Care and Joint Packages of Care presented to the 24th February 2015 SMT. MIAA had requested further documentation. Review commenced Q3 on systems and processes. MIAA review being presented to SMT 10th March and Quality Committee in April 2015.	N/A	N/A	N/A	N/A	4x3	4x3	4x3	3x3	3x3	3	3	9	►
REP004	Q3 Dec 2014	The closure of Breast Surgery Service (for new patients) at Southport & Ormskirk poses a risk to the CCG and concerns for local residents.	Objective 1: to consolidate a robust Strategic Plan within the CCG's financial envelope	Reputational/ Adverse publicity	Chief Delivery and Integration Officer (Tracy Jeffes)	- pro-active engagement exercise with effective public and key stakeholders - safe services have been put in place via Aintree Hospital Trust Patient Safety maintained throughout - Equality Impact Assessment	4	4	16	- Change of services as a result of Clinical Safety to be communicated effectively ~~- Engagement with patients to understand experiences of old and new services in order to improve patient experience where possible:~~ completed - draft pathway redesign, incorporating the findings of the engagement, to be presented to the Governing Body	~~March 2015~~ June 2015	~~April 2015~~ June 2015	Engagement consultation from January to February 2015. Engagement process now completed. Report to be presented to Governing Body in March. The next stage will be to redesign the pathway taking into account the findings of the engagement exercise. This will be presented back to the GB by end Quarter 1 15/16.	N/A	N/A	N/A	N/A	N/A	N/A	4x3	4x3	4x3	4	3	12	►

SOUTHPORT & FORMBY CCG - CORPORATE RISK REGISTER

Quarter 4 (March) 2014/15

Last Saved: 23/12/2014

By User: **Judy.Graves**

▼ Risk reduced
▶ Risk unchanged
▲ Risk increased

ID	Date Added	Principal Risk	2014/15 Strategic Objective	Domain Type2	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Due	Progress against action Plan	Q1	Q1+1 (Jul 2014)	Q1+2 (Aug 2014)	Q2 (Sept 2014)	Q2+1 (Oct 2014)	Q2+2 (Nov 2014)	Q3	Q3+1	Q3+2	L	C	Q4	Change Since Last Update
REP005	Q3 Dec 2014	Local residents may be concerned by possible closures of Litherland Town Hall OOH Pharmacy Service	Objective 1	Reputational/ Adverse publicity	Chief Delivery and Integration Officer (Tracy Jeffes)	-Equality Impact Assessment completed - Initial consultation undertaken and completed - alternative service provision has been identified and communicated in order to gain feedback on alternative option	3	4	12	-Further engagement exercise to provide further information and gain better understanding of options and mitigations available to the CCG. This will inform the Full EIA doc - feedback needed on alternative service option	March 2015 March 2015	March 2015 March 2015	Outcome of all work presented to Governing Body for a decision in January 2015. Decision taken at Governing Body to close service. No adverse publicity yet however further communication is needed. Governing Body approved closure of service subject to key recommendations (a) ensuring medical supplies to those that may have difficulty in getting (b) clear communication to the public for signposting to alternative services. Next step is implementation of plan of alternative service for supply of medication and communicating position to the public. (a) GOTODOC, the out of hours provider, has agreed to the supply of medicines to those who have difficulty travelling to pharmacies at time of consultation. (b) communications have now gone out to inform residents of changes.	N/A	N/A	N/A	N/A	N/A	N/A	3x3	3x3	3x3	3	3	9	▶
Statutory Duty																										
STA001	Q3 2013/14	Absence of a robust process for management of conflict of interests could lead to flawed decision making and/or legal challenge.	All	Statutory Duty	Chief Delivery and Integration Officer (Tracy Jeffes)	Standards of Business Conduct Policy ratified Conflicts of Interest Policy Declarations of Interest at each Committee/Governing Body Agenda Register of Interests in place & publicly available COI Approvals Panel Terms of Reference have now been approved and the group is fully operational. Additional Strategic Governance support in place via CSU to review and enhance management of Conflicts of Interest & embedding process in CCG.	2	4	8	Final policy to be developed and presented to the Audit Committee meeting in January 2015.	March 2015	March 2015	Review and update of existing arrangements continue and involves support from the Chair of the Audit committee as well as other key CCG leads and additional Strategic Governance support via CSU. The Conflicts of Interest review took place during September and a progress update was presented to Audit Committee in October. The Audit Committee Chair is involved in this process (as well as the MIAA) and the Audit Committee welcomed progress so far. Recommendations were made in respect of improvements to the Register of Interests and these are being implemented. The work will also be linked into the Anti Bribery policy work that MIAA are undertaking and was agreed that the review would extend to November. At the end of December 2015 NHS England issued new guidance for CCGs in respect of Conflicts of Interest. The guidance was amended to better deal with conflicts of interest that may arise under new co-commissioning arrangements and the associated joint committee decision making. In order to ensure the guidance was captured in the updated policy, the submission of the new policy will now take place in March in time for implementation in 15/16. Draft Policies have now been developed in accordance with NHSE guidance and will be available for approval by Audit Committees in March	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2	4	8	▶
STA002	Q1 2014/15	Risk that patients could be harmed or receive inadequate care due to failure to implement of recommendations and action plan following CQC style Safeguarding Peer Review	Objective 5 - Implementation of 2014-15 phase of Primary Care quality strategy / transformation	Statutory Duty	Chief Nurse (Debbie Fagan)	CCG Authorised without conditions (by NHS England). Identified an internal process of assurance CCG work plan with MIAA in 14/15 to include review of CCG Safeguarding arrangements Outcomes shared with RIV and CCG network. Priority area re Voice of Children and Young People's/Vulnerable Adults is an agenda item for EPEG Recommendations and updates regularly reported to the Quality Committee. Steering Group established. Review and updates presented to the Safeguarding Adults Board and Safeguarding Children's Board. A finalised Memorandum of Understanding A finalised Service Specification	2	4	8	~~Draft Memorandum's of Understanding (MoU) specification to be presented to Safeguarding Steering Group for sign off November/December 2014.~~ Completed Position going to advert February 2015.	~~December 2014~~ March 2015	~~January 2015~~ April 2015	Executive Summary recommendations to Quality Committee June 2014., with updated action plans presented August and October 2014. Share outcome of RIV and CCG Network: fed back re establishment of Steering Group. Steering Group now set-up and dates set for forth coming meetings. Peer review presented to CCG Governing Body in July 2014. Chief Nurse met with Safeguarding with CCG 1/8/14 to discuss progress in order to update action plan. Priority area re Voice of Children and Young People's/Vulnerable Adults discussed at EPEG meeting in August 2014. Further work and meeting with LA to further strengthen what available locally. Review presented to Safeguarding Adult Board in October 2014. Date set to present to local Safeguarding Children's Board in December 2014 - Action plan presented to Quality Committee (QC) in October 2014. QC requested EPEG lead on Voice of Child and Young Person's action plan: QC expressed concern regarding the host's progress against their actions identified in the action plan and highlighted the need for partners to deliver against their actions. Next update to QC in January 2015: requires agreement prior to project plan rollout. - Liaison with host CCG regarding deliverables that are dependent on hosted services - continues. - Draft Memorandum's of Understanding (MoU) specification to be presented to Safeguarding Steering Group for sign off November/December 2014. Service specification to inform MoU developed and awaiting finalisation. Updated CCG action plan shows positive improvement against action plan. Position of MoU to be confirmed. MoU and service specification now finalised. - Job Descriptions for named GP finalised: waiting confirmation of contractual issues, then out to advert. Finance confirmed, going to advert February 2015. Recruitment has commenced. Update received at Steering Group in February 2015. Will inform the update of the CCG Action Plan. Safeguarding Strategy approved by Quality Committee who have recommended it be approved by the Governing Body.	2x4	2x4	2x4	2x4	2x4	2x4	2x4	2x4	1x4	1	4	4	▶

Quarter 4 (March) 2014/15

Last Saved: 23/12/2014

By User: Judy.Graves

▼ Risk reduced
► Risk unchanged
▲ Risk increased

ID	Date Added	Principal Risk	2014/15 Strategic Objective	Domain Type2	Risk Owner	Identified Controls in Place	L	C	Initial Risk Rating	Additional controls required	Due Date	Review Due	Progress against action Plan	Q1	Q1+1 (Jul 2014)	Q1+2 (Aug 2014)	Q2 (Sept 2014)	Q2+1 (Oct 2014)	Q2+2 (Nov 2014)	Q3	Q3+1	Q3+2	L	C	Q4	Change Since Last Update
STA003	Q1+2 (August) 2014/15	Risk that patients could be harmed or receive inadequate care due to failure to implement CCG statutory requirements detailed within the new Special Education needs Code of Practice for Children and Young People	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Statutory Duty	Chief Nurse (Debbie Fagan)	Commissioned CSU to support the CCG to develop systems and processes. CCG are part of the local partnership in delivering this agenda: sit as part of the Steering Group. Chief Nurse Chairs Joint Commissioning Task and Finish Group. SMT receiving progress updates on delivery. Provider performance also on agenda and discussed at Quality Contract meetings. Chief Nurse undertaking role of designated Medical Officer. Jointly commissioned arrangements in place for Health Co-ordinator. Updates received by Governing Body Provider performance discussed at Quality Committee	3	4	12	Highlight the issues at SMT and Governing Body	Ongoing		CSU team have presented at SMT progress to date on delivery with a further update given in August 2014. Governing Body have been provided update in Chief Officer report Identified Chief Nurse to undertake role of designated Medical Officer while further models are considered: implemented 1st September 2014. Discussed provider performance at the Quality Contract meeting and linked waiting times for specified services to what may be required as part of Health & Education Plan. Links between requirements for SEN and personalisation made to general work being undertaken within CCG around personal health budgets. Jointly commissioned arrangements in place at LCCG for a Health Co-ordinator post within LCH to co-ordinate health needs to be part of Educate and Health Care Plan (EHCP). Awaiting confirmation from Sefton council of transition funding that may be made available to CCG to commission the health input into the transitioning of statements for children and young people to EHCP: expected October/November 2014. Still waiting confirmation from the local authority (LA) regarding transition funding: Chief Nurse has requested information from LA however not received. Has been escalated to Chief Officer. Still awaiting confirmation. 02/02/15 - e-mail received from CSU confirming the role of the project management function of the LA. Narrative has been provided to the LA to support the request for funding for transition plans. Awaiting response from LA. Still awaiting final agreement for funding to be given to CCG from Local Authority: to commission support for transition plans i.e. statements to Education Health Care Plan.	N/A	N/A	3x4	1x4	1x4	1x4	1x4	1x4	1x4	1	4	4	►
NEW STA004	Q4	Risk that patients could be harmed or receive inadequate care due to poor practice and/or lack of compliance with standards at provider trust.	Objective 1 - Improved quality of commissioned services, whilst achieving financial balance	Statutory Duty	Chief Strategy & Outcomes Officer (Karl McCluskey)	- Joint Governing Body Development Sessions - detailed analysis on specialities	4	4	16	Need to ensure quality and constitutional standards are maintained in all areas of delivery. Awaiting publication of CQC Reports	March 2015	March 2015	Ongoing challenges for short and long-term delivery: - Analysis carried out on some specialities - Joint Governing Body Development sessions established. First meeting held. - links established with supporting authorities	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4	4	16	N/A

MEETING OF THE GOVERNING BODY
MAY 2015

Agenda Item: 15/95	**Author of the Paper:** Tracy Jeffes Chief Delivery and Integration Officer Email: Tracy.Jeffes@southseftonccg.nhs.uk Tel: 0151 247 7049
Report date: May 2015	

Title: Corporate Objectives 2015/16

Summary/Key Issues:

The CCG has revisited its current Corporate Objectives and developed a proposal for 2015/16.

The proposed Corporate Objectives were discussed at the CCG Senior Leadership Team and Operational Team meeting in May 2015.

Recommendation

The Governing Body is asked to approve this report.

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				
Clinical Engagement	x			
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees	x			

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

Report to the Governing Body
May 2015

1. Introduction and Background

1.1 The CCG has revisited its current Corporate Objectives and developed a proposal for 2015/16.

1.2 The proposed Corporate Objectives were discussed at the CCG Senior Leadership Team and Operational Team meetings in May 2015.

2. Proposed Corporate Objectives 2015/16

1 To place clinical leadership at the heart of localities to drive transformational change.

2 To develop the integration agenda across health and social care.

3 To consolidate the Estates Plan and develop one new project for March 2016.

4 To publish plans for community services and commission for March 2016.

5 To commission new care pathways for mental health.

6 To achieve Phase 1 of Primary Care transformation.

7 To achieve financial duties and commission high quality care.

3. Recommendations

The Governing Body is asked to approve the proposed Corporate Objectives for 2015/16.

Tracy Jeffes
Chief Delivery and Integration Officer
May 2015

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/96	**Author of the Paper:** Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southportandformbyccg.nhs.uk Tel: 0151 247 7006
Report date: May 2015	

Title: Draft Commissioning Strategy, Vision and Blueprints for Transformation Programmes

Summary/Key Issues:

This paper sets out a clear commissioning strategy vision and blueprints in support of the CCG strategic plan. One year in to the five year strategic plan, the CCG has undertaken a review of its priorities, approach and direction of travel. While the priorities remain the same, the CCG has recognised the need for increased focus on delivery, with a much greater emphasis on locality working. The blueprints have been developed in conjunction with the respective clinical and managerial leads and include high level plans which are integrated with each other to progress the transformation of commission services that the CCG aspires to as part of its overall strategy.

The CCG has affirmed its focus on the two strategic programmes of CVD and respiratory. It has now cemented blueprints (primary care, community support, intermediate care, mental health and unplanned care). These are all locality facing and aimed at building services at a local level to support localities in providing the optimum care closer to home and avoiding unnecessary hospitalisation.

Recommendation

The Governing Body is asked to approve the commissioning strategy and endorse the prioritisation of the blueprints, with a real emphasis and focus on locality delivery.

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 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	x			
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement	x			
Presented to other Committees	x			Presented to the Service Improvement and Redesign Committee

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

DRAFT COMMISSIONING STRATEGY, VISION AND BLUEPRINT FOR TRANSFORMATION PROGRAMMES

Southport and Formby CCG and South Sefton CCG Version 1.7 – May 2015

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

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FOREWORD

Over the last year our two Clinical Commissioning Groups, South Sefton and Southport and Formby have spoken to people across Sefton about their own health conditions, the services they access, their experiences of local health care and the kind of care and support they want to help them get back to independent living.

The case for change across the whole health and social care system is made by the need to address the demands arising from an ageing population, increasing numbers of people with multiple long-term conditions and significant reductions in public expenditure.

Developing integrated care means overcoming barriers between primary and secondary care, physical and mental health, and health and social care to provide the right care at the right time in the right place. We are therefore working in collaboration with our health and social care colleagues and partners across Sefton to define the ***'New Models of Care'*** required for Sefton residents, with a particular emphasis on ***'Integrated Care'***.

Delivery of these models requires strong leadership, effective partnership working and a commitment to deliver change. Success will be measured on the improved health and care outcomes for our Sefton residents.

As public sector organisations we are facing unprecedented challenges and we need to ensure we can support increasing demand, as well as improving the quality of care provided patients, with more limited resource.

To be signed by Fiona and each chair?

Plus pics?

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 wellbeing of our population

DRAFT

EXECUTIVE SUMMARY

Clinical commissioning groups are the statutory bodies responsible for commissioning local health services for local communities. The people we serve deserve to have a premium quality health service. Working together, South Sefton and Southport and Formby clinical commissioning groups have engaged with key stakeholders in the wider local health economy and with local people to identify priorities for improving health and health care.

As two CCGs we have identified three main strategic priority areas as the focus for all our work:

- Caring for our older and vulnerable residents
- Unplanned care
- Primary care

This strategy is at a point in time in terms of its development and alignment. Alongside the development of the CCG plans, we are working with partners on the delivery of our system wide Vision for 2020. In recent weeks the CCGs and its partners across health and social care have begun a process to strengthen planning and delivery of our future system and this was launched through a successful event titled 'Shaping Sefton', held in February 2015.

The event was supported by the King's Fund, who demonstrated evidence of the benefits, in particular to the experience of service users and their families, seen when organisations and services work together, make a compelling case for care to be co-ordinated around the needs of people and populations.

We will build on this event and undertake an in depth process with our partners to include more detailed agreement of the whole system programmes to be undertaken and work to establish cross-organisation governance protocols.

Therefore the CCGs key transformational programmes described later in this document are representative in terms of purpose and content, but will continue to be refined as we work with partners in the system to develop plans and mobilse resources. The intention is to harmonise effort into one single plan for the system.

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Integrated care is a key lever to commission for patient outcomes. From direct NHS health care services through to social care and voluntary services, who can provide additional on-going support for recovery and management. Every service provider will be expected to work together to improve overall outcomes of service users.

Whilst there are services available in the community to support people to manage their long term conditions and help prevent hospital admissions, these are not comprehensive and sometimes 'dis-jointed', also information sharing is limited. Services are not always straight forward to access or able to offer a rapid response and are not as well-known as emergency departments.

We will commission integrated out of hospital services, which support all patients especially those with long term conditions. In doing so, we aim to:

- Decrease the gap between expected prevalence and recorded prevalence of long term conditions
- Improve the health outcomes for people who have been diagnosed with a long term condition
- Increase the provision of healthcare in the community for people who have been diagnosed with a long term condition
- Reduce inequalities in the identification of treatment and services for people with long term conditions
- Support people with long term conditions to maintain their quality of life through being better able to manage their own care
- Provide more care closer to home

We are keen to drive forward integrated care, giving explicit consideration to ways we can increase joint working.

We will systematically implement:

Risk profiling, integrated services, care planning and self-management

Fewer unplanned admissions, better patient outcomes and satisfacton, improved quality of care

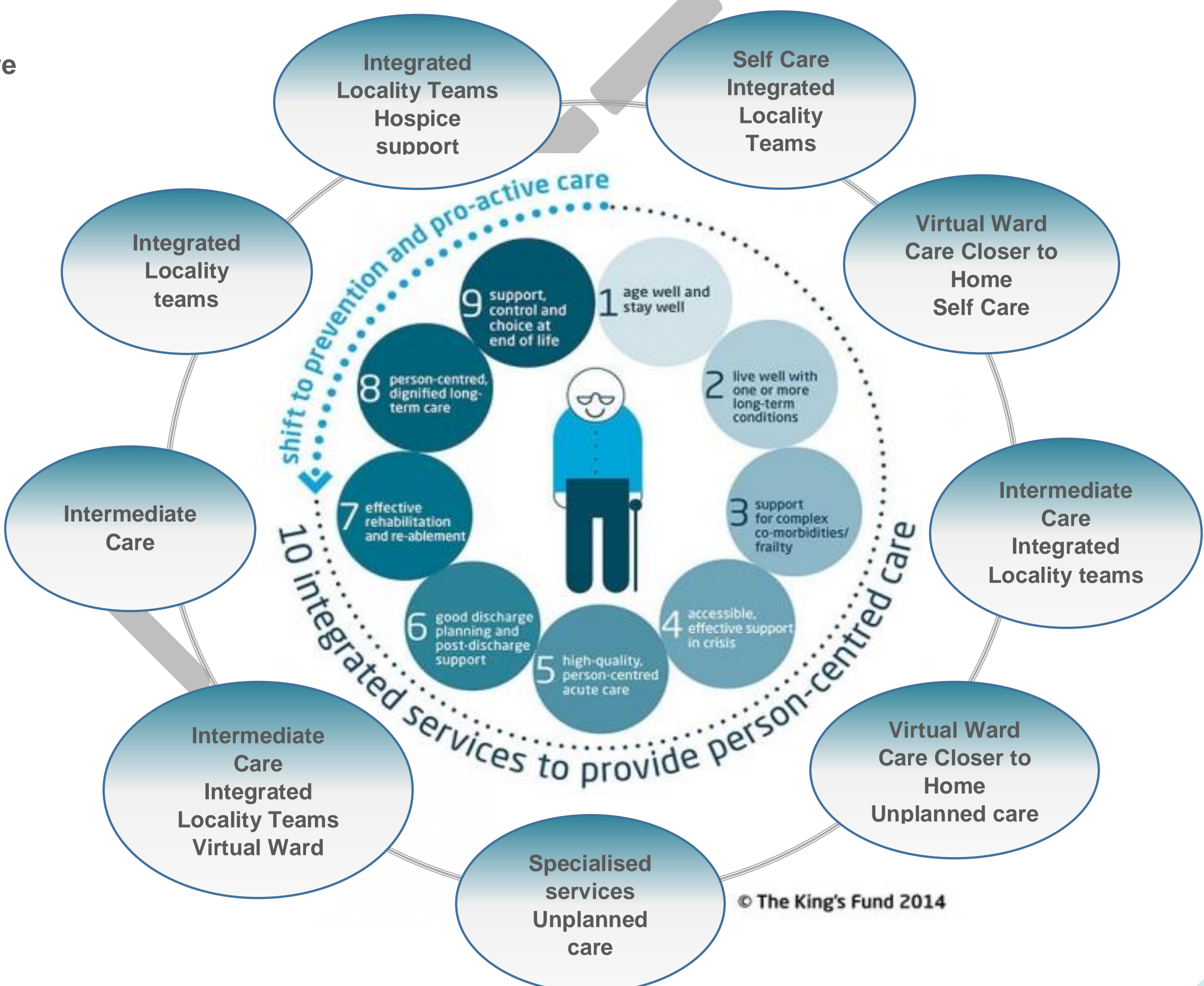
DRAFT

The core of the diagram below has been developed by the Kings Fund and outlines the different stages of care, it has been enhanced to show what services in Sefton available to support our residents at each of the individual stages. The vision will be to deliver care at neighbourhood level through integrated locality teams based on the needs of the residents.

Diagram one:
Components of Care

South Sefton Localities:
- Bootle
- Crosby
- Maghull
- Seaforth and Litherland

Southport and Formby Localities:
- Ainsdale & Birkdale
- Central Southport
- Formby
- North Southport

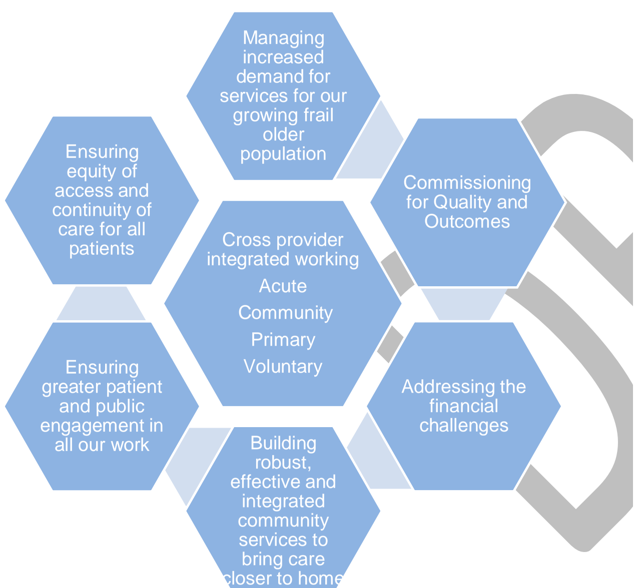


INTRODUCTION

The purpose of this document is to describe the aims and ambitions for our transformation programmes and how we are working across the health and social care system to improve quality and outcomes for our patients, as well as drive efficiencies and achieve sustainable services that meet the needs of our local population and improve outcomes. This documents articulates the changes required within the Sefton health and social care system and how the commitments made to implement our vision are being translated into programmes of work.

We describe our major transformation programmes, highlighting what we are doing and how we plan to do it amidst a national context of profound financial challenge.

We know there are specific underlying challenges in our local health economy that we must address over the next two years and into the future if we are to achieve our vision:



- The system is too complicated: it has grown organically, not strategically
- Access to many services is limited, because the system is difficult for both patients and professionals to navigate
- In particular, the system is failing to provide co-ordinated and integrated care for frail elderly and patients with complex needs
- Prevention and early treatment services are often inadequate, allowing patients to continue ‘cycling’ around the system until their issue become acute
- A&E is the easiest part of the system for patients to access, hence receives the largest flows
- Queues build up in A&E as a result of difficulties with flow management
- Information is not shared effectively between, and sometimes within, provider organisations

BLUEPRINT

A blueprint is used to define a programme of transformational change. It articulates the future state in more detail than a high-level vision and sets out the operational capability that will need to be put in place to enable the required outcomes and benefits. The blueprint comprises the key aspects of the business operations of not only the CCGs but also all stakeholders that must change for the system to work.

This document provides an outline of how comprehensive healthcare services for physical and mental health for all age groups and its interactions with social care could be configured in the future to maintain and improve patient experience and clinical outcomes while demand for care increases despite increasingly tight budgetary constraints.

It is a model for how services should be configured regardless of the organisations involved of its delivery. It has been designed based on input by a broad base of stakeholders that included representatives of all local providers, commissioners, patients and the general public of Sefton. We will build on this model with our partners to include more detailed agreement of the whole system programmes to be undertaken and work to establish cross-organisation governance protocols

This document is focused on the following Transformational Programmes currently underway across Southport and Formby CCG and South Sefton CCG:

- Primary Care
- Community Care
- Intermediate Care
- Urgent Care
- Mental Health

These programmes are central to our vision for integrated, personalised services in Sefton. An additional work programme focussing on elective and planned care is currently being scoped to identify additional opportunities to provide care closer to home.

A whole system approach has been developed to focus the model of care required to deliver integrated services. The system blueprint model for integrated services is shown in Diagram two below:

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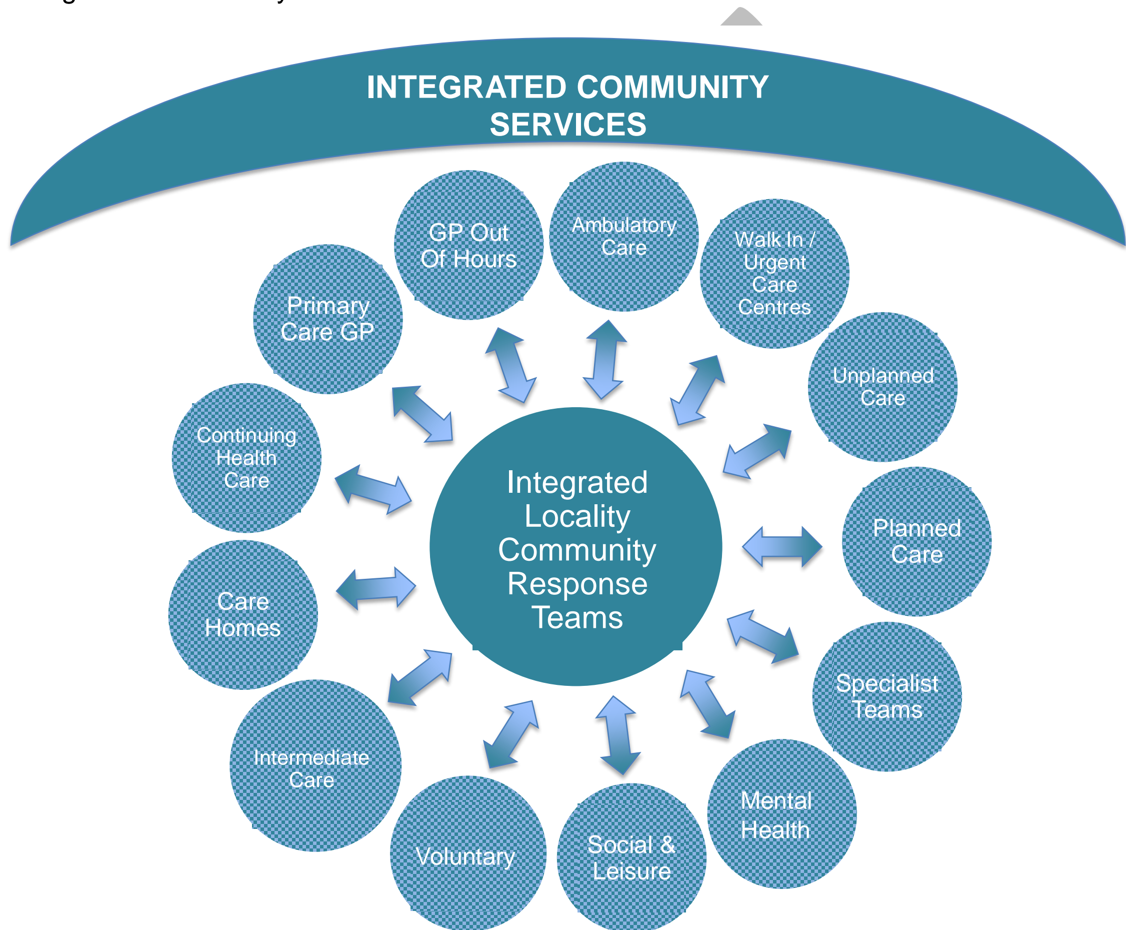
Diagram Two:

System blueprint for Integrated Community Services



OUR VISION - SOUTH SEFTON AND SOUTHPORT AND FORMBY CLINICAL COMMISSIONG GROUPS

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 wellbeing of our population

Our vision will be delivered in collaboration with our partners through our high impact transformation programmes. These programmes will focus on three key principles:

- Whole system transformation with collective ownership and culture change of all partners
- Patient pathways rather than organisational structures
- Clinical and patient led

OUR AIMS

- An empowered workforce with a common understanding of our vision
- Breaking down of silos – building trust amongst organisations
- Organisations have shared responsibility for issues in the health economy
- Autonomy to act beyond organisational boundaries

KEY ENABLERS

- Access to shared medical records and care plans for all care professionals anywhere
- Improved communications and relationships between all care professionals
- Risk management across the system contributing to more efficient and effective care (financial risk and clinical governance)
- Financial and contractual levers aligned

KEY DELIVERABLES

- Reduce hospital avoidable deaths by 13%
- Improve health related quality of life for people with one or more long term conditions by 8.5%
- Reduce emergency admissions by 20%
- Achieve a 3.5% reduction in non-elective activity
- Improve in-patient experience by 13%
- Improve patient experience in GP and out of hours care by 30%

POTENTIAL CHALLENGES TO DELIVERY:

- Cultural differences between professional groups
- Different workforce terms and conditions
- Technology solutions for data/information sharing
- Differential financial pressures

NEXT STEPS

- Undertake an in depth process with our partners to include more detailed agreement of the whole system programmes enabled through the overarching Shaping Sefton programme
- Establish cross-organisation governance protocols
- Agree phased priority approach
- On-going evidence-based analysis of outcomes of new care models
- Regular review of programmes against plan
- Changes to be implemented from years 2015/16, with whole system change embedded by 2020

This document, and our vision for integrated and co-ordinated care, aligns to the vision and objectives set-out in The NHS Five Year Forward View "High quality care for all, now and for future generations"[1].

It also supports the recommendations outlined in The Dalton Review[2], which focusses on reducing variation in the quality of care across Provider organisations and developing new organisational forms. It encourages organisations to look at developing models of care that best suit local circumstances and individuals rather than existing organisational structures. This document reflects those recommendations and focusses on the patient receiving the right care at the right time and in the right place.

Integration is built upon collaborative working, shared decision making and jointly defined priorities. We have worked with our partners and patient representative groups to ensure our local priorities are appropriately aligned.

[1] Five Year Forward View NHS England October 2014 http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
[2] Examining new options and opportunities for providers of NHS care The Dalton Review December 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf

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BETTER CARE FUND

The Better Care Fund (BCF) provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients, services users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare the Better Care Fund in 2015/16[3]. Local Better Care Fund plans must meet a number of national conditions:

- Plans must be jointly agreed and include an explanation of how local adult social care services will be protected;
- Include how 7-day services in health and social care will support patients being discharged and prevent unnecessary admissions at weekends;
- Use the NHS number to enable better data sharing between health and social care;
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional; and
- Consider the impact of changes on the acute sector.

The Health and Wellbeing Board in Sefton has worked together with local people, communities and partners to develop a Vision for the Borough. Our vision is:

Together we are Sefton – a great place to be!

We will work as one Sefton for the benefit of local people, businesses and visitors

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

Our vision for integration is to deliver personalised coordinated care,

health and wellbeing services with, and around, the person

[3] http://www.england.nhs.uk/wp-content/uploads/2015/03/bcf-operationalisation-guidance-1516.pdf

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

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

We will work with parents and carers so that all children and young people have opportunities to become healthy and fulfilled adults, and create a place where older people can live, work and enjoy life as valued members of the community. We will seek to improve opportunities and support residents to make choices so that people are able to live, work and spend their time in a safe and healthy environment, and provide early support so that people can remain independent for longer.

We aim to provide cost effective support in the right place, at the right time, at the right quality, and we will seek to achieve this by focussing on the following key integration schemes:

- Promoting self care, well-being and prevention through the development of an ***Integrated Wellness and Health Improvement Service***, a Healthy Places Healthy Homes initiative (to address housing, environment, transport and employment) and a robust information and advice service. The Healthy Places scheme seeks to tackle the "causes of the causes" of ill health and reduce demand on both wellness and illness services
- Building on the existing ***Virtual Ward and Care Closer to Home programmes*** to deliver *integrated care at a locality level* - which will deliver greater coherence of processes, methods and tools used by all at a locality level, supported by integrated teams; - *delivering better patient experience and health outcomes in support of a reduction in unplanned admissions to hospital*
- Deliver *a **new Intermediate Care and Reablement pathway*** to support more people to receive intermediate care and reablement services based on need and pulling together a joint strategy for intermediate care focussing on delivering care closer to home; *with the aim of helping people regain their ability to carry out activities of daily living and reduce need for long term care packages*

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These schemes will offer better, early intervention and prevention opportunities promoting greater self-care/self-help/self-management and a reduction on reliance of public sector services. This will be achieved by appropriate advice and information, and integrated approaches to service provision across professional and organisational boundaries through a single point of access (a seamless front door).

These schemes align to the CCGs transformation programmes and will be supported by a series of enablers, namely:

- a single point of access for all service users, supported by integrated single assessments
- transformational leadership - changing behaviours and cultures in the workforce
- enablement of appropriate sharing of person specific data, risk stratification tools and information across partner agencies
- a consistency of messages through a regular communications and engagement process
- an integrated approach across the CCG's and Council, whereby all engagement relates and contextualises integration and the Better Care Fund as part of our joint strategic approach
- development of a robust integrated commissioning process for all health and social care provision
- support for the changes, through effective finance & resource management

We are focusing on a core cohort of people – those with mental health issues, dementia, and other long term conditions and the frail elderly and people who care for others - an approach which aligns with the continued ambitions of the Health and Wellbeing Board in protecting the most vulnerable.

These deliverables are consistent with, and evidenced through, the feedback and data within our Sefton Strategic Needs Assessment, the Health and Wellbeing Strategy, the Strategic Plans for NHS Southport and Formby and South Sefton CCGs as well various forums and patient engagement events - including "Big Chat", "Mini Chat" and "Community Chats" events hosted throughout the Borough. The Health and Wellbeing Board has also utilised the National Voices approach to ensure that the public, patients and service users (including carers) have directly influenced the priorities within our Health and Wellbeing Strategy.

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SEFTON PEOPLE AND THEIR NEEDS

Sefton Strategic Needs Assessment

The Sefton Strategic Needs Assessment (SSNA) [4] provides the data and intelligence on which the commissioning and delivery of health and social care services is based. We have a duty to have regard to the SSNA when developing our plans for health services for the local population. Sefton Council also use the SSNA to shape commissioning strategies for adult, children's and public health services. Together, the partners on the Health and Wellbeing Board use the SSNA to set the Sefton Health and Wellbeing Strategy 'Living Well in Sefton' and inform joint commissioning priorities.

The SSNA 2014/15 has taken a different approach to previous years and is based on the principle that understanding health and wellbeing first requires an understanding of the ***people*** who live and work in the Borough, the ***place*** and the influences on health across the ***life course*** (being born, growing up, being an adult and growing old in Sefton). The benefit of this life course approach is that it encourages thinking around the broad range of factors that impact on health and wellbeing at different stages of life and helps to promote a joined up strategic approach across the Health and Wellbeing Board and its partners.

A summary of the key issues, are included below.

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[4] http://sefton.gov.uk/your-council/plans-policies/strategic-needs-assessment-(ssna).aspx

SEFTON PEOPLE AND THEIR HEALTH NEEDS

Children and Young People

- One in five children live in **low income** families
- One in five 14-17 year olds state they drink **alcohol** once a week
- 13% of 14-17 year olds claim to **smoke**
- By year 6 one in three children are **overweight or obese**
- **Low birth weight** babies

Long Term Conditions

- One in four have their day-to-day **activities limited** due to a long term condition
- **COPD** – two out of every three sufferers resides in South Sefton
- More than 11,000 Sefton residents are registered as having **chronic liver disease**
- 13,171 residents suffer from **Diabetes** which is predicted to increase by 14% by 2030
- One in 16 suffer from **Asthma**
- One in six suffer from **high blood pressure**
- Incidence rate of **Cancer** in Sefton is significantly higher than the national rate

Older People

- **Ageing population** set to increase further by 2021
- 49% predicted increase in **Dementia** sufferers between 2015 and 2030
- 57% of **Diabetes** sufferers over 65
- **Joint replacements** account for 15% of elective admissions
- Higher mortality rates for **COPD** and **Heart Attack** against the national average

Lifestyle

- 560 patients admitted annually to hospital with **drug** related conditions
- One in five adults admit to **binge drinking**
- One in five adults are **smokers**
- 14.7% of pregnant mothers are **smokers** at time of delivery
- More than half of adults in Sefton are **overweight, obese** or **very obese**
- 7.3% of Sefton residents classify themselves as in **bad** / **very bad health**, compared to 5.5% across England

Mental Health

- Around one in five females and one in eight males are thought to have some sort of **mental illness**
- South Sefton CCG amongst top 10% of CCGs for sufferers of **Depression**
- **Anti depressant** prescribing in Sefton in 13/14 totalled £1.7m
- Three in four **suicides** are male
- There has been a 47% increase in emergency hospital admissions over the last five years for people with **Schizophrenia**

Further detailed information on both the JSNA and the Health and Wellbeing Strategy can be found at:

http://sefton.gov.uk/your-council/plans-policies/strategic-needs-assessment-(ssna).aspx

http://www.sefton.gov.uk/media/450582/health-wellbeing-strategy-2014.pdf

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OUR STRATEGIC PLANNING PROCESS

Throughout 2014 a series of events and meetings were held to inform and support the future model of commissioning for South Sefton CCG and Southport and Formby CCG. Partners from across the health economy including, patients, clinicians, and representatives from the community and voluntary sector were invited to these events and the outputs have informed the future model described in this document.

Both Commissioners and Providers of services to the localities have agreed that the work must focus on meeting population health needs, patients must be at the centre of this transformation.

The size of this change cannot be underestimated. It is a large scale change in terms of the level of ambition, the number of organisations involved and the emergent final state. The scale of change is a leadership challenge and will require distributed leadership to deliver the significant process, structure and cultural change.

The next steps will be for the health economy to continue working together to agree the financial and activity/contractual agreements and for operational and clinical staff to work together across organisational boundaries to deliver the vision for the Sefton population.

We will deliver our vision through the following five transformational programmes:	
Primary Care	**We will develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service.**
Community Care	**We will commission services that better link together right across health and social care – from hospital and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.**
Unplanned Care	**We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.**

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Intermediate Care	Our aim is to have ONE point of access, ONE assessment, ONE care planning process. We will do this by commissioning co-ordinated care for patients via integrated services and be responsive to patients needs.
Mental Health	Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long term neurological condition within community based networks of care

Our transformation service models will all encompass the following six characteristics:

New approaches to ensuring the citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care	**Wider primary care provided at scale, bringing services closer to home**	**A model of integrated care between health, social and the third sector**
Access to the highest quality urgent and emergency care when appropriate	**A stepped change in the productivity of elective care**	**Specialised services concentrated in centres of excellence**

PHASED DELIVERY APPROACH:

Throughout the planning of our programmes we are adopting a four phased delivery approached, outlined below:

Phased Approach			
Phase One Assessment	**Phase two Strategic Planning**	**Phase three Implementation**	**Phase four Delivery**
Situation summary Recognise the need for change either to solve a problem or take advantage of an opportunity ➢ Review evidence that a change is required via stakeholder engagement, data analysis and reports on service provision. Test out others' views on the need for change ➢ Networking and establishing connections across health and social care to test current service provision including review of patient experience data Using appropriate diagnostic techniques, confirm the presence of hard complexity and difficulty rather than a mess ➢ Current data analysis re patient flows between services in acute and community, interaction with third sector organisations	**Generate options** Develop ideas for change into clear options for achievement of the objectives ➢ Engage provider re discussions about areas of excellence in service provision and ideas the provider and local authority may have re service improvement. Understand national examples of excellence. Consider range of options ➢ Link providers to consider alternative provision	**Develop Implementation strategies** Select preferred options and plan how to implement ➢ Finalise implementation plan with CCG, providers and Local Authority ➢ Agree implementation plan with provider	**Implement performance dashboard** Agree set of metrics to be monitored and reported on ➢ Discuss and agree with Providers as necessary

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Identify objectives and constraints	**Edit options and detail selected options**	**Carry out the planned changes**	**Monitor Activity and Performance**
Set up objectives for systems of interest ➢ Review national guidance as to performance measures. ➢ Understand referral patterns and challenges to service delivery.	Fully describe chosen option ➢ Present findings to senior leadership team within the CCG and Local Authority ➢ Informal sharing with providers Decide what is in scope and how it will work ➢ Understand wider financial pressures and impact upon project. ➢ Agree financial value to provide scope for changes Open engagement with provider as to change model ➢ Link with provider organisations to discuss and shape likely vision for future delivery Consider whether higher level change is feasible ➢ Understand funding mechanism arrangements between CCG and local authority. Develop operational detail of pathway ➢ Plan stakeholder engagement event, in partnership between CCG, Local Authority, acute and community providers, to understand the challenges and	Involve all interested parties ➢ Seek approval from CCG Membership ➢ Seek ratification by CCG Board ➢ Publish Strategy Allocate responsibilities ➢ Discussions with provider ➢ Agree Commissioning Intentions ➢ Contractual levers Monitor progress ➢ Develop performance dashboard	Receive activity reports ➢ Frequency to be agreed dependent upon provider/activity ➢ To be based on outcomes Report Activity ➢ Agree reporting structure and frequency to various stakeholders Highlight issues ➢ Review activity and performance and highlight issues/concerns with relevant provider and SMT

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	facilitate discussions to progress project.		
Identify performance and measures Describe how the achievement of the objectives can be measured ➢ Discuss feasibility of data collection with service providers. Benchmark service delivery – outcomes and performance - against proposed measures ➢ Request and collate evidence from providers Benchmark service delivery – patient experience - against proposed measures ➢ Request and collate evidence from providers to form benchmark against which to monitor future performance.	**Evaluate options and measures** Finalise operational details of pathway ➢ Summarise findings and circulate to all parties. ➢ Evaluate requirement for framework/memorandum of understand. Evaluate the performance of the chosen options against performance criteria identified ➢ Formally present outline strategy to CCG and local authority ➢ Outline new performance measures with providers and reinforce data collection Wider clinical engagement ➢ Engage clinicians for comments on strategy		
	Governance Strategic and operationalisation ➢ Draft Governance framework ➢ Agree Governance framework Legal framework ➢ Draft Memorandum of Understanding ➢ Execute Memorandum of Understanding		

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FINANCIAL

The overriding financial strategy is to safeguard a long term sustainable financial position which ensures the CCGs overall objectives around patient care for our population can be achieved.

This can only be attained through sensible and realistic financial planning, a measured approach to risk and long term view of the local health system, which will mean difficult financial decisions will have to be taken.

Sefton health economy faces significant financial pressures - those experienced currently requiring additional support, and those anticipated into the future for which there is unlikely to be support available from external sources. This means that the basis upon which commissioners fund services will need to change radically so that it can continue to provide for the care needs of the community now and into the future.

Significant investment is going to be required to redesign and rebalance the system so that it is both effective and affordable. For us to manage pressures in a sustainable way the shape and size of existing providers will need to change dramatically, with more care being provided outside of acute settings and greater emphasis on community partners to manage and reduce overall demand entering into the care system. We will need to work collectively across the health and social care system to share resources and remove unnecessary duplication. Patient centred care provision will mean cross organisational boundaries and funding mechanisms need to change to facilitate and incentivise this.

Projected gap in 5 year if do nothing

The choice to 'Do Nothing' is not an option, outlined below is the annual profile. You will notice the pressure is primarily front-loaded in 15/16 and 16/17 this is to embed the transformational programmes outlined in the blueprint.

		2015/16 (£m)	2016/17 (£m)	2017/18 (£m)	2018/19 (£m)	Total (£m)
Southport and Formby CCG	Incremental QIPP Requirement	6,052	3,622	772	1,066	11,512
South Sefton CCG	Incremental QIPP Requirement	3,437	4,904	1,361	1,966	11,668

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Diagrams 3 and 4 below illustrate each CCG's spending on health by high level category of care

Diagram 3: South Sefton CCG total budget spend = approximately £230m

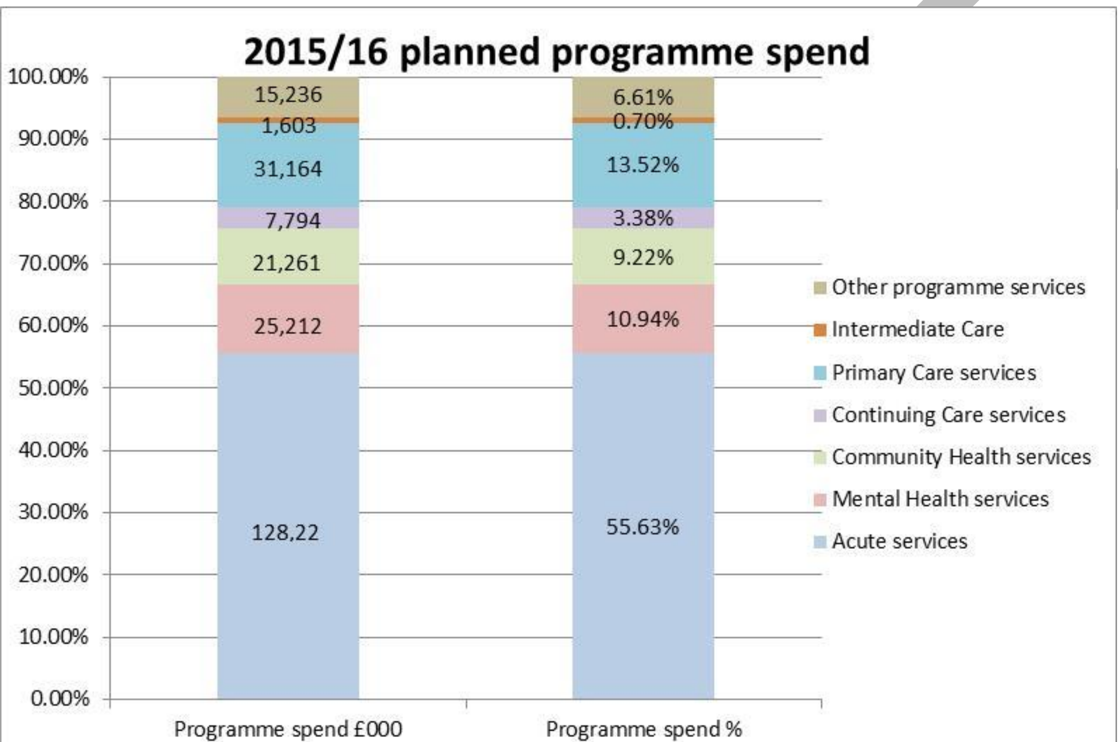

Diagram 4: Southport and Formby CCG total budget spend = approximately £170m

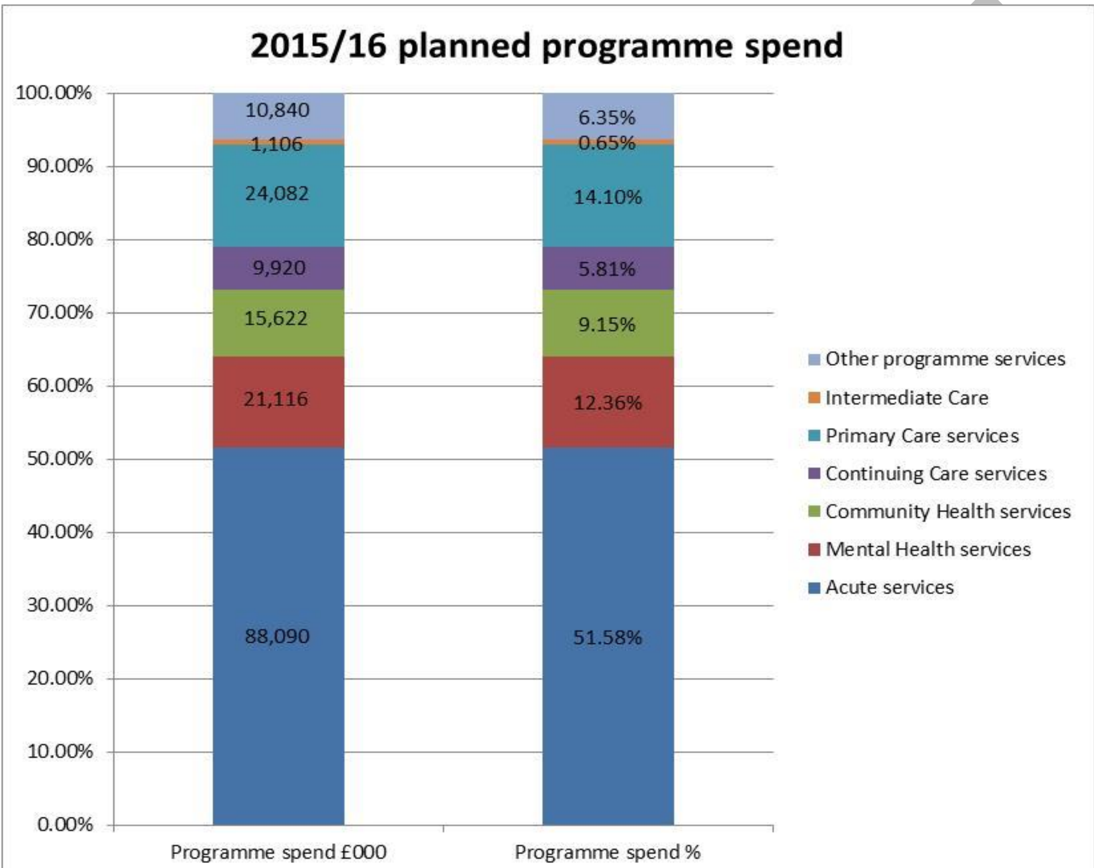

Table one below outlines the potential savings that could be generated from a 15% reduction in unplanned admissions for South Sefton CCG

Table 1: 15% reduction in unplanned admissions

South Sefton CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	£21,796,036	11,804	£26,155,244	14,165
Alder Hey Childrens NHS F/T	£973,958	681	£1,168,749	817
Central Manchester University Hospitals Nhs Foundation Trust	£4,800	5	£5,760	6
Countess of Chester Hospital NHS Foundation Trust	£9,464	10	£11,357	12
East Cheshire NHS Trust	£1,099	2	£1,318	2
Liverpool Heart and Chest NHS F/T	£108,226	50	£129,872	60
Liverpool Womens Hospital NHS F/T	£2,157,781	1,233	£2,589,338	1,480
Royal Liverpool & Broadgreen Hospitals	£1,398,842	841	£1,678,611	1,009
Southport & Ormskirk Hospital	£1,657,495	1,484	£1,988,994	1,781
ST Helens & Knowsley Hospitals	£268,465	231	£322,158	277
University Hospital Of South Manchester Nhs Foundation Trust	£1,867	3	£2,240	4
Wirral University Hospital NHS F/T	£53,007	53	£63,609	64
Wrightington, Wigan And Leigh Nhs Foundation Trust	£13,407	8	£16,088	10
			£34,133,337	**19,686**
	Average price			£1,734
	15% reduction in activity			2952.9
	15% reduction in cost at average Non-elective tariff			**£5,120,001**

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Table two below outlines the potential savings that could be generated from a 15% reduction in unplanned admissions for Southport and Formby CCG

Table 2: 15% reduction in unplanned admissions

Southport and Formby CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	593,553	309	£712,264	371
Alder Hey Childrens NHS F/T	293,583	172	£352,300	206
Central Manchester University Hospitals Nhs Foundation Trust	13,076	16	£15,691	19
Countess of Chester Hospital NHS Foundation Trust	1,239	2	£1,486	2
East Cheshire NHS Trust	1,604	2	£1,925	2
Liverpool Heart and Chest NHS F/T	338,420	103	£406,104	124
Liverpool Womens Hospital NHS F/T	142,928	78	£171,514	94
Royal Liverpool & Broadgreen Hospitals	446,341	203	£535,609	244
Southport & Ormskirk Hospital	19,704,834	12,891	£23,645,800	15,469
ST Helens & Knowsley Hospitals	142,439	119	£170,927	143
University Hospital Of South Manchester Nhs Foundation Trust	5,373	9	£6,448	11
Wirral University Hospital NHS F/T	28,359	23	£34,031	28
Wrightington, Wigan And Leigh Nhs Foundation Trust	13,534	10	£16,241	12
			£26,070,340	**16,724**
	Average price			£1,559
	15% reduction in activity			2508.66
	15% reduction in cost at average Non-elective tariff			**£3,910,551**

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Table three below outlines the potential savings that could be generated from a 20% reduction in A&E attendances for South Sefton CCG

Table 3: 20% Reduction in A&E attendances

South Sefton CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	2,837,109	25,883	£3,404,531	31,060
Alder Hey Childrens NHS F/T	571,095	6,593	£685,313	7,912
Central Manchester University Hospitals Nhs Foundation Trust	6,569	62	£7,883	74
Countess of Chester Hospital NHS Foundation Trust	3,955	43	£4,747	52
East Cheshire NHS Trust	1,072	9	£1,287	11
Liverpool Womens Hospital NHS F/T	134,016	1,452	£160,819	1,742
Royal Liverpool & Broadgreen Hospitals	310,362	3,646	£372,435	4,375
Southport & Ormskirk Hospital	424,075	4,453	£508,890	5,344
ST Helens & Knowsley Hospitals	39,757	430	£47,709	516
University Hospital Of South Manchester Nhs Foundation Trust	2,492	25	£2,990	30
Wirral University Hospital NHS F/T	17,718	163	£21,261	196
Wrightington, Wigan And Leigh Nhs Foundation Trust	3,937	38	£4,724	46
			£5,222,589	**51,356**
	Average price			£101.69
	20% reduction in activity			10271.28
	20% reduction in cost at average A&E tariff			**£1,044,518**

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Table four below outlines the potential savings that could be generated from a 20% reduction in A&E attendances for South Sefton CCG

Table 4: 20% Reduction in A&E attendances

Southport and Formby CCG	To month 10	Activity to month 10	Forecast (cost)	Forecast (activity)
Aintree University Hospitals NHS F/T	76,183	721	£91,419	865
Alder Hey Childrens NHS F/T	37,791	443	£45,349	532
Central Manchester University Hospitals Nhs Foundation Trust	7,157	76	£8,588	91
Countess of Chester Hospital NHS Foundation Trust	3,228	32	£3,873	38
East Cheshire NHS Trust	1,086	10	£1,303	12
Liverpool Womens Hospital NHS F/T	9,033	95	£10,839	114
Royal Liverpool & Broadgreen Hospitals	55,263	657	£66,315	788
Southport & Ormskirk Hospital	3,072,763	29,930	£3,687,315	35,916
ST Helens & Knowsley Hospitals	15,584	178	£18,701	214
University Hospital Of South Manchester Nhs Foundation Trust	2,279	21	£2,734	25
Wirral University Hospital NHS F/T	4,948	48	£5,938	58
Wrightington, Wigan And Leigh Nhs Foundation Trust	4,379	44	£5,254	53
			£3,947,631	**38,706**
	Average price			£101.99
	20% reduction in activity			7741.2
	20% reduction in cost at average A&E tariff			£789,526

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Table five below outlines the potential savings that could be generated from the management of new to follow up rates for South Sefton CCG

Table 5: management of new to follow up rates

Areas identified as outliers compared to peers New to follow ups to:	Annual value of cost reduction	Reduction Average Follow up = £100
National Average: Aintree University Hospitals FT - Rheumatology	218,000	2180 appointments
National Average: Liverpool Womens Hospitals - Gynaecology	188,000	1880 appointments
National Average: Royal Liverpool Broadgreen University Hospitals - Ophthalmology	53,000	530 appointments
Current plan – Southport & Ormskirk Trust - Rheumatology	10,000	100 appointments
Current plan - Renacres – Trauma & Orthopaedics	47,000	470 appointments
Total	**516,000**	

Table six below outlines the potential savings that could be generated from the management of new to follow up rates for Southport and Formby CCG

Table 6: management of new to follow up rates

Areas identified as outliers compared to peers New to follow ups to:	Annual value of cost reduction	Reduction Average Follow up = £100
National Average: Aintree University Hospitals FT - Rheumatology	40,000	400 appointments
National Average: Liverpool Womens Hospitals - Gynaecology	27,000	270 appointments
National Average: Royal Liverpool Broadgreen University Hospitals - Ophthalmology	76,000	760 appointments
Current plan - Southport & Ormskirk Trust - Rheumatology	196,000	1960 appointments
Current plan - isight - Ophthalmology	16,000	160 appointments
Current plan - Renacres – Trauma & Orthopaedics	63,000	630 appointments
Total	**418,000**	

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Planning assumptions

The CCGs maintain a five year financial planning model that provides a view of future financial sustainability and saving requirements. This financial model has been updated in the light of NHS England Planning Guidance for 2015/16 and revised CCG allocations, both published in late December 2014.

- Key financial planning assumptions are in line with national guidance as set out in *The forward view into action: planning for 2015/16* and supporting guidance issued by NHS England;
- Funding has been set aside from the allocation received for non-recurrent expenditure as specified in the guidance. This equates to 1.0% in 2015/16, plus a further contingency of 0.5%;
- Running costs will not exceed the allocation for this purpose;
- Clinical Commissioning Groups are required to make a surplus equivalent to 1% of allocation received.

Table seven below outlines the five year planning assumptions for both CCGs.

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Table 7:

	2014 -15	2015 -16	2016 -17	2017 -18	2018 -19
	%	%	%	%	%
Allocation assumptions					
CCG Allocation Growth	2.14%	1.94%	1.30%	1.70%	1.90%
Movement to Target	0.00%	0.00%	0.00%	0.00%	0.00%
Net Growth/(reduction)	**2.14%**	**1.94%**	**1.30%**	**1.70%**	**1.90%**
Running Costs assumptions					
Running Cost Allowance		-10.00%			
Cost increase assumptions					
Tariff assumptions - provider inflation	2.80%	2.70%	4.40%	3.40%	3.40%
Tariff assumptions - provider inflation (non-acute)	2.80%	2.70%	4.40%	3.40%	3.40%
Tariff assumptions - Efficiency Savings	-4.00%	-3.50%	-4.00%	-4.00%	-4.00%
Tariff leakage - acute care	0.00%	1.50%	2.00%	2.00%	2.00%
Non-demographic growth - Prescribing	5.00%	4.00%	4.00%	4.00%	4.00%
Non-demographic growth - Acute	0.50%	0.50%	0.50%	0.50%	0.50%
Prescribing Efficiency Savings	-4.00%	-1.00%	-1.00%	-1.00%	-1.00%
Non-demographic growth - Continuing Healthcare	4.00%	5.00%	5.00%	5.00%	5.00%
Non-demographic growth - other (non acute)	0.00%	1.50%	2.00%	2.00%	2.00%
Demographic Growth	0.18%	0.15%	0.29%	0.11%	0.25%
Business Rules					
Non Recurrent requirement for CCGs	1.50%	1.00%	1.00%	1.00%	1.00%
CCG Surplus	1.00%	1.00%	1.00%	1.00%	1.00%
Contingency	0.50%	0.50%	0.50%	0.50%	0.50%
"Call to Action" Fund	1.00%				

RISK

Each organisation that are members of the Health and Wellbeing Board have their own strategic and operational risk management arrangements in place for managing risks to their business operations and the achievement of improved outcomes. Set out below articulates the approach taken by both NHS South Sefton and NHS Southport and Formby CCGs.

Since taking up its full statutory functions on 1 April 2013 the CCGs have had in place risk and assurance arrangements capable of preventing, deterring, and managing risks. The Risk Management Strategy sets out the CCG's commitment to the management of all risk using an integrated approach covering clinical, non clinical and financial risk.

The overarching broad risks to the effective implementation of the transformation programmes are as follows:

Risk Description	Mitigation Controls
The overall system's financial risk is high. Financial risks include: • Impact of CCG allocations formula • Reduction in management cost allowance • Continuing Healthcare (CHC) activity growth • Council financial position	• Working closely as a systems to achieve service transformation and avoid destabilisation • Comprehensive savings programmes (QIPP) • Plan allows for growth
Partners relationship and trust, where the challenge to each organisation is significant. There is a risk of organisations being protective and working against the best interest of the system.	• Set of principles for working together agreed • Open communications and sharing of issues • Formal and informal forums set up to discuss issues and agree delivery
Capability and capacity is a risk within organisations as the scale of the transformation stretches resources in terms of people and budgets.	• Strong programme management in place • Project support requirements identified
Joint commissioning strategies and plans do not deliver the scale of transformation required across the system.	• Continued performance management • Robust business cases • Contract levers and risk share arrangements
IT interoperability - Risk to effective delivery of integrated records, technologies and information.	• iMersey to develop IT strategy • iMersey to provide detailed implementation plan and timeline

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TRANSFORMATION PROGRAMMES:

PRIMARY CARE

Primary care, and in particular care delivered by general practitioners and practice nurses, has been the cornerstone of the healthcare system since the inception of the National Health Service (NHS) in 1948. Good quality primary care is considered an essential feature of all cost-effective healthcare systems delivering improved outcomes at lower cost and with higher patient satisfaction. General practice is often quoted as providing the majority of care in the NHS whilst utilising only 9 per cent of the budget. In the NHS in England, more than 300 million consultations take place in general practice per year, which represents 90 per cent of all NHS contacts.

The two CCGs have a three year primary care quality strategy that has been developed in partnership with our member practices and has a real focus on energising the services provided in our local surgeries. The primary care system is currently running in a highly reactive way (i.e. managing patient demand simply by working longer and harder), with little time to actively find and support patients who are in potential danger of hospitalisation. General practice and wider primary care services face increasingly unsustainable pressures:

- **An ageing population**, **growing co-morbidities** and **increasing patient expectations -** resulting in large increase in consultations, especially for older patients, e.g. 95% growth in consultation rate for people aged 85-89 in ten years up to 2008/09. Number of people with multiple long term conditions set to grow from 1.9 to 2.9 million from 2008 to 2018
- **Increasing pressure on NHS financial resources** - which will intensify further from 2015/16
- **Funding streams are complicated** – fragmented and perceived as inequitable
- **Growing dissatisfaction with access to services** - Most recent GP Patient Survey shows further reductions in satisfaction with access, both for in-hours and out-of-hours services. 76% of patients rate overall experience of making an appointment as good
- **Persistent inequalities in access & quality of primary care -** including twofold variation in GPs and nurses per head of population between more and less deprived areas
- **Growing reports of workforce pressures -** including recruitment and retention problems

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What is primary care for?

In 2007, a prominent primary care academic, Barbara Starfield, described primary care as:

"The provision of first contact, person-focused, ongoing care over time that meets the health related needs of people, referring only those too uncommon to maintain competence, and coordinates care when people receive services at other levels of care."[5]

Primary care provides universal and comprehensive access for all. It provides a holistic approach to an individual's care, diagnoses and manages disease, prevents illness and protects health by promoting healthy behaviours, having a whole population focus. It is the first element of the continuing healthcare process and supports patients to navigate across multiple care providers and settings.

What primary care represents

The general practice registered list establishes a primary care 'home' for patients, carers and their families and represents the potential for a close, direct relationship with a single coordinator of their care right from their birth through to the end of life.

We already know from our public engagement work that people in Sefton want a service that provides timely and convenient access to care. Those with more complex physical and mental health needs want a service that provides GP-patient continuity, is seamlessly coordinated and supports them to stay well.

We are committed to supporting our member practices to look at new models of care in general practice. Our aim is to develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service in support of a reduction of 15% in unplanned admissions.

A three year Local Quality Contract was introduced in August 2014, to secure investment in General Medical Practice linked to locally driven quality markers. This has provided an opportunity for individual practice financial stability over a 3 year period in line with national drivers Improving General Practice – A Call to Action[6] as well as fulfilling our CCG strategic objectives.

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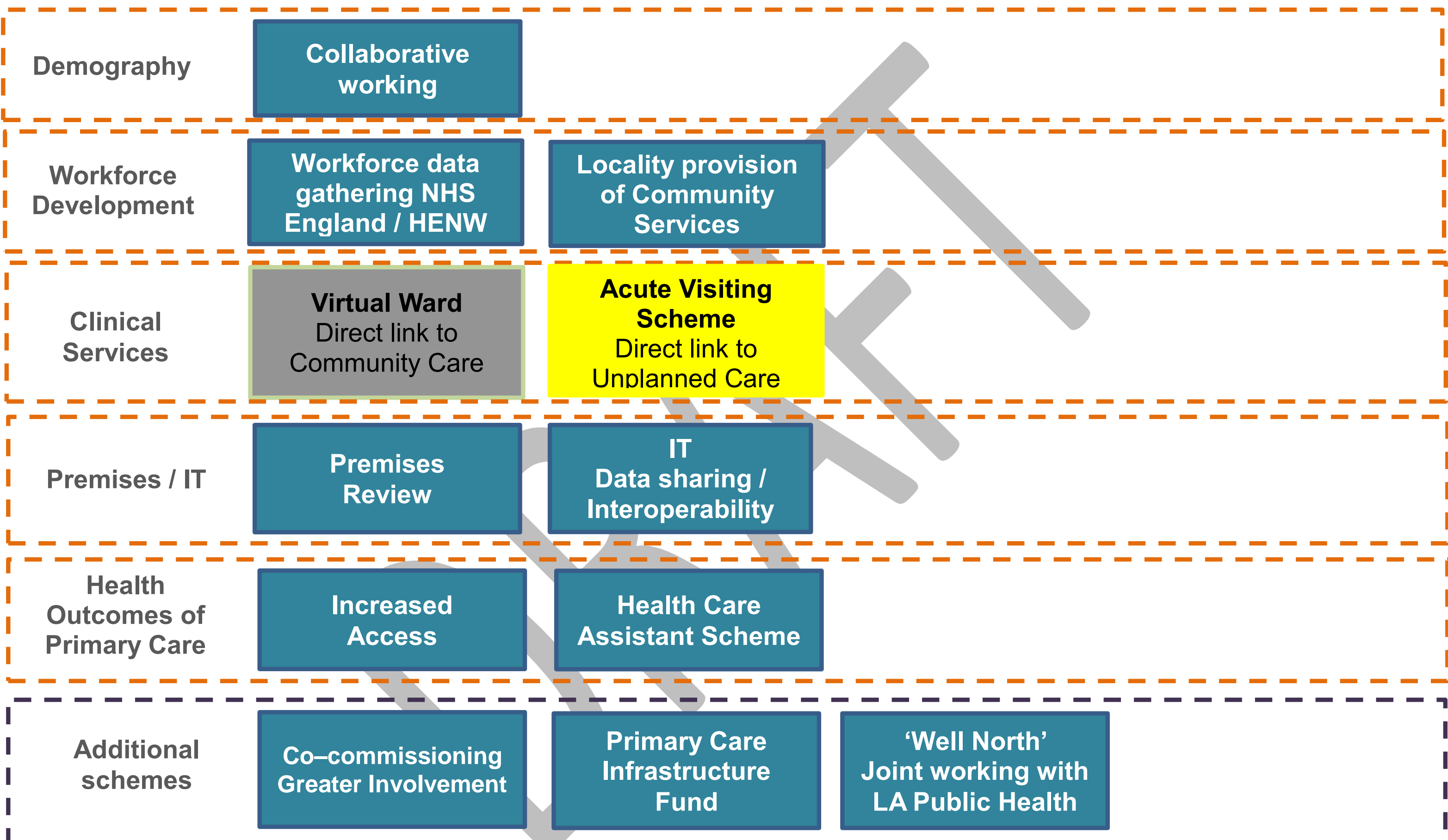
[5] Barbara Starfield 2007
[6] NHS England Improving General Practice – A Call to Action (March 2014)


PRIMARY CARE PROGRAMMES SOUTH SEFTON
Demography
Collaborative working
Workforce Development
Workforce data gathering NHS England / HENW
Locality provision of Community Services
Clinical Services
Virtual Ward Direct link to Community Care
Acute Visiting Scheme Direct link to Unplanned Care
Premises / IT
Premises Review
IT Data sharing / Interoperability
Health Outcomes of Primary Care
Increased Access
Health Care Assistant Scheme
Additional schemes
Co–commissioning Greater Involvement
Primary Care Infrastructure Fund
'Well North' Joint working with LA Public Health
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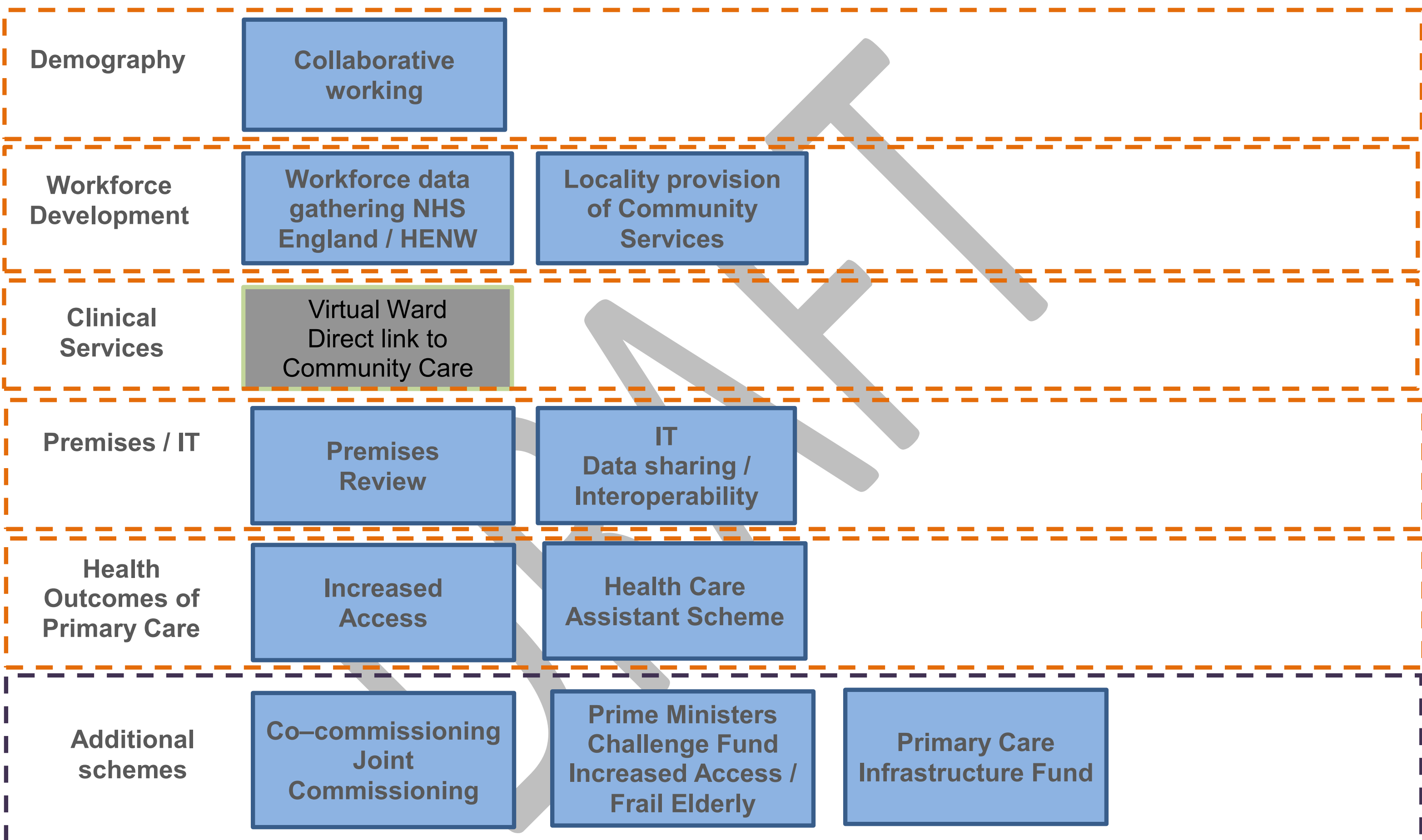
PRIMARY CARE PROGRAMMES SOUTHPORT AND FORMBY



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COMMUNITY CARE

This is an area where we believe we can make the biggest difference to the quality and effectiveness of health and social care. Many people who receive both health and social care support have to cope with several sets of professionals coming to see them, asking similar questions and assessing them for many of the same conditions and problems. Many of these people are living with one or more long term condition and a significant number are elderly.

Working more closely together, we will empower staff in our provider and social care organisations to achieve a better understanding of how multi-professional teams can support people holistically – for example, staff will be encouraged and empowered to identify gaps in service and potential solutions for doing things better in the interests of the people they support.

Working in a more integrated way will help minimise delays, reduce duplication or fragmentation of services, reduce the number of different professionals who need to be involved, and ensure that information is shared between different professionals more effectively.

To be effective, the community care model must be the result of true partnership, not just between health and social care staff but also with people who use the services (along with their families and carers) and the local community in each locality.

We will review existing pathways, in conjunction with patients and local providers, in order to identify:

- Gaps in service provision
- Barriers to access which may result in unintended inequalities
- Potential improvements - such as provision of greater diagnostic services out of hospital

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VIRTUAL WARD SOUTH SEFTON

Virtual Ward provides co-ordinated Health and Social Care for patients who are at high risk of emergency admission to hospital – such as those with long term conditions and frail or vulnerable older people.

It is called "Virtual" because you stay in your own home and "Ward" because it works like a hospital ward, where all the different members of the team meet regularly and work in a co-ordinated way to support you with your health and well-being needs.

By working together more closely through the Virtual Ward, the team can better manage each patient's condition to keep them well and prevent them from being admitted to hospital unnecessarily.

Virtual Ward teams are organised according to Community Nurse Team localities and there are four locality based groups. Each dedicated Virtual Ward team consists of a wide range of professionals from across health and social care. By working more closely together, these professionals provide more effective, joined up and collaborative care and treatment for patients:

Ward manager	Ward clerk
Community matron	District nurse lead
Health and wellbeing trainer	Pharmacist
Occupational therapists	Physiotherapists
Rehabilitation facilitator	Community geriatrician
Social worker	

The teams hold fortnightly Virtual 'ward rounds', commonly known as a multi-disciplinary team (MDT) meetings. This is where all appropriate community health and social care professionals come together to review individual patients, and to decide how they can better co-ordinate their care. Decisions and information from these meetings is then communicated directly to the patient's registered GP, updating their clinical notes.

This MDT approach reproduces the strengths of a hospital ward in the community by using a multi-disciplinary team approach in healthcare provision. It is called "virtual" because the ward does not exist physically and patients remain in their home.

The teams will look after the patients identified by the Risk Stratification tool as well as patients identified by other healthcare professionals who have been caring for them.

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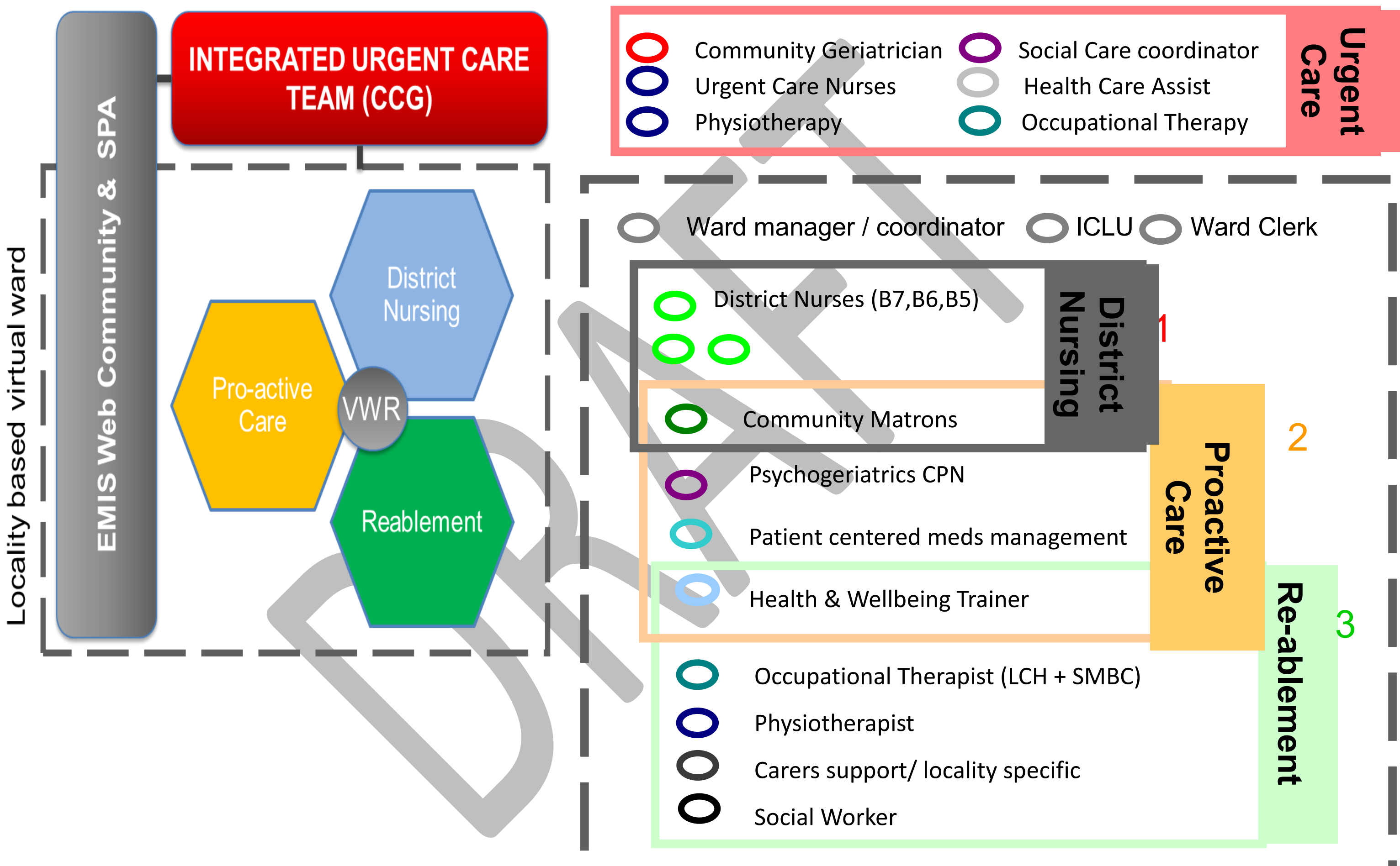

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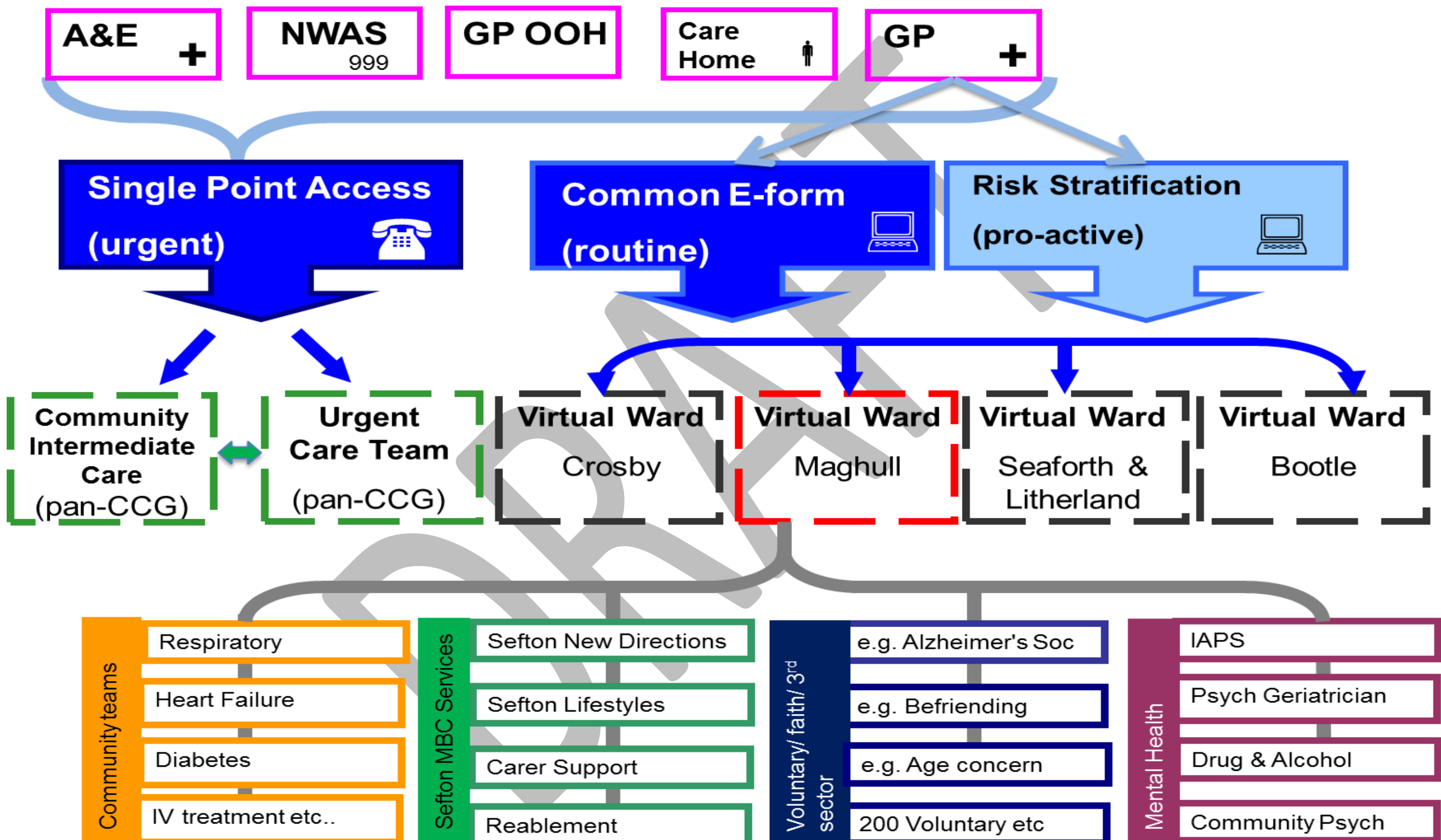
VIRTUAL WARD MODEL AND PATHWAY (SOUTH SEFTON)



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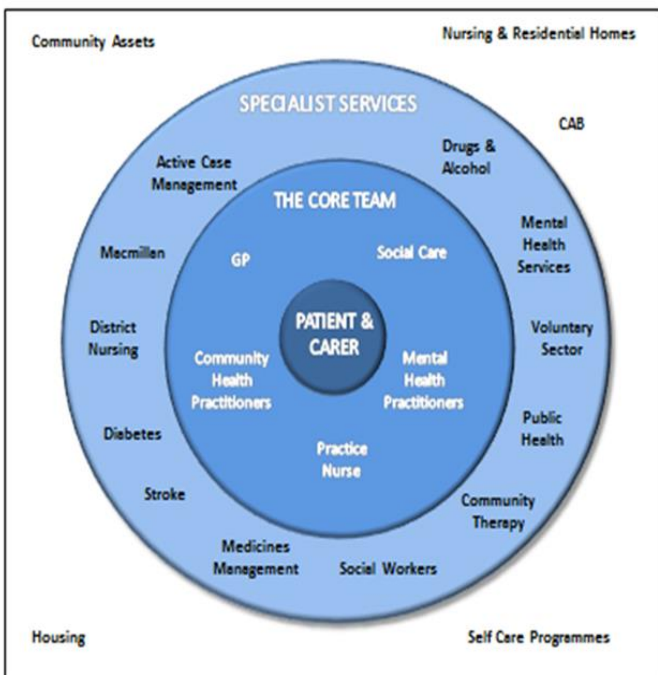
CARE CLOSER TO HOME SOUTHPORT AND FORMBY

The Care Closer to Home programme is about allowing everyone to live fulfilling, independent lives, which are supported by safe, quality, patient centred, accessible and seamless services. This will be delivered by a skilled, committed, satisfied and integrated workforce, who together with the public and colleagues across the health, social care and voluntary sectors, take pride in providing quality care. We will achieve this by being innovative and having the vision and courage to do the right thing, building trust and co-ownership with care providers, partners and patients through effective two way communication and listening to experiences of care.



The core benefits of delivering this vision for the community and patients will include:

- Care and treatment will be accessible closer to home, or in the most appropriate setting
- Reduce need to visit A&E due to alternatives available locally
- Multi-disciplinary teams will be integrated and made up of individuals offering various clinical skills
- Care will be seamless and involve healthcare colleagues working closely together and working to a single care plan for a patient
- Everyone will learn more about self-care and how to help manage their own conditions
- Greater understanding of which health service to use and when, due to clear signposting and easier access

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Our ultimate aim is to improve the outcomes and experiences of individuals and communities through the delivery of cost effective, integrated seamless care, support and treatment. To achieve this we will work together to transform our local health and care services to:

- Better co-ordinate, plan and deliver more personalised care and support to people living with long-term conditions and the frail elderly, in order to improve their quality of life and health outcomes
- Develop local community services to offer better access to care and support across the 7 day week
- Support the optimal delivery of elective care; utilising community support, where appropriate, to ensure individuals stay in hospital is minimised
- Design an urgent care system that delivers integrated services outside of hospital for people whose physical or mental health need for urgent care can be met by responsive advice, support and treatment closer to home
- Ensure that end to end integrated care pathways in and out of hospital run smoothly, ensuring evidence based care is consistently and equitably delivered to all individuals and communities in support of the best patient experience possible
- Empower communities and offer greater choice to individuals, by providing transparent information about the range and quality of health and care services available
- Effectively engage individuals, communities and our stakeholders in working with us to transform and redesign the way in which health and social services are provided to deliver better health and wellbeing for all

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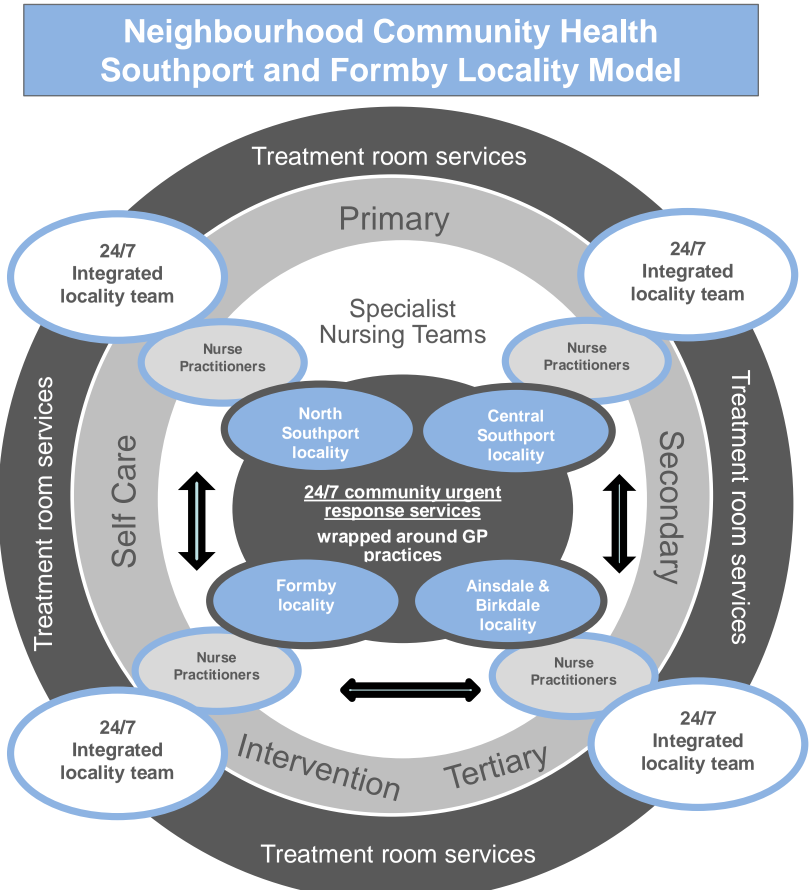
CARE CLOSER TO HOME MODEL (SOUTHPORT AND FORMBY)



CONTINUING HEALTH CARE

When it is assessed that an individual's primary need is a health need, the NHS offers a package of continuing health care. This is a package of ongoing care arranged and funded solely by the NHS.

If a patient requires continuing health care, South Sefton and Southport and Formby CCGs are committed to helping them to stay at home, provided that is safe for the patient and the staff looking after them to do so. We follow a number of key principles to guide this decision and if we are unable to support a package of care provided at your home we will offer you alternative care.

Eligibility is assessed through a process as defined in the Department of Health National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.

The first step in the process for most people will be a screening process using the checklist.

If an individual is referred for a full assessment for NHS continuing healthcare, the decision support tool should be completed following a multi-disciplinary assessment.

The fast track pathway tool is used in circumstances where an individual has a rapidly deteriorating condition that may be entering a terminal phase.

The CCG currently commission (160 for South Sefton and 114 for Southport &Formby) packages of continuing healthcare. The CCG also contributes funded nursing care (FNC) for (354 patients in SS and 509 patients in S&F)

Joint Funding

Adult: Informal arrangement with no panel in place. Agreement with CHC team and LA on the contribution of each organisation joint package.

Child: CHC team represent the CCG at joint panel meetings with the LA on assessment of the needs of the child, the care package to be provided and CCG contribution to the package.

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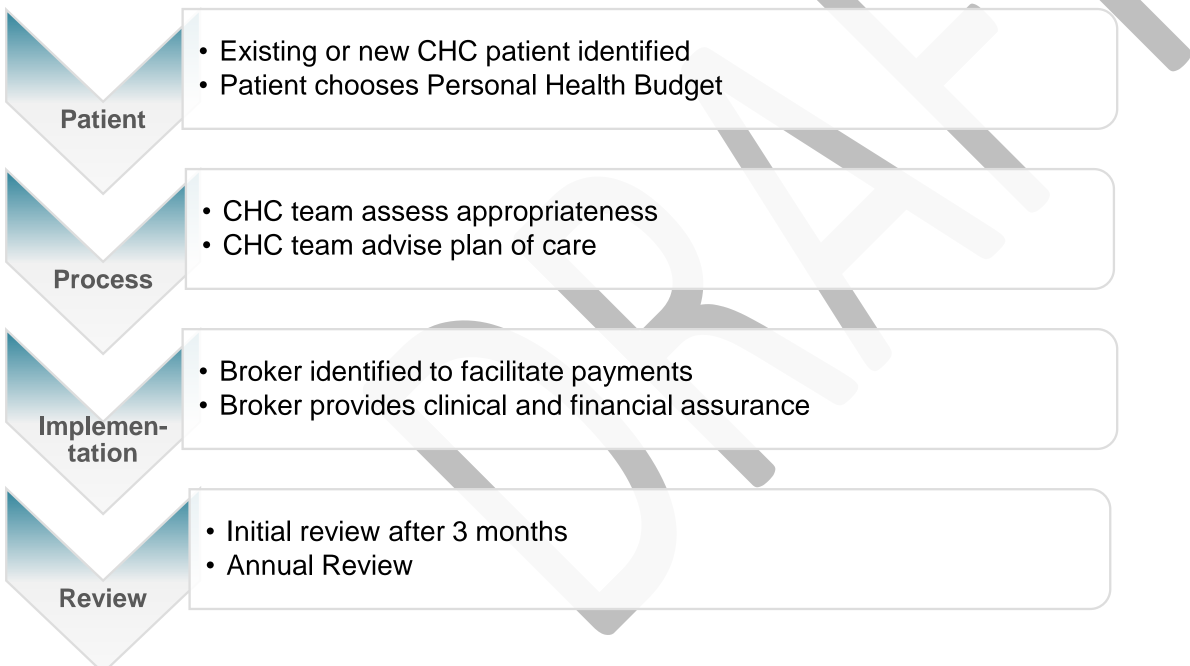
Personal Health Budget (PHB)

The CCG has a duty to ensure people eligible for NHS Continuing Healthcare and Continuing Care for Children benefit from the "right to have" personal health budget. A personal health budget is an amount of money to support the identified healthcare and wellbeing needs of an individual who is in receipt of Continuing Healthcare Funding and choose PHB as the option for provision of care. This is planned and agreed between the individual, or their representative, and the CCG. A care and support plan helps people to identify their health and wellbeing goals, together with their local NHS team, and set out how the budget will be spent to enable them to reach their goals and keep healthy and safe.

Personal Health Budgets Process:



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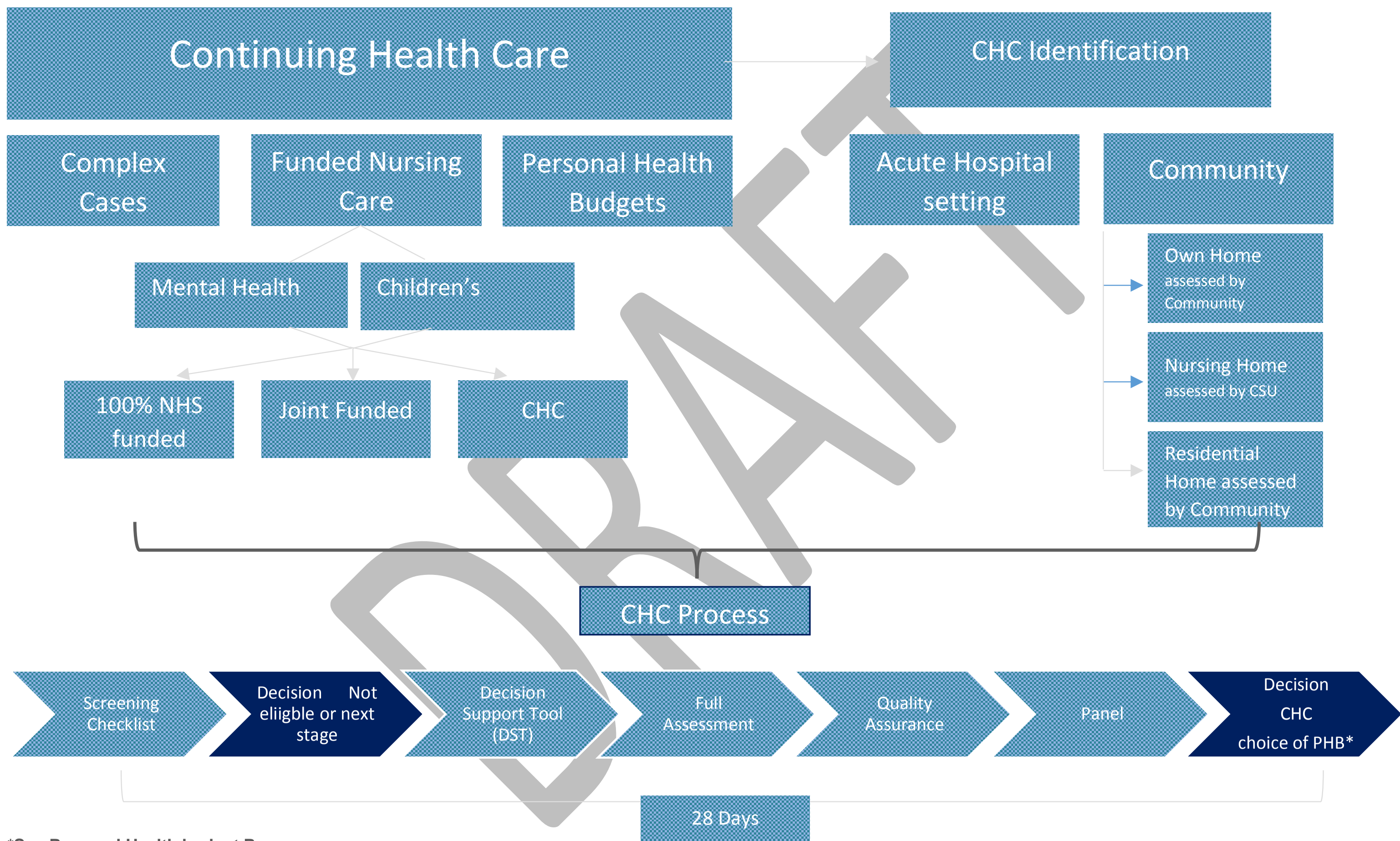
CHC DRAFT PATHWAY



*See Personal Health budget Process

INTERMEDIATE CARE

Intermediate care was defined by the Department of Health (2001)[7] and "Halfway Home" (2009)[8] 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.

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. Through the better care fund joint working, we now have in place an agreed strategy written in partnership with the Local Authority and we will monitor delivery via the joint Implementation Group which has a robust governance framework in place.

We know we must do better at commissioning our intermediate care facilities and we will commission an improved model to reduce admissions to acute care settings and facilitate the discharge and return home of patients following admission to our acute trusts.

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.

The local approach 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 our 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.

Key to delivery of this model are a Community Emergency Response Team (CERT) based in Southport and Formby and a Community Intermediate Care Team (CICT) located in South Sefton. They will act as the 'gatekeeper' or single point of access to the Intermediate Care Service across the two CCG footprints. This will facilitate the "one point of access, one assessment, one care planning process" approach.

[7] http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf
[8] Intermediate Care – Halfway Home (DH 2009)

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They will be an integrated, proactive, multi-agency and multi-disciplinary teams 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).

Both CERT and CICT 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 they will ensure that each individual's care is person-centred and that their journey through the Intermediate Care pathway is timely and seamless.

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.

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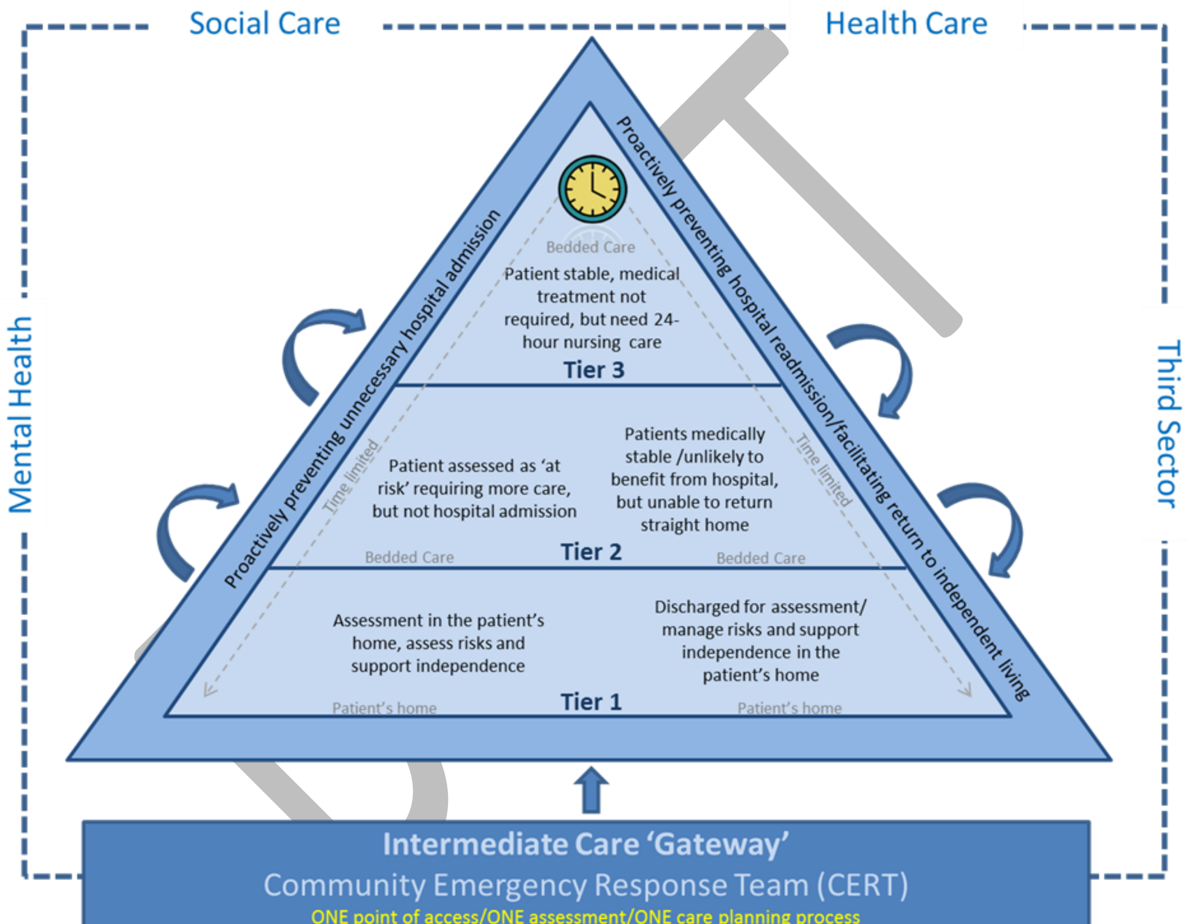
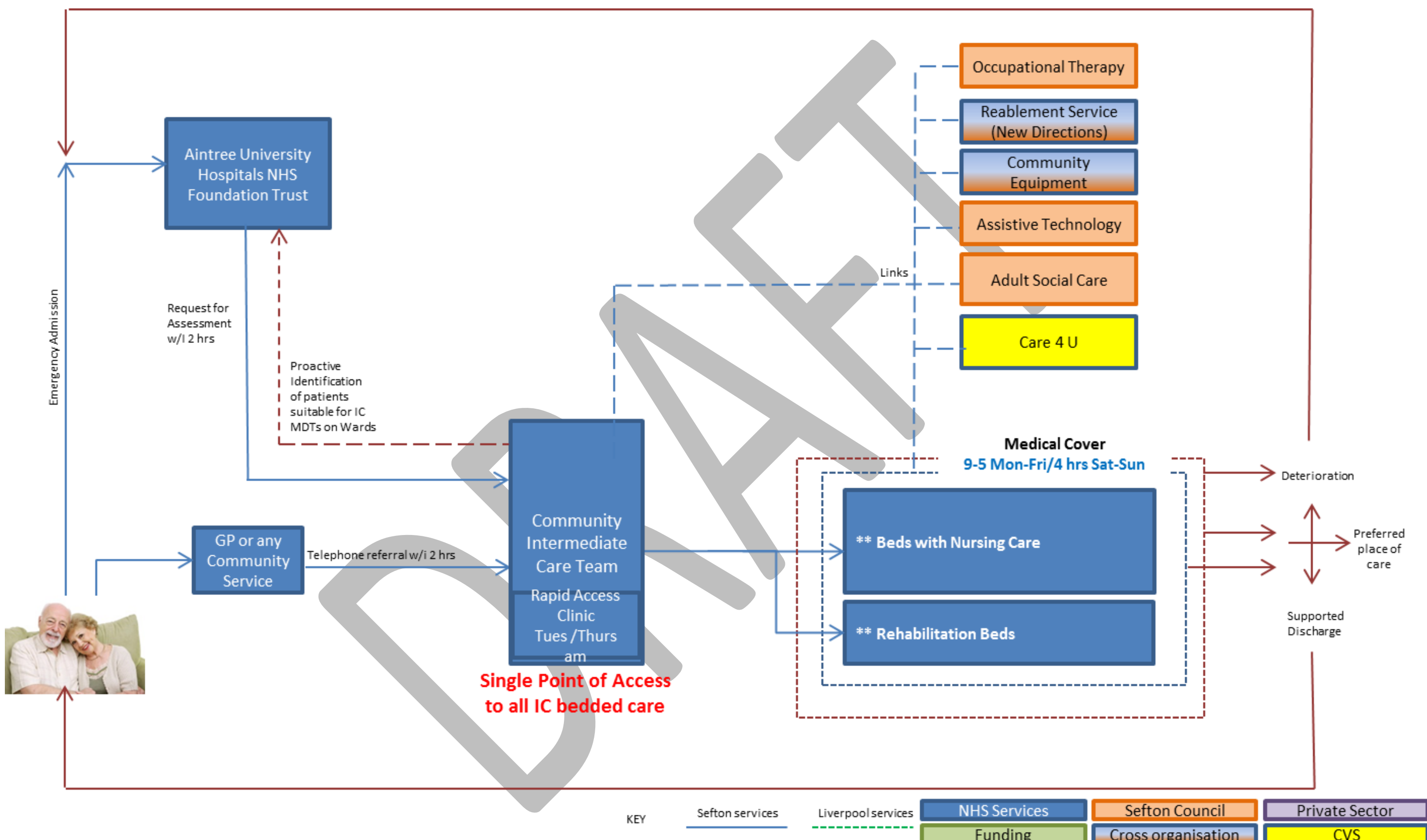
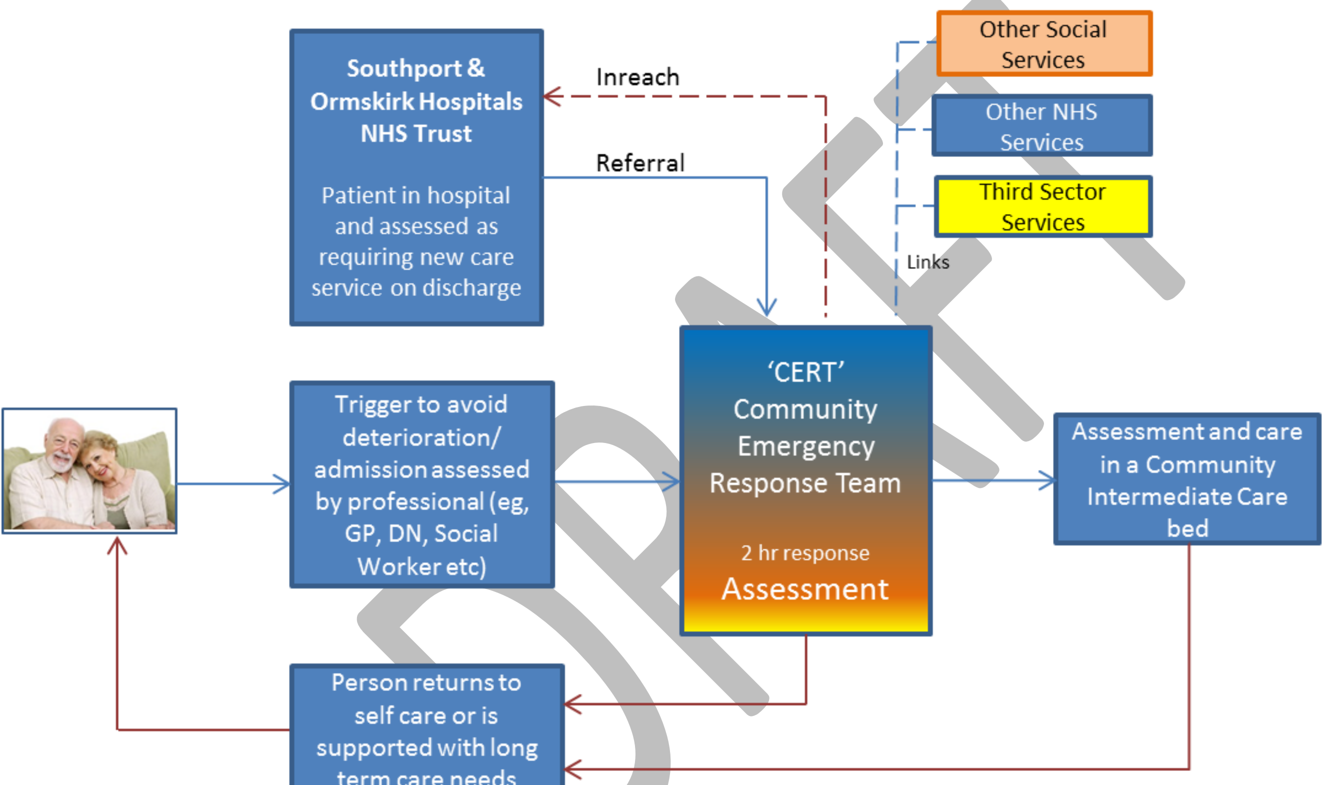
DRAFT INTERMEDIATE CARE MODEL



INTERMEDIATE CARE PATHWAY SOUTH SEFTON



INTERMEDIATE CARE PATHWAY SOUTHPORT AND FORMBY



UNPLANNED CARE

There is widespread national recognition and agreement that the health and social care system is under considerable pressure to deliver better patient outcomes against a backdrop of finite resources and increasing demographic pressures, alongside changing patient expectations. Over the last few years there has been considerable focus on the need for transformational change to manage these pressures to deliver better patient experiences and outcomes as it has been recognised that incremental change will not deliver the benefits that health and care suppliers (providers), patients and the government are seeking. These changes impact all areas of the health and social care economy, and over the last few years national attention has increasingly focused on the urgent and emergency care system.

Local strategies also reflect the national position with a desire to transform the urgent and emergency care system. The 5 Year Forward View (2014-19) sets out a collective vision to create a sustainable health and care economy that supports people to be healthy, well and independent. It acknowledges the issues driving change within the urgent and emergency care system.

The real challenge in A&E is the flow of patients into, around and out of the hospital. More than two thirds of all hospital beds are occupied by people admitted in an emergency. When wards are full, and staff overstretched, people who need to be admitted to hospital end up waiting in A&E.[9]

Urgent care should not be considered as a stand-alone, discrete service but embedded within patient pathways to ensure a joined up approach to care.

Evidence suggests that as attendances at A&E departments continue to rise, a significant proportion could be more appropriately dealt with by Primary and Community services. This would result in better utilisation of specialist A&E skills and enable more effective relationships being developed between the patient and primary care in managing their condition.

Professor Keith Willett who is leading on 'Transforming urgent and emergency care services in England'[10], has outlined the vision for urgent and emergency care, a visual model of this can be seen in Diagram three below:

[9] Alternative guide to the urgent and emergency care system animation transcript The Kings Fund January 2015
[10] Update on the Urgent and Emergency Care Review NHS England August 2014

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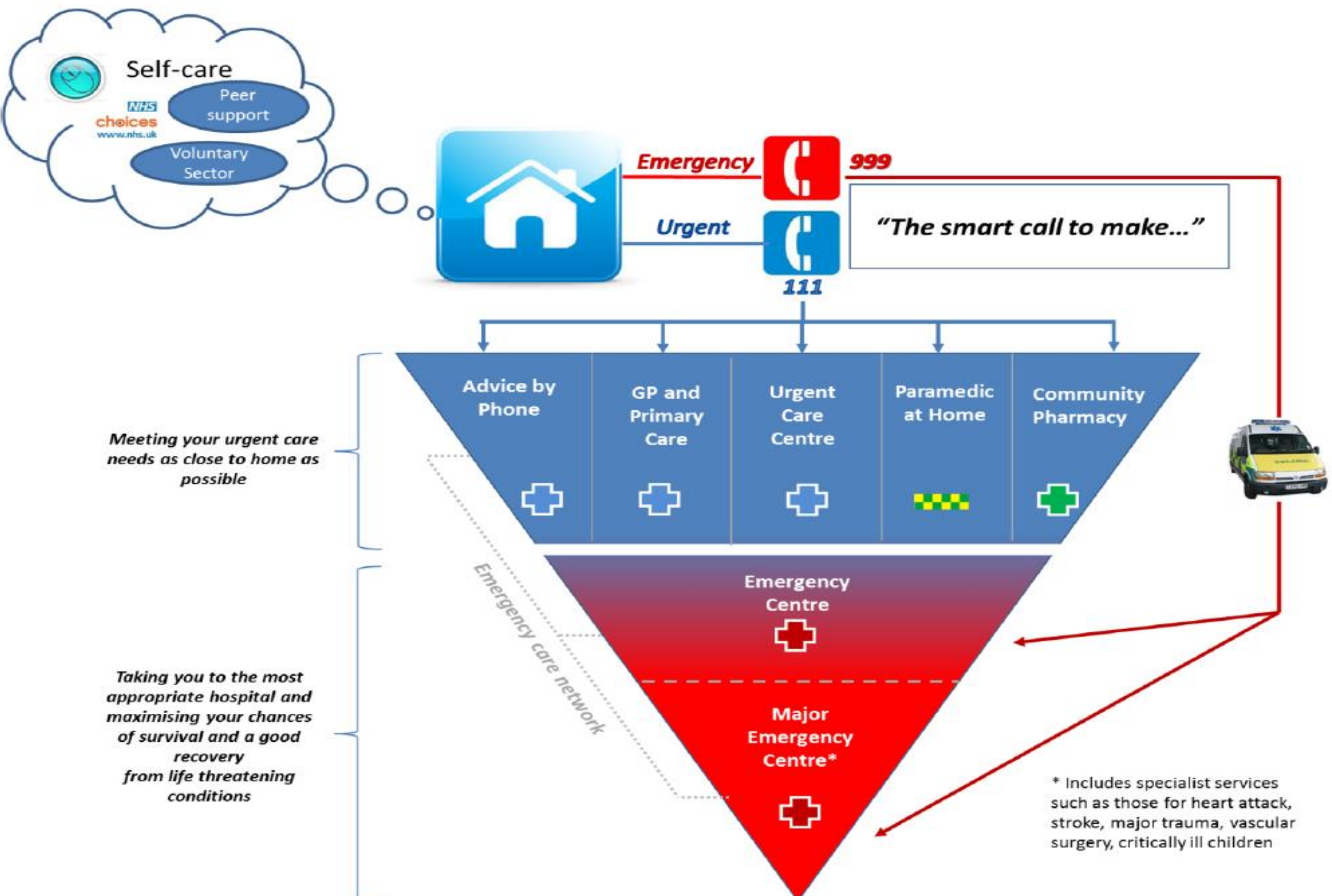
Diagram three:



UNPLANNED CARE SOUTH SEFTON

South Sefton CCG will continue to improve immediate and emergency care across the system to ensure that our patients get the right care at the right time and in the right place - be that primary care, community, or acute care. The commissioning of high quality and accessible urgent care services for our residents continues to be an important priority.

In recent years there has been increasing pressure placed on urgent and emergency care systems as patients seek greater assurance regarding their condition and more rapid responses from services.

We are currently developing our model to provide urgent response within two hours for our community services led by a consultant geriatrician and supported by GPs and other clinicians to reduce the reliance on A&E departments.

We will work collaboratively across the health sectors to ensure that patients are supported to access urgent care as needed. We will commission services across Primary Care, Community and Acute care to support patients and their clinical needs. Our integrated community mode includes social service, community services, mental health services, therapies and voluntary services, this is aimed to proactively identify and support patients at risk of future unplanned care episodes.

We will continue to develop clinically led pathways to deliver the most appropriate services to the patient need.

Our focus will be on:

- Unplanned Care teams are available to provide Urgent Care in the Home
- The Unplanned Care Team can call on support of the Unplanned Care Centre and utilise intermediate beds
- Patients can access an Unplanned Care Centre which has the support of the acute hospital
- At all times, patients with acute needs can be streamed to the acute hospital.
- Both the acute hospital and intermediate beds can step patients down to a supported discharge team
- There is whole system operational management and control

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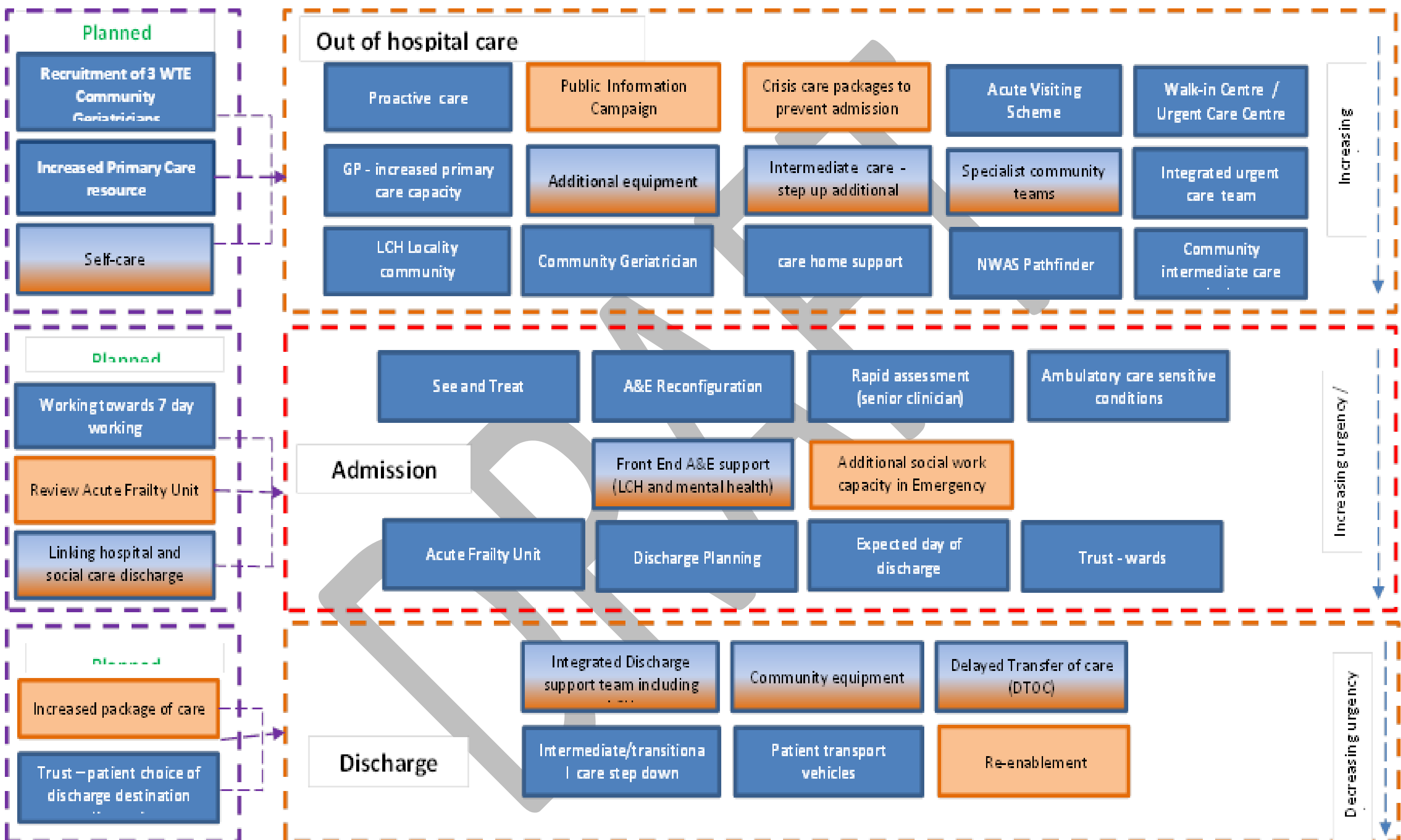
South Sefton Model for Unplanned Care



UNPLANNED CARE SOUTHPORT & FORMBY

The delivery of high quality and accessible urgent care services is an important priority for the Southport and Formby Health economy. We aim, as commissioners of care, to ensure that urgent care services in the future are delivered in a seamless integrated way to best meet the needs of our local population.

We recognise that the urgent care system is complex and the number of different entry points can be confusing to people. At times when people need things to be simple, in reality they are faced with a confusing set of options. We recognise that our role is to remove this confusion and present the public with a straightforward set of options that are obvious and easy to navigate.

Meeting the demand of unplanned care in Southport and Formby is inextricably linked to both primary and community care provision.

We will focus on delivering the following:

- The patient is supported in making informed decision
- Community Emergency Response teams are available to provide Urgent Care in the Home
- Community Emergency Response teams can utilise intermediate beds to avoid a hospital admission as well as step down from hospital care
- At all times, patients with acute needs can be streamed to the acute hospital.
- GP's proactively identify patients at risk of hospital admission and are able to enact (?) interventions through the community nursing teams
- Extra access to GP practices is being provided
- There is whole system operational management and control including escalation plans and urgent care dashboard

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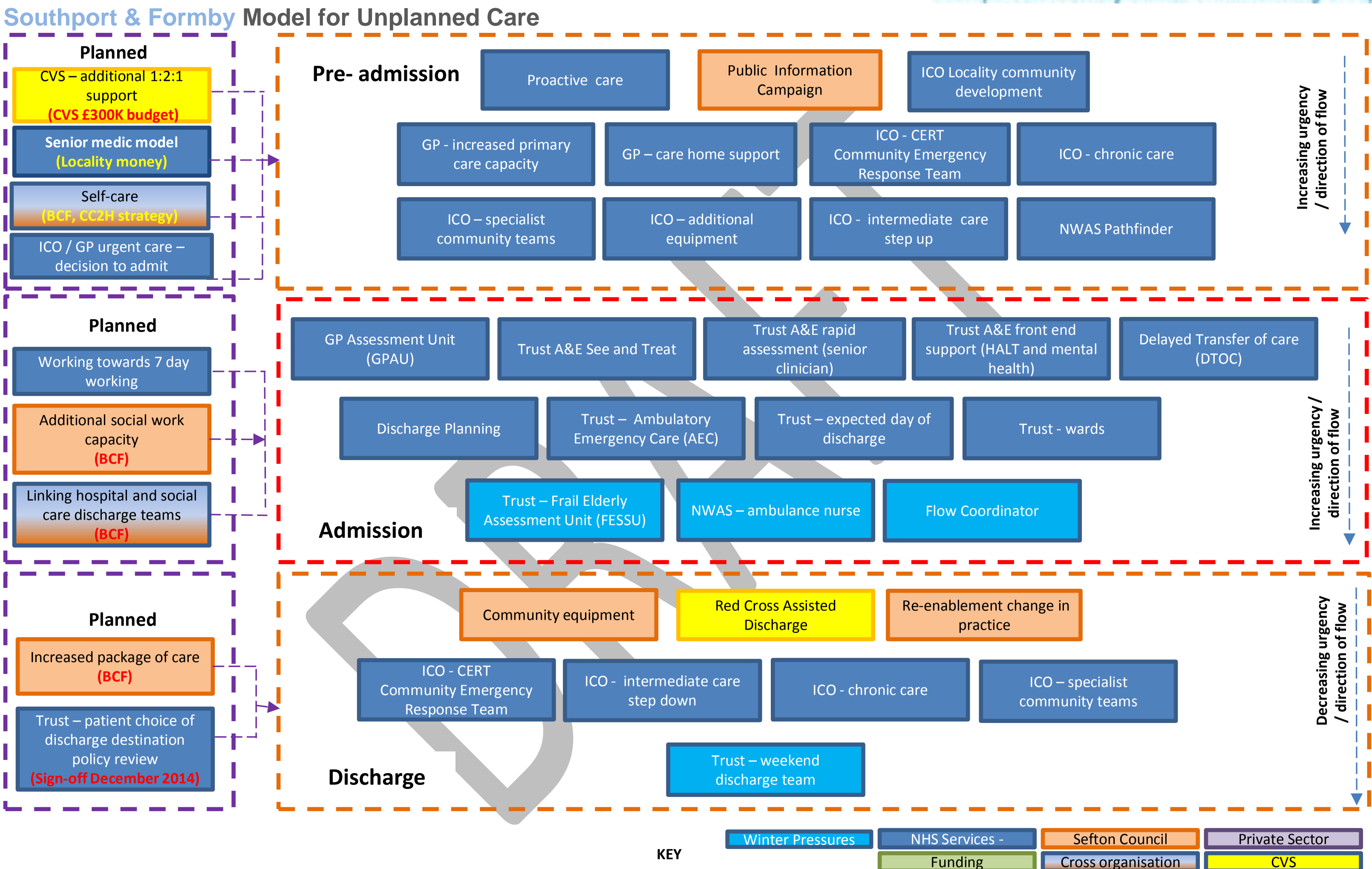
NHS
South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group
Southport & Formby Model for Unplanned Care
Planned
CVS – additional 1:2:1 support (CVS £300K budget)
Senior medic model (Locality money)
Self-care (BCF, CC2H strategy)
ICO / GP urgent care – decision to admit
Pre- admission
Proactive care
Public Information Campaign
ICO Locality community development
GP - increased primary care capacity
GP – care home support
ICO - CERT Community Emergency Response Team
ICO - chronic care
ICO – specialist community teams
ICO – additional equipment
ICO - intermediate care step up
NWAS Pathfinder
Increasing urgency / direction of flow
Planned
Working towards 7 day working
Additional social work capacity (BCF)
Linking hospital and social care discharge teams (BCF)
GP Assessment Unit (GPAU)
Trust A&E See and Treat
Trust A&E rapid assessment (senior clinician)
Trust A&E front end support (HALT and mental health)
Delayed Transfer of care (DTOC)
Discharge Planning
Trust – Ambulatory Emergency Care (AEC)
Trust – expected day of discharge
Trust - wards
Trust – Frail Elderly Assessment Unit (FESSU)
NWAS – ambulance nurse
Flow Coordinator
Admission
Increasing urgency / direction of flow
Planned
Increased package of care (BCF)
Trust – patient choice of discharge destination policy review (Sign-off December 2014)
Community equipment
Red Cross Assisted Discharge
Re-enablement change in practice
ICO - CERT Community Emergency Response Team
ICO - intermediate care step down
ICO - chronic care
ICO – specialist community teams
Trust – weekend discharge team
Discharge
Decreasing urgency / direction of flow
KEY
Winter Pressures
NHS Services -
Funding
Sefton Council
Cross organisation
Private Sector
CVS
57

MENTAL HEALTH

Our mental health services require review and redesign to ensure they are built around the needs of Sefton residents. We will commission an all age mental health and dementia service across Sefton which is a recovery based clinical model, supportive of home care, visible, easily accessible, of high quality, safe and will deliver beneficial outcomes to the patient.

Dementia services will be enhanced so they can meet the growing demands of local people, their families and their carers.

The Government has included a specific objective for the NHS to "put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole". In line with mental health strategy and the National dementia strategy there is a fundamental shift from output focused and volume driven commissioning to outcome focused and recovery orientated service provision.

A range of services will be available to meet the patients need. There will be a reduction in stigma associated with mental health issues and confidence in local services. A focus on patient recovery and satisfaction in their experience will be tangible in local services with equal regard for mental health as physical health.

We have identified the following key priority areas to focus on:

- Primary Care
- Parity of Esteem
- Dementia
- Redesign and commission and All Age service to include Child and Adolescent Mental Health (CAHMS)
- Brain Injury
- Outcomes and Activity Information

Primary Care: We will actively facilitate work with GPs and mental health services, including 3rd Sector, to enable collaborative working to be undertaken. We will undertake a training needs analysis to ascertain the level of mental health awareness across the GP community. There will be an increased focus on locality working which will enable mental health services to be targeted at a neighbourhood level.

Parity of Esteem: We will work with our current mental health providers, Mersey Care NHS Trust and all physical health providers, to ensure that physical needs of mental health and dementia patients are met in a timely and co-ordinated manner. A future model which envisages services working in integration is to be actively encouraged.

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Dementia: The current pathways are disjointed and there is an inequity across the two CCG areas as to how the dementia services are delivered. The work undertaken to-date has identified that some patients could be better managed in a primary care setting. Current estimates suggest there are almost 4,500 people aged over 65 affected by dementia, as a result of an ageing population it is forecast that by 2030 that number will have increased by 49% to over 6,600. Dementia services might best be delivered by an integrated service comprising of integrated health, social care, the third sector and nursing home provision, this would be a major shift from the current model of provision.

Child and Adolescent Mental Health (CAHMS): The national framework for Children, young people and maternity services highlighted the importance of ensuring safe and effective transition. Locally, in mental health services, transition arrangements for 16-18 year olds appear to be confusing and having two organisations involved, Mersey Care NHS Trust and Alder Hey, exacerbates this issue and carries an element of risk. Organisational barriers may affect these patients, therefore, it is paramount that we look to redesign the current CAMHS pathway to aim for a single mental health provider for young people instead of the current system of multiple providers. This new pathway could be a precursor to the development of a single and ageless service for all mental health patients who require secondary mental health services.

Brain Injury: The Brain Injury pathway is disjointed and whilst there are links between the service provided by Mersey Care through their Brain Injuries Unit and the Intensive Rehabilitation service provided by Walton Centre for Neurology moving to a new contracting arrangement whereby Walton Neurology sub contract the Mersey Care NHS Trust element of provision would enable the overall Brain Injury pathway to be more co-ordinated than at present.

Outcomes and Activity Information: The planned introduction of mental health Payment by Results (PbR) is a major organisational change for both providers and commissioners. Commissioners will need to understand in detail how the services they are purchasing meet the needs of individual people, how this directly affects the prospects for patient recovery and crucially identify any financial risks. Financial modelling and profiling of risk will need to be undertaken by the CCGs for assurance purposes.

The current mental health contracting currencies are out of date and many activity indicators are catchment and not CCG based. The Task Group believes that mental health outcomes should be predicated on more social based outcomes and it has commenced discussions with Mersey Care NHS Trust to agree an initial suite of measureable outcomes and CCG based activity measures for inclusion in 2015/16 contracts.

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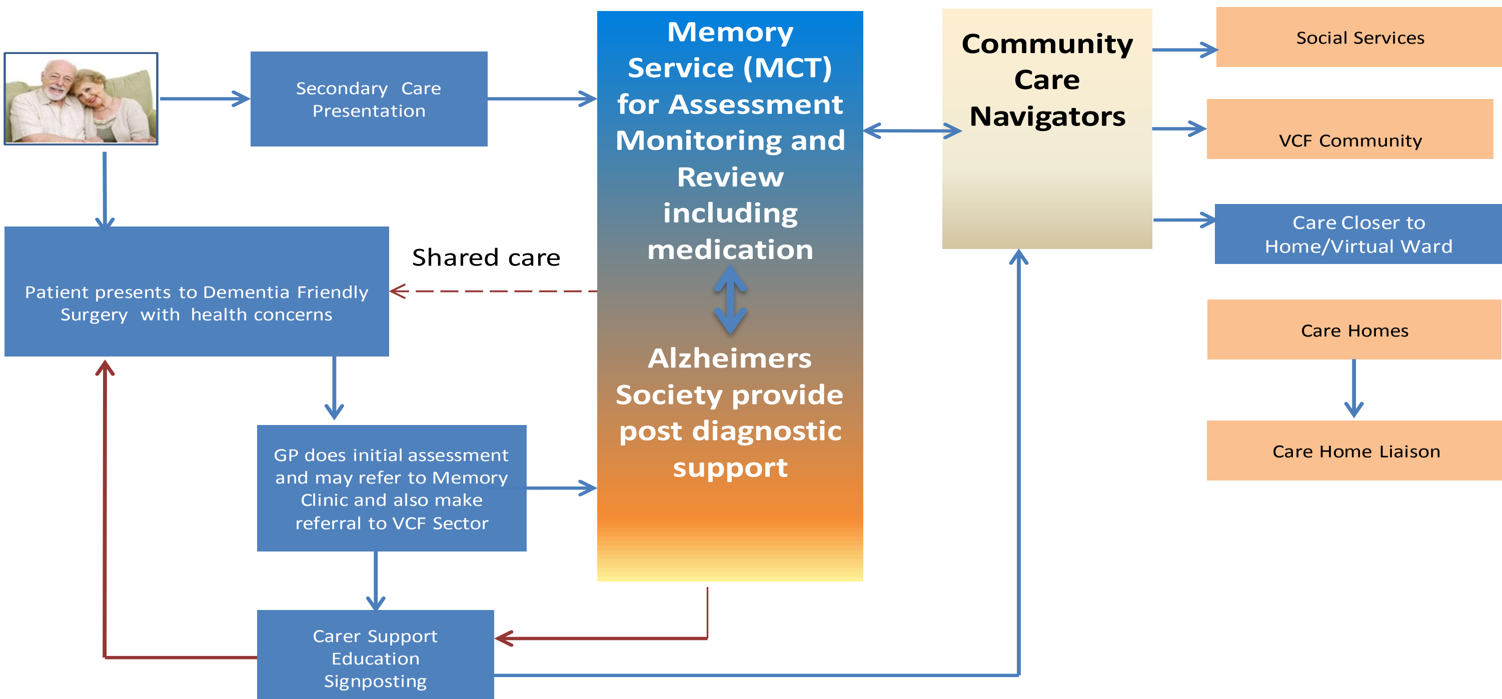
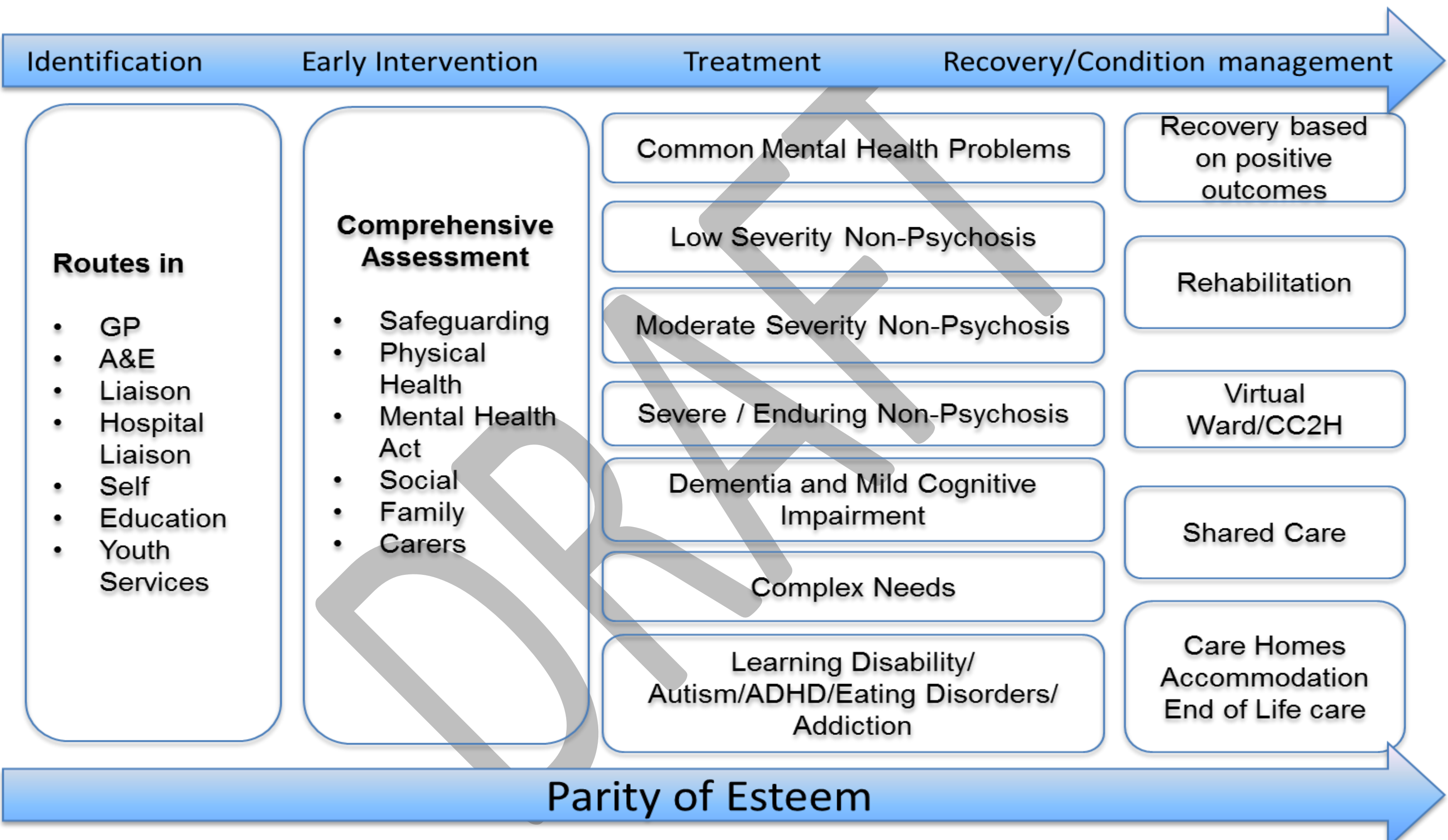
Future Dementia Pathway



MENTAL HEALTH MODEL OF CARE



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ACTION, DELIVERY AND GOVERNANCE

We will focus on delivery of our transformation programmes through the agreed governance structures outlined in Appendix one, whilst these transformational programmes are the main focus, they are not the only mechanism for delivering improvements and driving quality, safety and standards in health and care.

The ongoing improvement and enabling activity aimed at raising standards of care across the system are set out for each CCG below. The anticipated impact of these activities is being assessed and modelled to enable us to continue to improve health service within a sustainable local health and social care system. High level action plans, alongside benefits and measures are attached in Appendix two.

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ACTIONS, DELIVERY AND TIMELINES SOUTH SEFTON CCG

PRIMARY CARE

Scope and Rationale

The aim of the Primary Care transformation programme is to develop a population-based approach to primary care and support them to improve access to primary care and enhance quality of service.

Outcomes

- Better patient experience
- Reduce A&E attendances
- Reduction in referrals
- Reduction in admissions
- Increased prevalence rates
- Reduction in re-admissions
- Reduced length of stay
- Reduced number of admissions from care homes
- Increased quality and provision of primary care diagnostics and monitoring

Priority Projects/Activities

- Increased access
- Enhanced management of patients over 75
- Workforce
  - Succession Planning
- Early detection:
  - CVD – increased uptake of Health Checks
  - Hypertension – recording,_management and treatment
  - Atrial Fibrillation (AF) Management – improve case finding and management
- Planned Care
  - Increase use of Choose and Book utilisation

Contribution to Strategic Priorities

- Primary Care transformation
- Frail Elderly
- Unplanned Care

Workstream name: *Primary Care* — **Date:** *09 Feb. 15*

Senior Manager Lead: *Angela Parkinson* — **Updated:**

Programme Aim

We will develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service.

ID Number	Action	Responsible Lead	Date due for Completion	Actual completion date	RAG
SSPC01	**Increased access** Extended access to clinicians for chronic disease management. No closure in core hours, additional access outside of core hours. Link to Local Quality Contract (LQC)	Angela Parkinson	Aug 15		
SSPC02	**Enhanced management of patients over 75** Improved care for patients in care homes by offering more intensive health treatment Link to Local Quality Contract (LQC)	Moira McGuiness	Sept 15		
SSPC03	**Workforce** Succession planning and locality development HEE data capture LMC report Link with HCA scheme in collaboration with Hugh Bird College	Angela Parkinson	Mar 17		
SSPC04	**Early detection** CVD Increased uptake of Health Checks. Hypertension – recording, management and treatment Atrial Fibrillation (AF) Management – improve case finding and management	Sharon Forrester	Mar 16		
SSPC05	**Planned Care** Increase use of Choose and Book utilisation for both acute and community services	Terry Hill	Sept 15		

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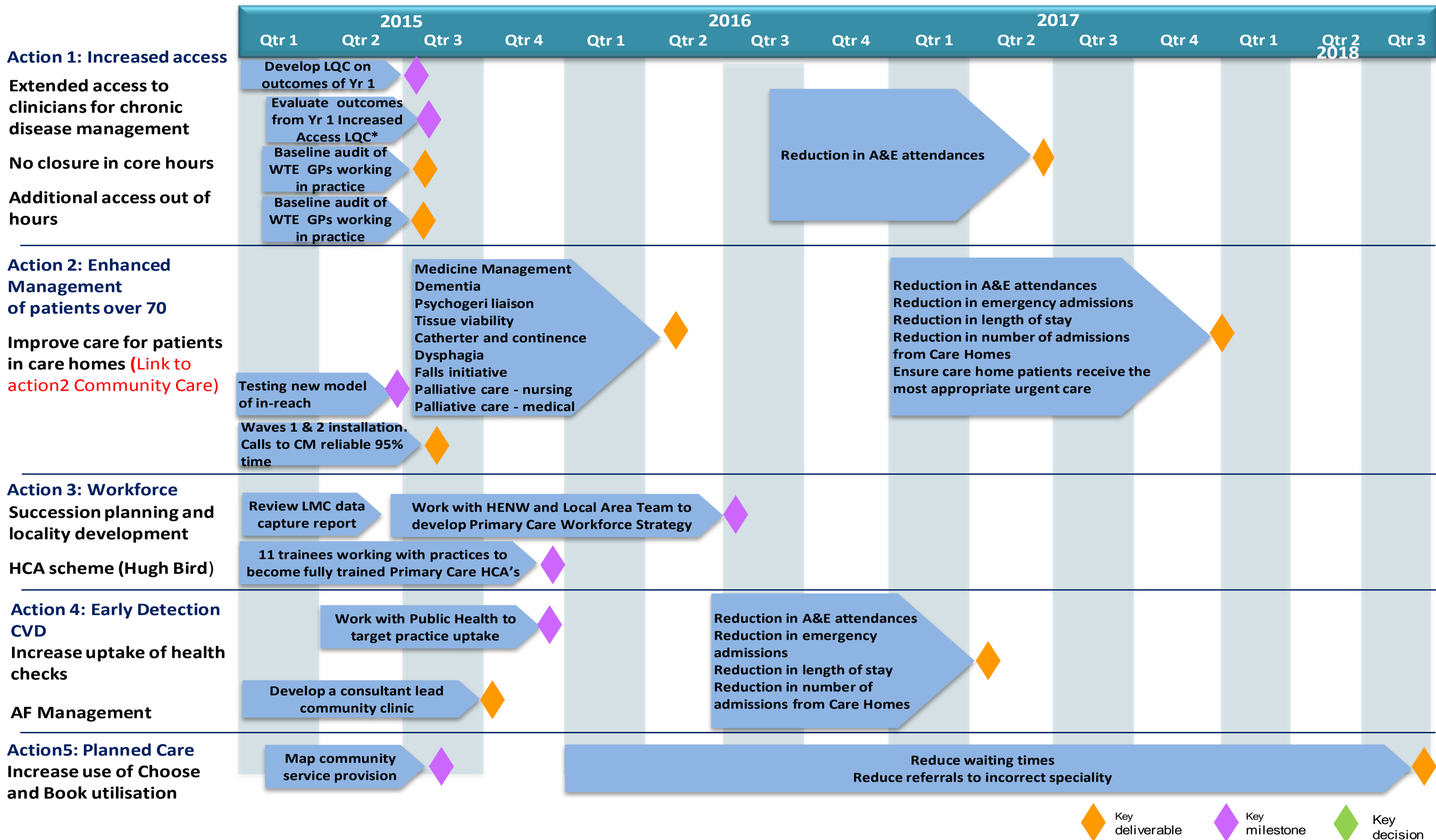

NHS
South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group
South Sefton Primary Care - Timeline
2015
2016
2017
2018
Qtr 1
Qtr 2
Qtr 3
Qtr 4
Action 1: Increased access
Extended access to clinicians for chronic disease management
No closure in core hours
Additional access out of hours
Develop LQC on outcomes of Yr 1
Evaluate outcomes from Yr 1 Increased Access LQC*
Baseline audit of WTE GPs working in practice
Baseline audit of WTE GPs working in practice
Reduction in A&E attendances
Action 2: Enhanced Management of patients over 70
Improve care for patients in care homes (Link to action2 Community Care)
Testing new model of in-reach
Waves 1 & 2 installation. Calls to CM reliable 95% time
Medicine Management
Dementia
Psychogeri liaison
Tissue viability
Catherter and continence
Dysphagia
Falls initiative
Palliative care - nursing
Palliative care - medical
Reduction in A&E attendances
Reduction in emergency admissions
Reduction in length of stay
Reduction in number of admissions from Care Homes
Ensure care home patients receive the most appropriate urgent care
Action 3: Workforce
Succession planning and locality development
HCA scheme (Hugh Bird)
Review LMC data capture report
Work with HENW and Local Area Team to develop Primary Care Workforce Strategy
11 trainees working with practices to become fully trained Primary Care HCA's
Action 4: Early Detection CVD
Increase uptake of health checks
AF Management
Work with Public Health to target practice uptake
Develop a consultant lead community clinic
Reduction in A&E attendances
Reduction in emergency admissions
Reduction in length of stay
Reduction in number of admissions from Care Homes
Action5: Planned Care
Increase use of Choose and Book utilisation
Map community service provision
Reduce waiting times
Reduce referrals to incorrect speciality
Key deliverable
Key milestone
Key decision
* Local Quality Contract

COMMUNITY CARE

Scope and Rationale

We will commission services that better link together right across health and social care – from hospital and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.

Priority Projects/Activities

- Locality and virtual wards
- Care Homes
- Community urgent care team
- Review Integrated care pathways for long term conditions – focus on urgent care:
  - Diabetes
  - Heart Failure
  - COPD
  - Palliative Care
  - Dementia and Frailty
- Review of Community Tier 2 services and activity

Outcomes

- Improved support for frail elderly
- Reduction in unplanned/emergency admissions
- Reduction in re-admissions
- Reduced length of stay
- Better health outcomes
- Reduced mortality rates
- Reduce A&E attendances
- Better patient experience
- Care closer to home
- Reduce referrals into secondary care
- Increase number of people dying in usual place of residence
- Admission avoidance
- Self Care

Contribution to Strategic Priorities

- Frail Elderly
- Unplanned Care

Workstream name: *Community Care*			***Date:*** *09 Feb. 15*		
Senior Manager Lead: *Steve Astles*			***Updated:***		
Programme Aim *We will commission services that better link together right across health and social care – from hospital and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.*					
ID Number	**Action**	**Responsible Lead**	**Date due for Completion**	**Actual completion date**	**RAG**
CC01	**Locality and Virtual Wards** Further development of locality modelling to ensure community services are wrapped around GP practices	Steve Astles Peter Chamberlain	Ongoing		
CC02	**Care Homes** • Community geriatrician in-reach to care homes • Community Matrons • Telehealth	Steve Astles	 Mar 15 Apr 15 Apr 15		
CC03	**Community Urgent Care** Integration of all community urgent care providers including: • NWAS pathfinder step down to UCT and GP OOH • Integration and assimilation of CRT and cellulitis to UCT • Acute trust front door community urgent care coordinator	Steve Astles Andy Mimnagh	Jun 15		
CC04	**Review and redesign Integrated Care Pathways for Long term conditions. Phase 1 focus on urgent care element** • CVD • COPD • Dementia & Frailty	Steve Astles Sharon Jenny Kevin Thorne			
CC05	**Review of Community/Tier 2 services and activity** • De-commission and procurement	TBC			

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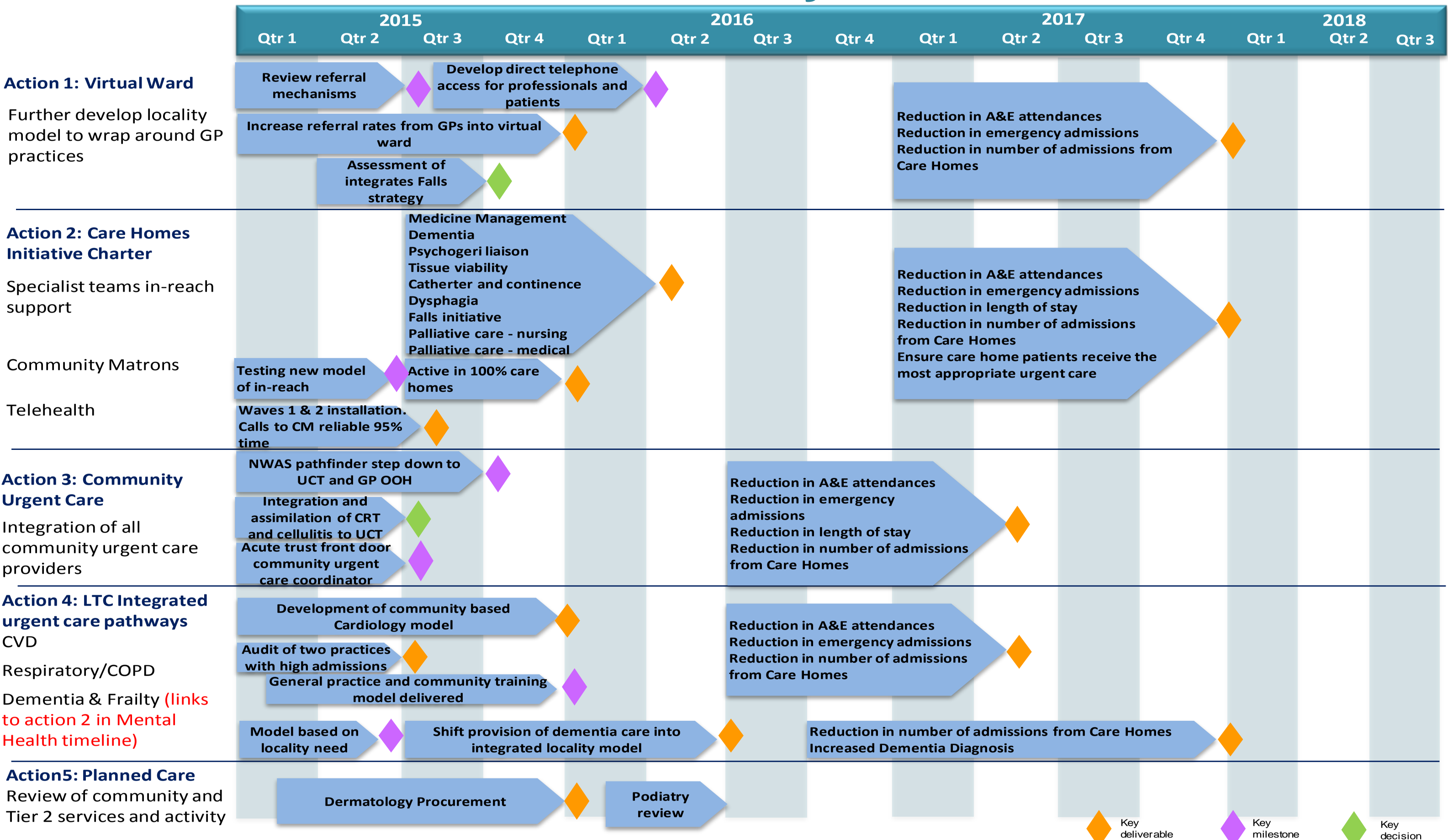
South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group
South Sefton Community Care - Timeline
2015
2016
2017
2018
Qtr 1
Qtr 2
Qtr 3
Qtr 4
Action 1: Virtual Ward
Further develop locality model to wrap around GP practices
Review referral mechanisms
Develop direct telephone access for professionals and patients
Increase referral rates from GPs into virtual ward
Assessment of integrates Falls strategy
Reduction in A&E attendances
Reduction in emergency admissions
Reduction in number of admissions from Care Homes
Action 2: Care Homes Initiative Charter
Specialist teams in-reach support
Medicine Management
Dementia
Psychogeri liaison
Tissue viability
Catherter and continence
Dysphagia
Falls initiative
Palliative care - nursing
Palliative care - medical
Reduction in A&E attendances
Reduction in emergency admissions
Reduction in length of stay
Reduction in number of admissions from Care Homes
Ensure care home patients receive the most appropriate urgent care
Community Matrons
Testing new model of in-reach
Active in 100% care homes
Telehealth
Waves 1 & 2 installation. Calls to CM reliable 95% time
Action 3: Community Urgent Care
Integration of all community urgent care providers
NWAS pathfinder step down to UCT and GP OOH
Integration and assimilation of CRT and cellulitis to UCT
Acute trust front door community urgent care coordinator
Reduction in A&E attendances
Reduction in emergency admissions
Reduction in length of stay
Reduction in number of admissions from Care Homes
Action 4: LTC Integrated urgent care pathways
CVD
Development of community based Cardiology model
Respiratory/COPD
Audit of two practices with high admissions
General practice and community training model delivered
Reduction in A&E attendances
Reduction in emergency admissions
Reduction in number of admissions from Care Homes
Dementia & Frailty (links to action 2 in Mental Health timeline)
Model based on locality need
Shift provision of dementia care into integrated locality model
Reduction in number of admissions from Care Homes
Increased Dementia Diagnosis
Action5: Planned Care
Review of community and Tier 2 services and activity
Dermatology Procurement
Podiatry review
Key deliverable
Key milestone
Key decision

INTERMEDIATE CARE

Scope and Rationale

The Intermediate Care aim is to have ONE point of access, ONE assessment, ONE care planning process. This will be enabled by commissioning co-ordinated care for patients via integrated services and being responsive to patient's needs.

Outcomes

- More integrated, efficient and effective intermediate care
- Reduce hospital admissions
- Reduce re-admissions
- Reduce length of stay
- Ensure decisions about long term care are not made in an acute setting

Priority Projects/Activities

- Better Care Fund priority
  - Integrated approach with local authority
- Single entry coordination for all intermediate care
- Integrated care at locality level
- Increase use of appropriate use of step up / step down beds
- Stroke:
  - Development of Intermediate care beds in nursing homes

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care transformation

Workstream name: *Intermediate Care*			**Date:** *09 Feb. 15*		
Senior Manager Lead: *Melanie Wright*			**Updated:**		
Programme Aim *Our aim is to have ONE point of access, ONE assessment, ONE care planning process. We will do this by commissioning co-ordinated care for patients via integrated services and be responsive to patients needs.*					
ID Number	**Action**	**Responsible Lead**	**Date due for completion**	**Actual completion date**	**RAG**
IC01	**Ward 35** Serve notice to decommission current service	Mel Wright	01/04/15		
IC02	**Procurement** Go out to market to reprocure enhanced intermediate care bed provision	Mel Wright	*01/04/16*		*Not yet started*
IC03	**Better Care Fund** Work with local authority to enhance intermediate care transition arrangements Better Care Fund initiative	Mel Wright	Ongoing		
IC04	**Integrated care at locality level** Incorporate into virtual ward model with particular focus on frail and elderly with long term conditions, ensure timely discharge and support from intermediate care Better Care Fund initiative	Mel Wright	*01/04/16*		
IC05	**Step up/down** patient flow - appropriate increase in use of step up beds particularly requested by GPs - Awareness raising exercise with GPs	Mel Wright	*31/03/16*		*Not yet started*
IC06	**Stroke** Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Sharon Forrester	*31/03/16*		

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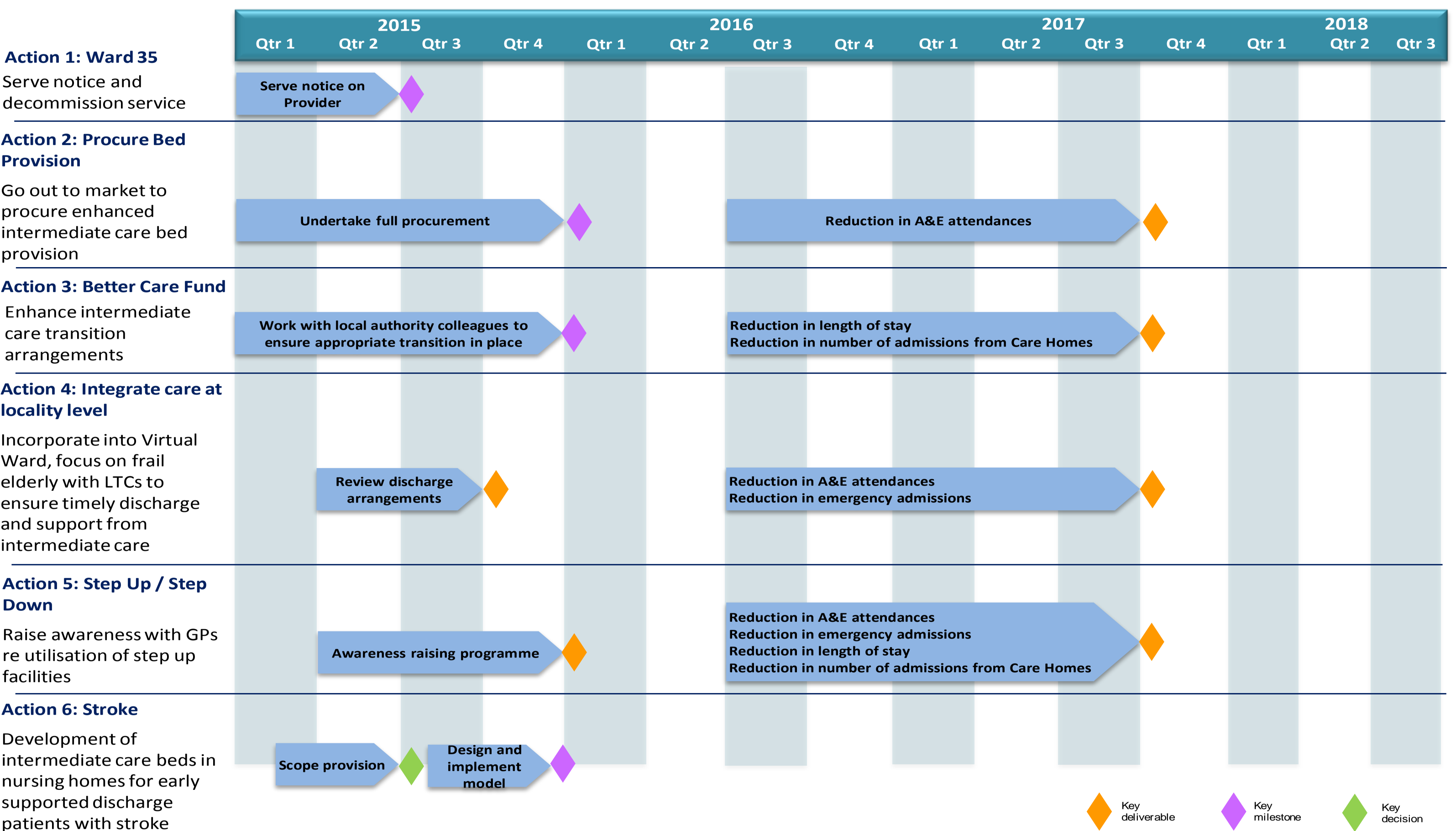
South Sefton Intermediate Care - Timeline



UNPLANNED CARE

Scope and Rationale

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

Outcomes

- Reduced emergency admissions
- Reduced readmissions
- Reduced A&E attendances
- Reduced non-elective admissions
- Admission avoidance
- Reduction in admissions
- Increased availability of ambulances
- Increased discharges to home
- Reduced time from discharge to home
- Reduced patients in long term care
- Reduced average length of stay
- Increase number of adults making healthy lifestyle choices
- Increase people's feeling of involvement and confidence to be involved

Priority Projects/Activities

- Review of walk in centre and development of Urgent Care Centre
- Transportation review to support walk in centre model
- Acute visiting scheme
- NWAS pathfinder
- Development of bids from Community Voluntary Sector to support urgent care admissions

Contribution to Strategic Priorities

- Primary Care transformation
- Frail Elderly
- Unplanned Care

Workstream name: *Unplanned Care*	**Date:** *09 Feb. 15*
Senior Manager Lead: *Steve Astles*	**Updated:**

Programme Aim

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

ID Number	Action	Responsible Lead	Date due for completion	Actual completion date	RAG
UC01	**Closure of Darzi practice** Review of Walk in Centre and impact of closure of Darzi practice, development of an Urgent Care Centre	*Steve Astles Andy Mimnagh*	*Sept 15*		
UC02	**Transportation** Explore ambulance transportation requirements to support Walk in Centre as part of new model of care as an alternative to A&E	*Steve Astles Terry Hill*	*June 15*		
UC03	**Acute Visiting scheme** Develop service to ensure patients are treated at home and avoid conveyance to hospital	*Steve Astles*	*Mar 16*		
UC04	**NWAS pathfinder** Work with ambulance service and other providers to improve decision-making before making transfer to urgent care settings.	*Steve Astles*	*Mar 16*		
UC05	**Community Voluntary Sector (CVS) and Public Health** Development of the bids from CVS to focus on urgent care to support patients to avoid admission	*Steve Astles Geraldine O'Carroll*	*May 15*		

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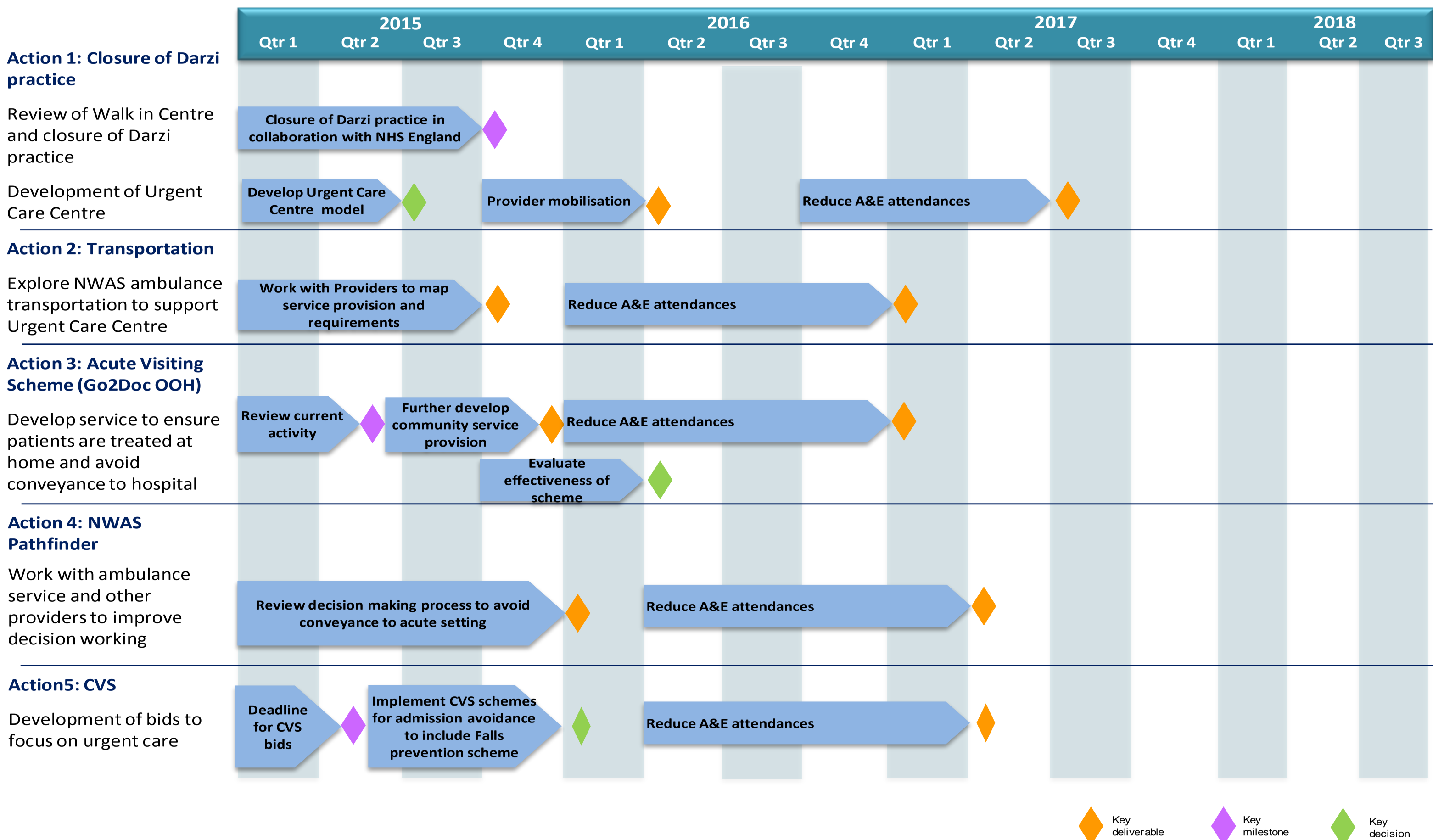
South Sefton Unplanned Care - Timeline



MENTAL HEALTH

Scope and Rationale

Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long neurological condition within community based networks of care

Priority Projects/Activities

- Outcomes and Activity
  - Develop suite of measurable outcomes with Provider
- Dementia
  - development of integrated locality model
- Commission All Age Mental Health Service
  - To incorporate Child and Adolescent mental health services (CAMHS)
- Brain Injury
  - Move to new contracting arrangements following review by Cheshire and Mersey Clinical Network
- Primary and Community Care Development
  - Training analysis

Outcomes

- Dementia diagnosis
  - 75% of identified population by 2015/16
  - 90% of identified population by 2018/19
- More people independently managing dementia
- Reduce Tier 4 placements
- Improve response times
- Reduce waiting times
- Early Identification
- Improve patient experience

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care Transformation

Workstream name: Mental Health	*Date: 09 Feb. 15*
Senior Manager Lead: *Geraldine O'Carroll*	***Updated:***

Programme Aim

Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long neurological condition within community based networks of care

ID Number	Action	Responsible Lead	Date due for completion	Actual completion date	RAG
MH01	**Outcomes and Activity** Agree a suite of measureable outcomes with Mersey Care	*Malcolm Cunningham*	*Dec 15*		
MH02	**Dementia** Shift provision of dementia care from current provider to integrated locality model	*Kevin Thorne*	*Mar 16*		
MH03	**Redesign and commission All Age Mental Health Service** To incorporate Child and Adolescent mental health services (CAMHS)	*Gillian Bruce*	*Phase one Mar 16*		
MH04	**Primary and Community Care Development** Undertake training analysis and map workforce development	*Geraldine O'Carroll*	*Mar 16*		
MH05	**Brain Injury** Move to new contracting arrangement following review by Cheshire and Merseyside Clinical Network	*Geraldine O'Carroll Martin McDowell*	*Mar 17*		

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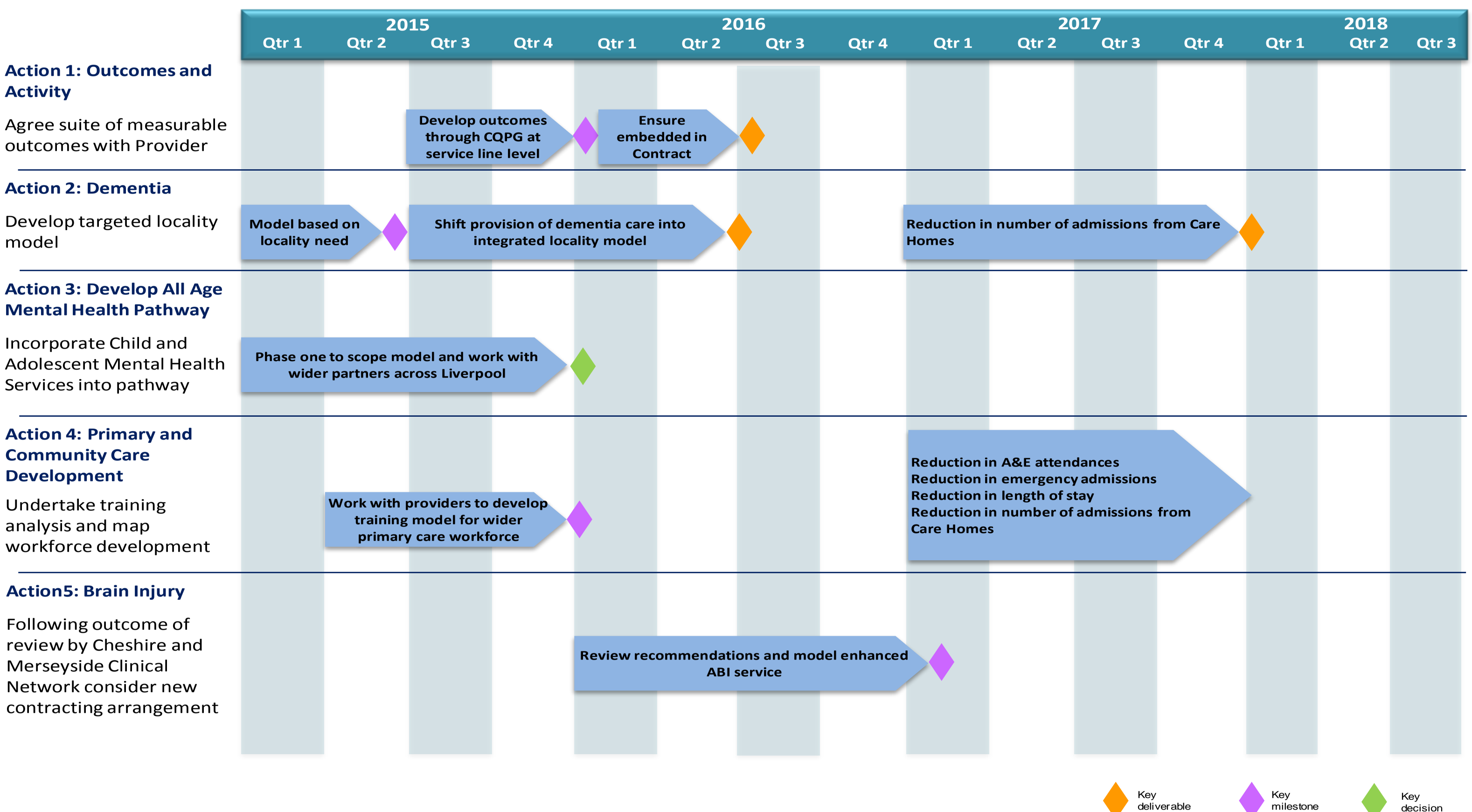
South Sefton Mental Health - Timeline



TIMELINE

Key workstream delivery schedule for South Sefton CCG:

	2015-16	2016-17	2017-18	2018-19	2019-20
Primary Care					
Increased access	→	★			
Enhanced management of patients over 75	→	→	→	→	→ ●
Workforce	→	→	■ (dark)		
Early detection	→	→	★		
Planned Care	→	→	→	→	→ ●
Community Care					
Locality and Virtual Wards	→	→	→	→	→ ●
Care Homes	→	★			
Community Urgent Care	→	★			
Integrated Care Pathways for Long term conditions	→	→	→	→	→ ●
Community Tier 2 services	→	→	■		
Intermediate Care					
Ward 35	→	■			
Procurement	→	→	★		
Better Care Fund	→	→	→	→	→ ●
Integrated reablement care at locality level	→	★			
Step up/down	→	★			
Unplanned Care					
Urgent Care Centre	★				
Transportation	★				
Acute Visiting scheme	→	■			
NWAS pathfinder	→	■			
Community Voluntary Sector (CVS) Bids	★				
Mental Health					
Outcomes and Activity	★				
Dementia	★				
Redesign and commission All Age Mental Health Service	■				
Primary and Community Care Development	★				
Brain Injury	→	→	★		

● = Ongoing Development ★ = Full Implementation ■ = Key Milestones

ACTION, DELIVERY & TIMELINES SOUTHPORT AND FORMBY CCG

PRIMARY CARE

Scope and Rationale

The aim of the Primary Care work stream is to develop a population-based approach to primary care and support them to improve access to primary care and enhance quality of service.

Outcomes

- Better patient experience
- Reduce A&E attendances
- Reduction in referrals
- Reduction in admissions
- Increased prevalence rates
- Reduction in re-admissions
- Reduced length of stay
- Reduced number of admissions from care homes
- Increased quality and provision of primary care diagnostics and monitoring

Priority Projects/Activities

- Increased access
- Enhanced management of patients over 75
- Workforce
  - Succession Planning
- Early detection:
  - CVD – increased uptake of Health Checks
  - Hypertension – recording,_management and treatment
  - Atrial Fibrillation (AF) Management – improve case finding and management
- Planned Care
  - Increase use of Choose and Book utilisation

Contribution to Strategic Priorities

- Unplanned Care
- Long term conditions

Workstream name: Primary Care | ***Date:*** *09 Feb 15*

Senior Manager Lead: *Angela Parkinson* | ***Updated:***

Programme Aim

We will develop a population-based approach to primary care and support them to improve access to primary care and enhanced quality of service.

ID Number	Action	Responsible Lead	Date due for Completion	Actual completion date	RAG
PC01	**Increased access** Extended access to clinicians for chronic disease management. No closure in core hours, additional access outside of core hours. Link to quality scheme	Angela Parkinson	Aug 15		Green
PC02	**Enhanced management of patients over 75** Improved care for patients in care homes by offering more intensive health treatment Link to quality scheme	Moira McGuiness	Sept 15		Amber
PC03	**Workforce** Succession planning and locality development HEE data capture LMC report	Angela Parkinson	Mar 17		Red
PC04	**Early detection** CVD Increased uptake of Health Checks. Hypertension – recording, management and treatment Atrial Fibrillation (AF) Management – improve case finding and management	Sharon Forrester	Mar 16		Amber
PC05	**Planned Care** Increase use of Choose and Book utilisation for both acute and community services	Terry Hill	Sept 15		Red

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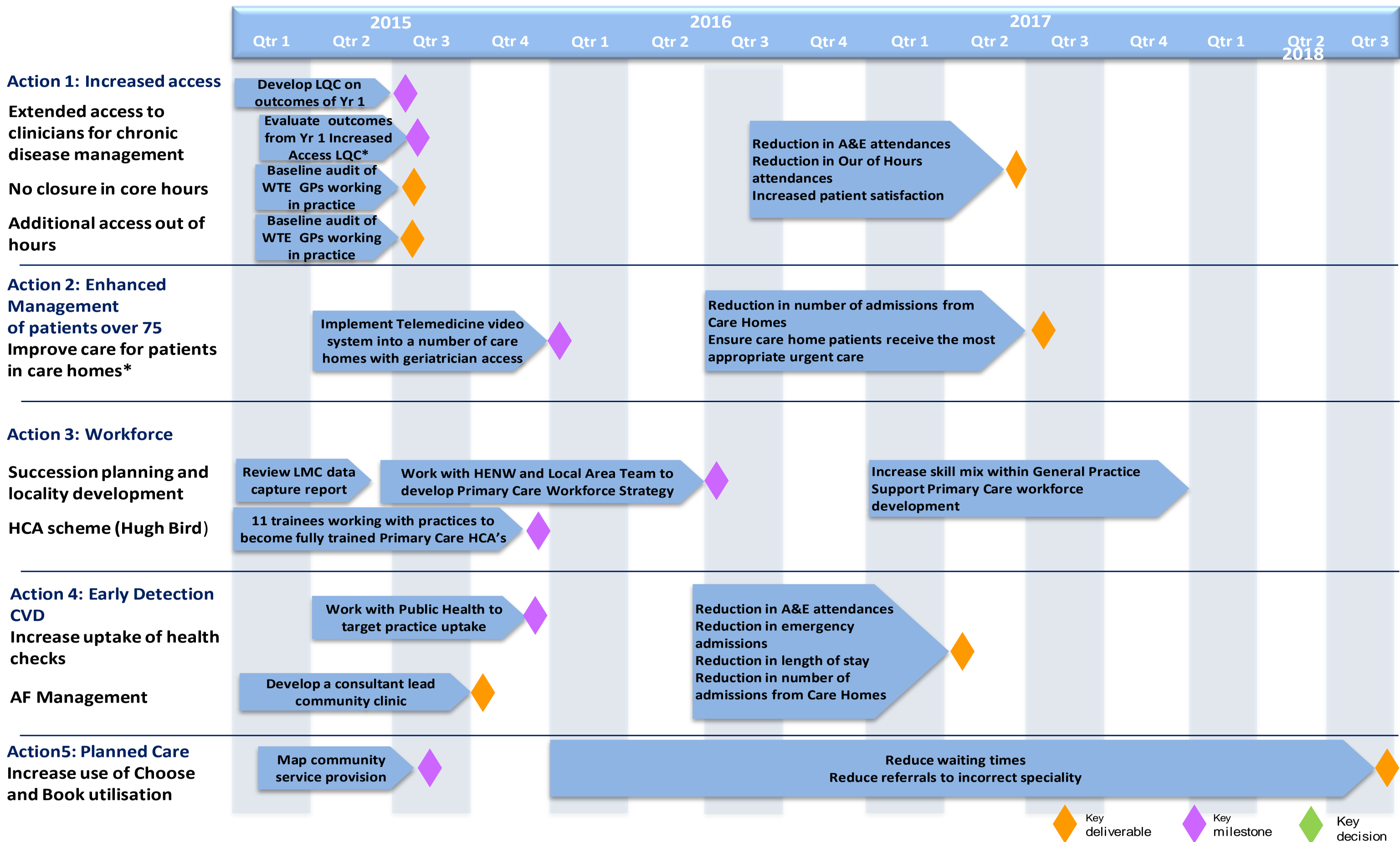
Southport and Formby Primary Care - Timeline



* Local Quality Contract

COMMUNITY CARE

Scope and Rationale

We will commission services that better link together right across health and social care – from hospital and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.

Outcomes

- Improved support for frail elderly
- Reduce A&E attendances
- Reduction in admissions
- Improve health outcomes
- Reduce inequalities
- Admission avoidance
- Long Term Condition support
- Discharge Support
- Increase the number people dying in their preferred place of care by 1%
- Increased use of clinical pathways

Priority Projects/Activities

- Further develop Integrated Community Services
  - Enhance skills of CERT
  - Review treatment rooms
  - Develop SPA
  - Develop Geriatrician model
- Implement developed care pathways
  - Diabetes
  - Cardiology
  - Respiratory
  - Dementia
  - End of Life
  - Frail elderly
- Review of community tier 2 services
- Reduce unplanned admissions for children with:
  - Asthma
  - Epilepsy
  - Diabetes
  - CF

Contribution to Strategic Priorities

- Unplanned Care
- Frail Elderly

Workstream name: *Community Care*			***Date:*** *09 Feb. 15*		
Senior Manager Lead: *Billie Dodd*			***Updated:***		
Programme Aim *We will commission services that better link together right across health and social care – from hospital and community and social services, to GP practices and voluntary, community and faith sector organisations – and where as much care and support as possible is delivered outside of hospital, making it easier for people to access at the times that are more convenient to them.*					
ID Number	**Action**	**Responsible Lead**	**Date due for Completion**	**Actual completion date**	**RAG**
CC01	**Develop Integrated Community Services** • Enhance skills of Community Emergency Response Team (CERT) • Review treatment rooms • Develop Single Point of Access (SPA) • Develop Geriatrician model • Implement enhanced IV therapy service	Billie Dodd	Phase one - June 15 Phase two – Apr 16		
CC02	**Implement Developed All Age Care Pathways** • CVD /Cardiology / Diabetes • Respiratory • Dementia and Frail elderly	Sharron Forrester Terry Hill Jenny Kristensen Kevin Thorne	Jan 16		
CC03	**Review of Community/Tier 2 services and activity** • De-commission • Procurement	Billie Dodd	Phase one Dermatology Apr 16		
CC04	**Children** Reduce unplanned admissions for children with: • Asthma / Epilepsy / Diabetes	Jane Uglow	Apr 16		
CC05	**Discharge flow** Transfer management of discharge from acute into community	Mel Wright	Sept 15		

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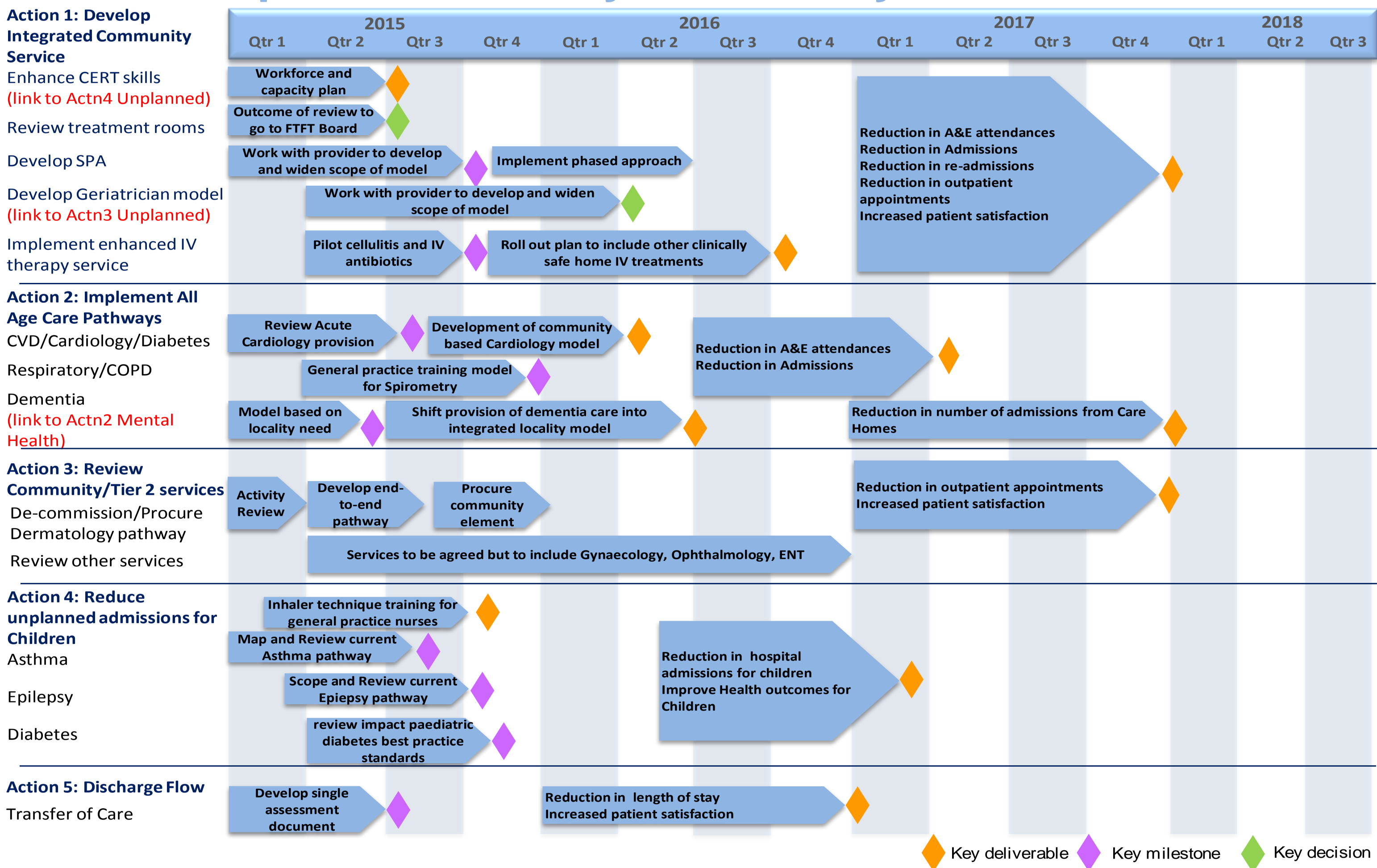
NHS
South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group
Southport and Formby Community Care - Timeline
2015
2016
2017
2018
Qtr 1
Qtr 2
Qtr 3
Qtr 4
Action 1: Develop Integrated Community Service
Enhance CERT skills
(link to Actn4 Unplanned)
Workforce and capacity plan
Review treatment rooms
Outcome of review to go to FTFT Board
Develop SPA
Work with provider to develop and widen scope of model
Implement phased approach
Develop Geriatrician model
(link to Actn3 Unplanned)
Work with provider to develop and widen scope of model
Implement enhanced IV therapy service
Pilot cellulitis and IV antibiotics
Roll out plan to include other clinically safe home IV treatments
Reduction in A&E attendances
Reduction in Admissions
Reduction in re-admissions
Reduction in outpatient appointments
Increased patient satisfaction
Action 2: Implement All Age Care Pathways
CVD/Cardiology/Diabetes
Review Acute Cardiology provision
Development of community based Cardiology model
Reduction in A&E attendances
Reduction in Admissions
Respiratory/COPD
General practice training model for Spirometry
Dementia
(link to Actn2 Mental Health)
Model based on locality need
Shift provision of dementia care into integrated locality model
Reduction in number of admissions from Care Homes
Action 3: Review Community/Tier 2 services
De-commission/Procure Dermatology pathway
Activity Review
Develop end-to-end pathway
Procure community element
Reduction in outpatient appointments
Increased patient satisfaction
Review other services
Services to be agreed but to include Gynaecology, Ophthalmology, ENT
Action 4: Reduce unplanned admissions for Children
Asthma
Inhaler technique training for general practice nurses
Map and Review current Asthma pathway
Epilepsy
Scope and Review current Epiepsy pathway
Diabetes
review impact paediatric diabetes best practice standards
Reduction in hospital admissions for children
Improve Health outcomes for Children
Action 5: Discharge Flow
Transfer of Care
Develop single assessment document
Reduction in length of stay
Increased patient satisfaction
Key deliverable
Key milestone
Key decision

INTERMEDIATE CARE

Scope and Rationale

The Intermediate Care aim is to have ONE point of access, ONE assessment, ONE care planning process. This will be enabled by commissioning co-ordinated care for patients via integrated services and being responsive to patient's needs.

Outcomes

- More integrated, efficient and effective intermediate care
- Reduce hospital admissions
- Reduce re-admissions
- Reduce length of stay
- Ensure decisions about long term care are not made in an acute setting

Priority Projects/Activities

- Tender Intermediate Care bed provision
- Better Care Fund
  - Integrated approach with local authority for care transition
- Integrated care at locality level to ensure timely discharge
- Increase use of appropriate use of step up / step down beds
- Stroke:
  - Development of Intermediate care beds in nursing homes

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care Transformation

Workstream name: *Intermediate Care* | **Date:** *09 Feb. 15*

Senior Manager Lead: *Melanie Wright* | **Updated**:

Programme Aim

Our aim is to have ONE point of access, ONE assessment, ONE care planning process. We will do this by commissioning co-ordinated care for patients via integrated services and be responsive to patients needs.

ID Number	Action	Responsible Lead	Date due for completion	Actual completion date	RAG
IC01	**Intermediate Care Bed Provision** Tender above service	Mel Wright	01/04/16		*Not yet started*
IC02	**Better Care Fund** Work with local authority to enhance intermediate care transition arrangements Better Care Fund initiative	Mel Wright	Ongoing		
IC03	**Integrated care at locality level** Incorporate into care closer to home model with particular focus on frail and elderly with long term conditions, ensure timely discharge and support from intermediate care Better Care Fund initiative	Mel Wright	*01/04/16*		
IC04	**Step up/down** patient flow - appropriate increase in use of step up beds particularly requested by GPs - Awareness raising exercise with GPs	Mel Wright	*TBC*		*Not yet started*
IC05	**Stroke** Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Sharon Forrester	*31/03/16*		

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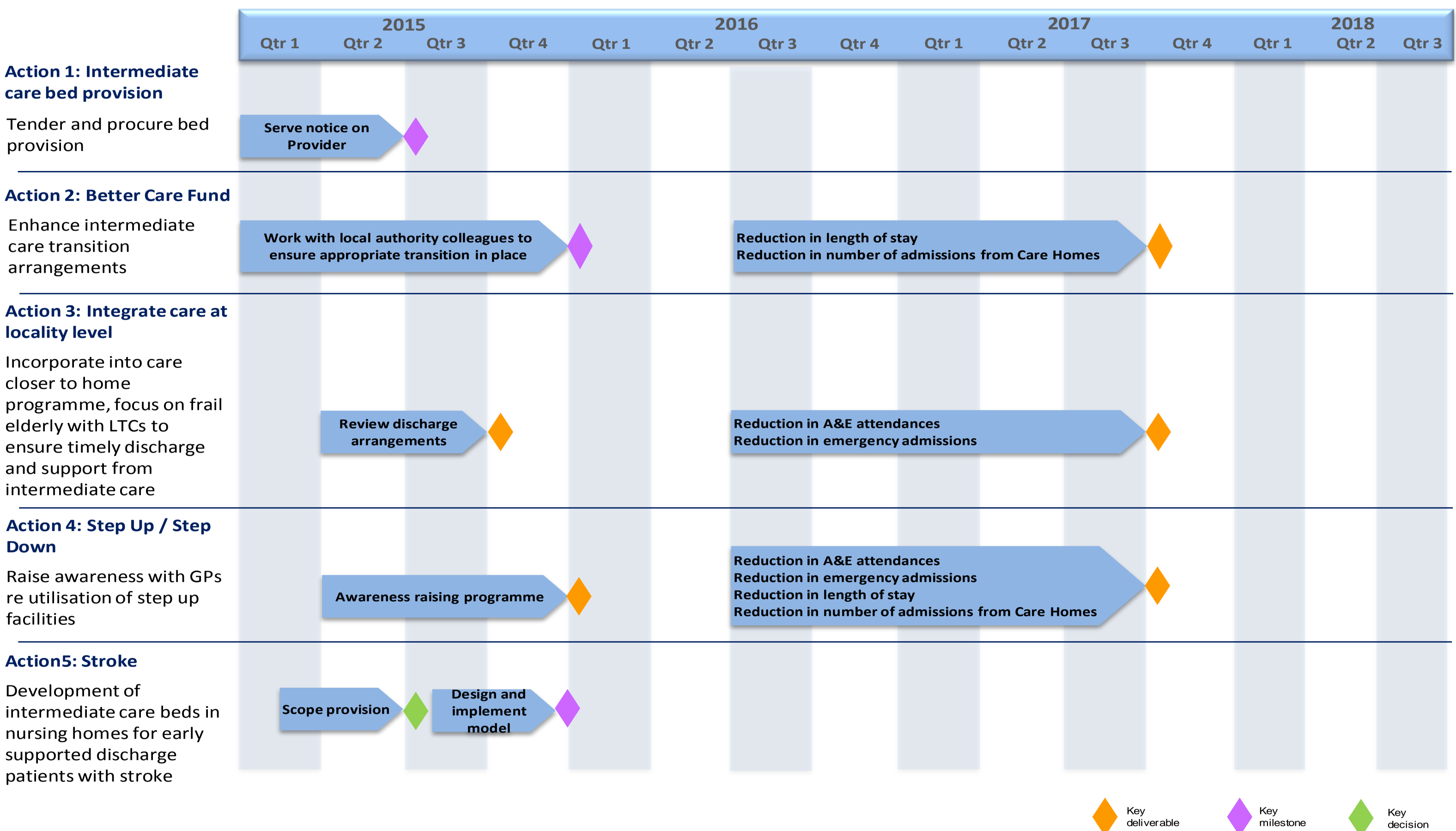
Southport and Formby Intermediate Care - Timeline



UNPLANNED CARE

Scope and Rationale

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

Priority Projects/Activities

- Primary Care Engagement
- Development Ambulatory Care Sensitive Conditions pathways:
  - CVD – Heart Failure reconfiguration
  - Diabetes – In reach diabetes nurse
- Implement Rapid Access Geriatrician Service
- Review role and function of Chronic Care Co-ordinators
- Development of bids from Community Voluntary Sector

Outcomes

- Reduced emergency admissions
- Reduced readmissions
- Reduced A&E attendances
- Reduced non-elective admissions
- Increased availability of ambulances
- Increase number of adults making healthy lifestyle choices
- Increase people's feeling of involvement and confidence to be involved
- Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking)
- Reduce hospital admissions

Contribution to Strategic Priorities

- Primary Care Transformation
- Frail Elderly
- Unplanned Care

Workstream name: *Unplanned Care*	**Date:** *09 Feb. 15*
Senior Manager Lead: *Billie Dodd*	**Updated:**

Programme Aim

We will support urgent and unplanned care for our residents, focusing on admission prevention by developing quality primary and community services. We will ensure a quality and optimum experience for patients in acute care whilst also ensuring patients are supported to be in the right place for their care needs.

ID Number	Action	Responsible Lead	Date due for completion	Actual completion date	RAG
UC01	**Primary Care** Engagement of GPs within Primary Care to support practices to manage patients via extended/integrated primary care teams within localities	Billie Dodd Angela Parkinson	Aug 15		
UC02	**Ambulatory Care Sensitive Conditions (ACS)** CVD • Heart Failure - reconfiguration • Stroke – link with network Diabetes • In reach diabetes nurse	Sharon Forrester Terry Hill	*Jun 16*		
UC03	**Raid Access Geriatrician Service** Further development of geriatrician role to support community teams	Billie Dodd	Operational Jun 15		
UC03	**Chronic Care Co-ordinators** Review of role and future development	Billie Dodd	*Apr 16*		
UC05	**Community Voluntary Sector (CVS)** Development of the bids from CVS to focus on urgent care to support patients to avoid admission	Geraldine O'Carroll	Jun 15		

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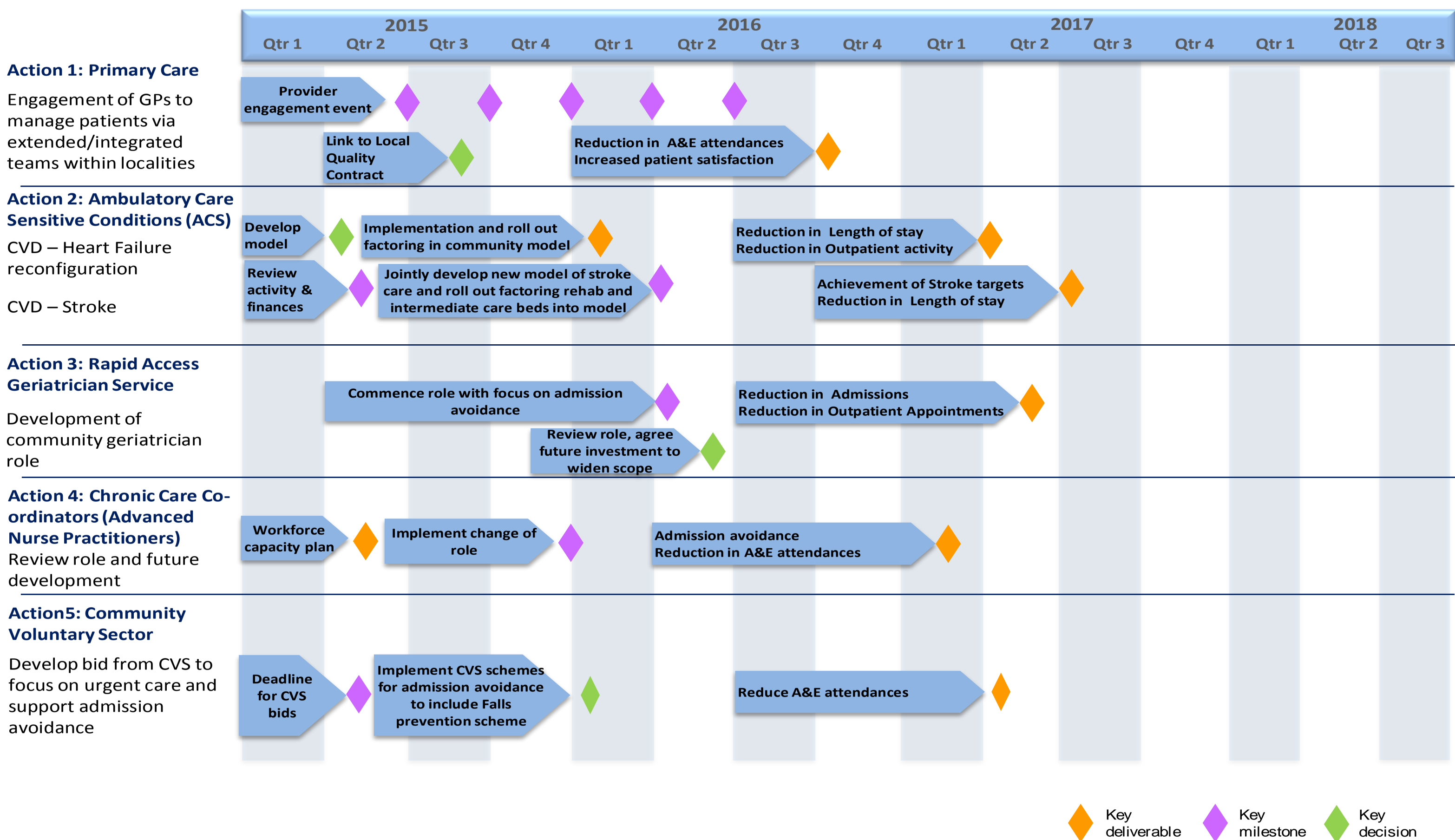
Southport and Formby Unplanned Care - Timeline



MENTAL HEALTH

Scope and Rationale

Our aim is to have a cradle to grave mental health service across Sefton which is recovery focussed, visible, easily accessible, of high quality, safe and deliver beneficial outcomes. Emphasis will be placed on early intervention, recovery and integrated mental and physical health to enable patients to be managed better in the community with a reduced reliance on acute interventions. Dementia will be treated as a long neurological condition within community based networks of care.

Outcomes

- Dementia diagnosis
  - 75% of identified population by 2015/16
  - 90% of identified population by 2018/19
- More people independently managing dementia
- Reduce Tier 4 placements
- Improve response times
- Reduce waiting times
- Early Identification
- Improve patient experience

Priority Projects/Activities

- Outcomes and Activity
  - Develop suite of measurable outcomes with Provider
- Dementia
  - development of integrated locality model
- Commission All Age Mental Health Service
  - To incorporate Child and Adolescent mental health services (CAMHS)
- Brain Injury
  - Move to new contracting arrangements following review by Cheshire and Mersey Clinical Network
- Primary and Community Care Development
  - Training analysis

Contribution to Strategic Priorities

- Frail Elderly
- Primary Care Transformation