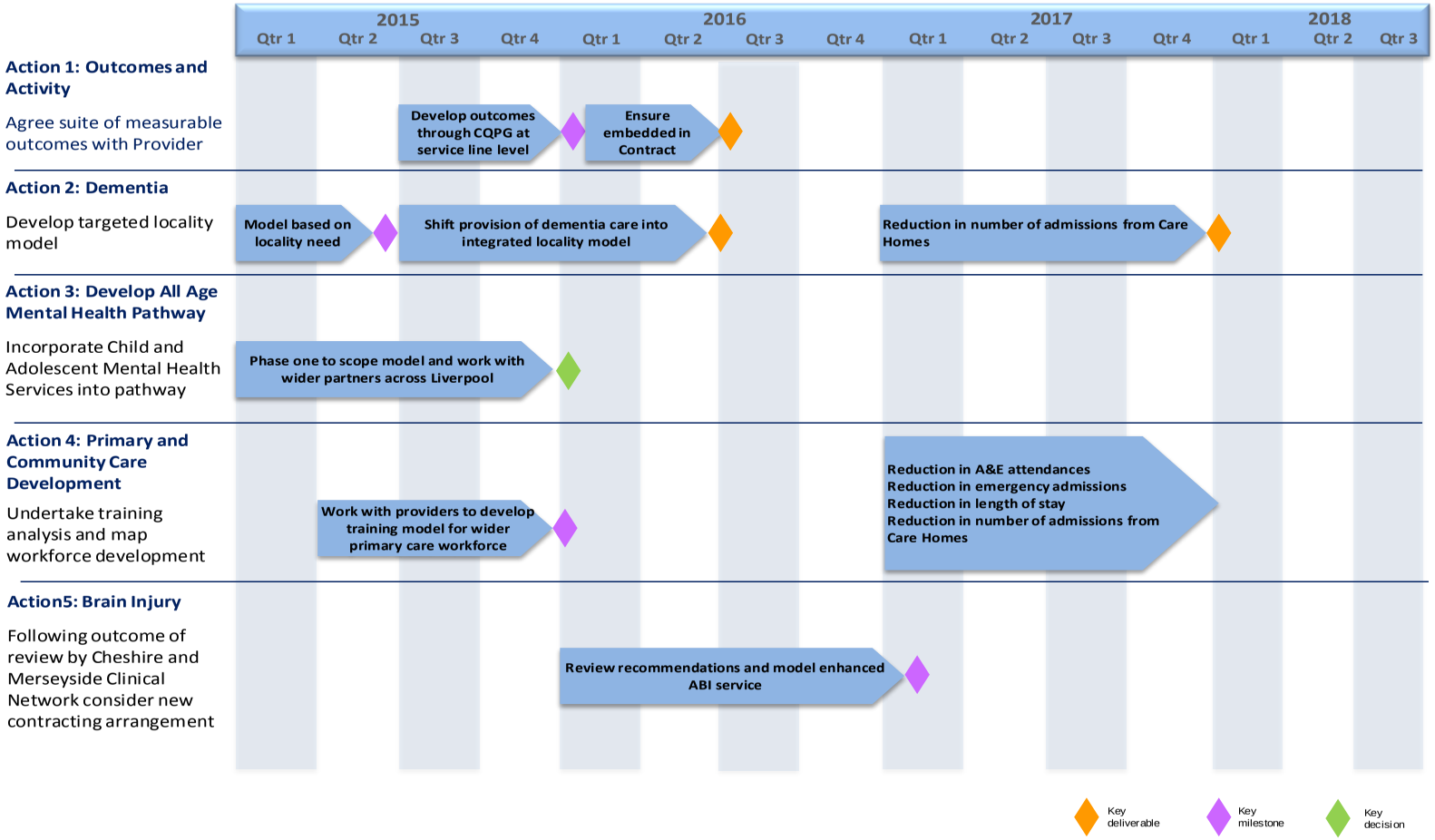
Workstream name: *Mental Health*	***Date:*** *09 Feb. 15*
Senior Manager Lead: *Geraldine O'Carroll*	***Updated****:*

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.

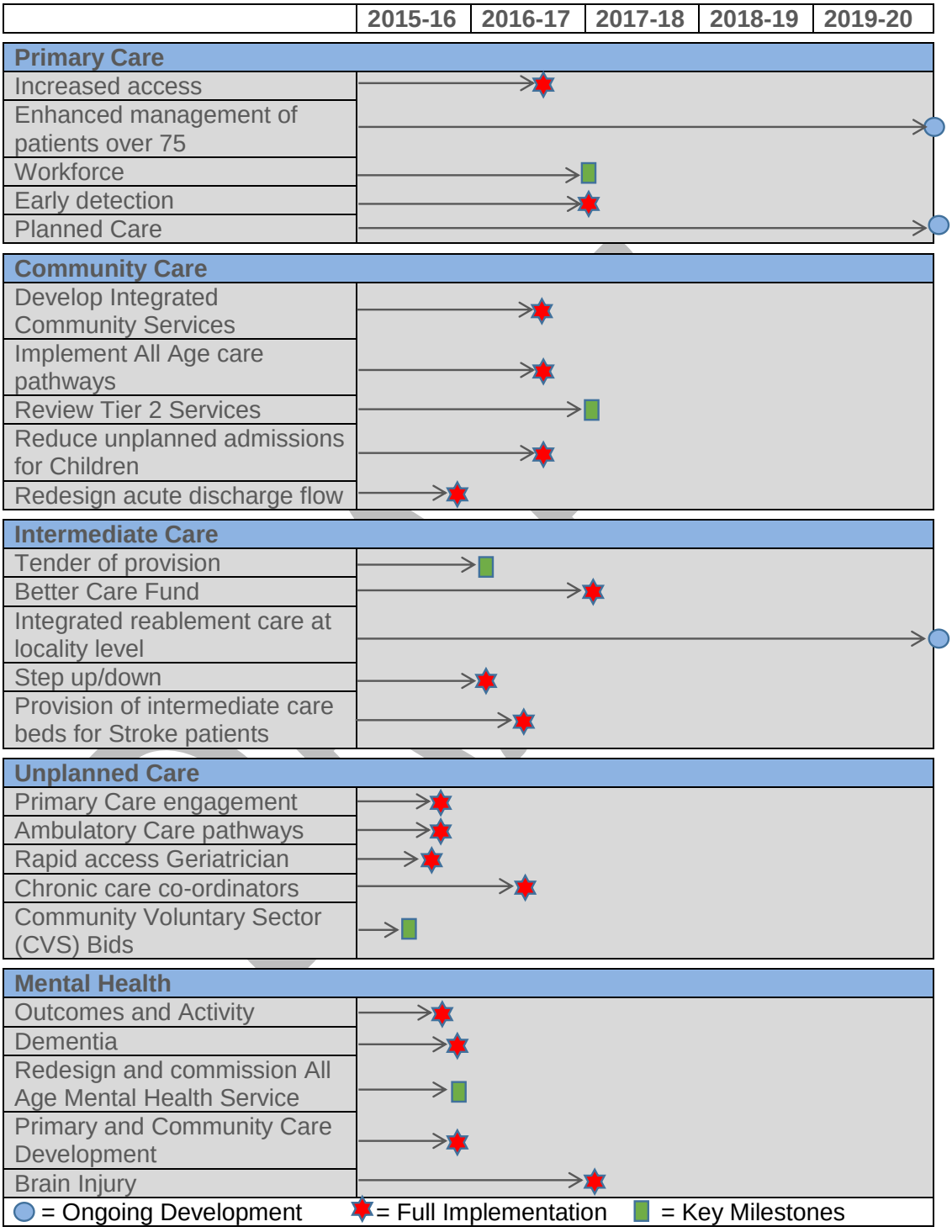
ID Number	Action	Responsible Lead	Date due for completion	Actual completion date	RAG
MH01	**Outcomes and Activity** Agree a suite of measureable outcomes with Mersey Care	*Malcolm Cunningham*	*Dec 15*		
MH02	**Dementia** Shift provision of dementia care from current provider to integrated locality model	*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*		

Southport and Formby Mental Health - Timeline



TIMESCALES

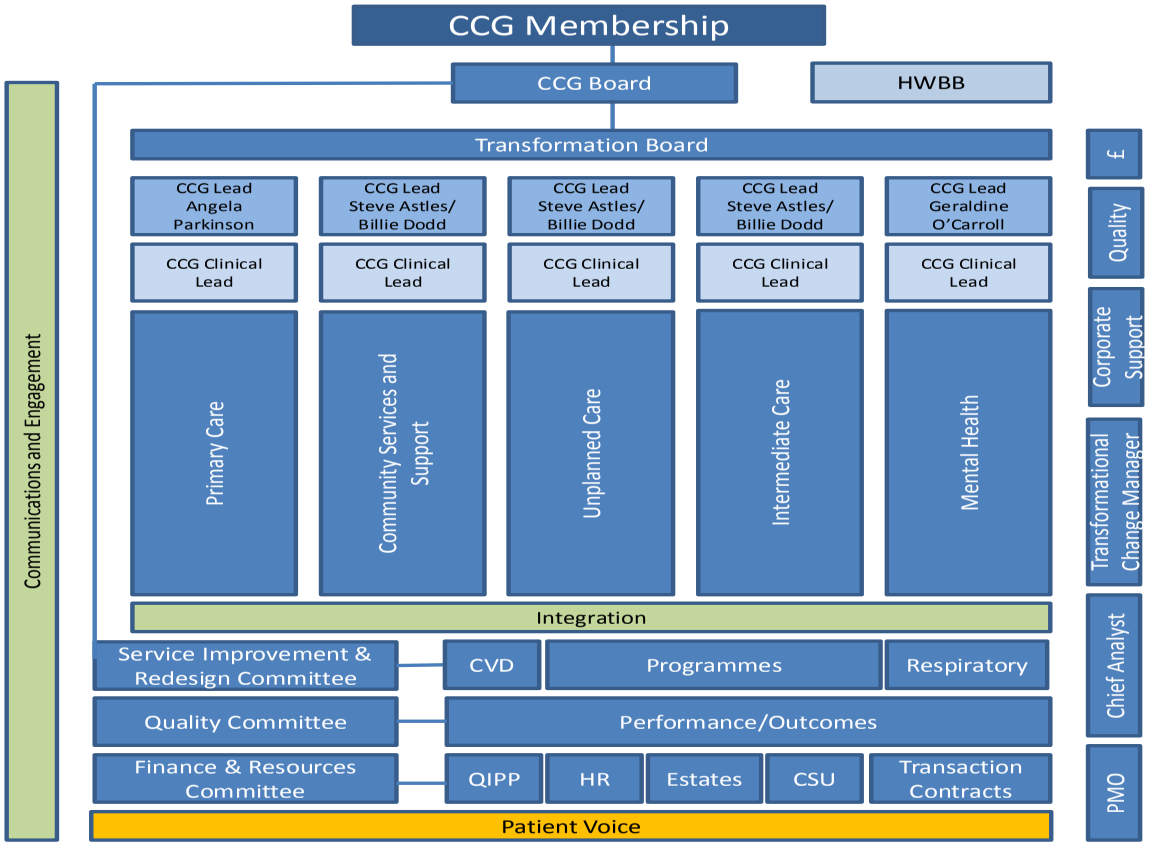
Key workstream delivery schedule for Southport and Formby CCG:

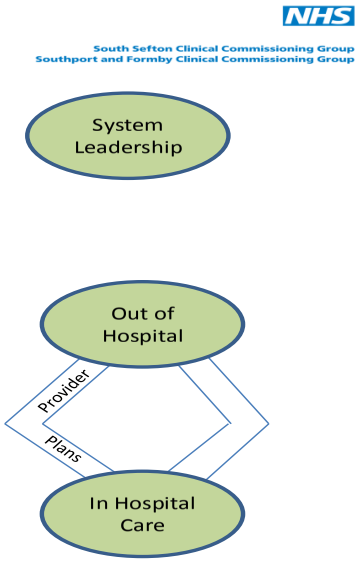


APPENDIX ONE
PROPOSED GOVERNANCE STRUCTURE

DRAFT GOVERNANCE STRUCTURE FOR DELIVERY

These transformation programmes will be managed, progressed and implemented through the individual multi agency gateway groups which will report formally into the Transformation Board.





Joint\management\transformation governance structure v5 060515.ppt

APPENDIX TWO
INITIATIVES, BENEFITS AND MEASURES
SOUTH SEFTON CCG

PRIMARY CARE

INITIATIVE	QUALITY BENEFIT	MEASURE
Increased access and patient choice	Extended access to clinicians. No closure in core hours, additional access outside of core hours.	Reduce A&E attendances
Collaboration across practices	Better patient access Care closer to home	Better patient experience
Co-commissioning – greater involvement	Co-ordination of service provision	Better patient experience
Workforce Planning and Development • Work with HEE to develop a Primary Care workforce strategy Heath Care Assistant scheme in collaboration with Hugh Bird College	Informed and empowered Workforce Succession Planning	Better patient experience Reduction in referrals Reduction in A&E attendances
Primary Care Infrastructure Fund	Potential to provide a wider range of services closer to home	Better patient experience Reduction in referrals
IT Data sharing / Interoperability	Holistic approach to patient care	Better patient experience
Early detection CVD • Increased uptake of Health Checks. • Hypertension – recording, management and treatment • Atrial Fibrillation (AF) Management – improve case finding and management	Prevention of multiple long term conditions Better patient outcomes Better management of patients with long term conditions	Reduce A&E attendances Reduction in admissions Increased prevalence rates Better patient experience
Early detection	Joint commissioning of rehabilitation facilities with Public Health and third sector Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Reduce A&E attendances Reduction in admissions Reduction in re-admissions Reduced length of stay Reduced number of admissions from care homes
Enhanced management of patients in care homes	Improved care for patients in care homes by offering more intensive health treatment	Reduced number of admissions from care homes

	Reduction in hospital acquired complications Maintain function level of patients Improve End of Life care	Reduced length of stay Reduction in Hospital acquired infections Increase the number people dying in their preferred place of care by 1%
Children • **obesity – supporting primary care and public health** • **Reducing variability within primary care by optimising medicines use**	Better Quality of Life Reduced morbidity Eradicating prescribing errors between secondary and primary care Support patients to get the best from their medicines	Reduction in referrals Reduction in admissions
Diabetes • **Prevention – Impaired Glucose Regulation (IGR)** • **Prevention – Increased awareness** • **Identify pilot areas to further develop pathways for IGR screening** • **Dashboard due to be rolled out to all practices to support practices to case find, identify and understand variation at practice level** • **Education – for both health professionals and patients**	Early intervention can prevent, delay or reverse the onset of diabetes Evidence of clinical and cost effectiveness for lifestyle interventions Offer of support every step of the way, take small steps, Provide assistance with willpower, coping strategies and practical support.	Reduction in referrals Reduction in admissions Better patient experience
Respiratory • **Primary care education programme covering Asthma and COPD all ages** • **Roll out inhaler technique across all localities** • **Review all at risk patients across all four localities**	Understand the impact the disease process regarding the quality of life of these patients and the importance of self management. Identifying the early detection of COPD. Increased self management	Reduce A&E attendances Avoid hospital admissions Better patient experience

Cancer • **Cancer Research UK – two posts in Merseyside and Cheshire undertaking practice visits** • **Programme of screening uptake** • **Embedding best practice via Macmillan GPs**	Increased awareness Earlier diagnosis Increased screening uptake Management of late effects of cancer and cancer treatments	Reduce A&E attendances Avoid hospital admissions Better patient experience
Planned Care • **Choose and Book utilisation** • **Choose and Book addition of community services**	Increased patient choice Reduce DNAs Increased	Reduce waiting times Reduce referrals to incorrect speciality Reduce referrals to secondary care Reduction in unplanned admissions
End of Life • **Access to Community geriatrician team to support Primary Care Team in complex cases** • **Collaborative working with Public Health to raise awareness of 'Dying Matters'** • **Raise public awareness around care planning** • **Develop bereavement frameworks to effectively and efficiently provide bereavement support and signposting to avoid future psychological distress and morbidity** • **TRANSFORM Education programme**	Extended access to clinicians. Care closer to home Co-ordination of service provision Holistic approach to patient care Promote public awareness of dying, death and bereavement improve the quality of end of life care	Increase the number people dying in their preferred place of care by 1% Reduction in unplanned admissions

COMMUNITY CARE SOUTH SEFTON

INITIATIVE	QUALITY BENEFIT	MEASURE
Locality and Virtual Wards • Enable direct telephone access for professionals and patients • Improve internal coordination including permanent role of dedicated virtual ward manager • Develop the community matron model • Facilitate improved integration across all disciplines through electronic and face-to-face mechanism including effective virtual ward round • Improve pro-active care program impact • Shared care planning for top 2% at risk including palliative and care home patients using standardised template • Access to all respective virtual ward staff to the common care record • Mobile working for all virtual ward staff • Electronic managed referrals into the virtual ward • Continuity and relational coordination of staff aligned to specific GP practices • Align health visitors and district nurses to practices • Streamline treatment room workflow and task shift to enable efficiency • Community Navigators (Health Trainers) in partnership with Public Health– focus on prevention and healthy living	Identification and case management of 'at risk' patients within the community Outcomes for the frail elderly and those with long-term conditions will be improved Co-ordination of care Integration of care Proactive nursing Re-ablement Common patient record and IT system	Reduction in unplanned/emergency admissions Reduction in re-admissions Reduced length of stay Better health outcomes

Care Homes • **Community matron for each locality to support care homes along with primary care** • **Promotion and support of NWAS/SSCCG care plan along with advanced care planning facilitated via care home facilitator (6 steps programme) and advanced care plan lead (new post)** • **Standardisation of care home protocols** • **Community geriatrician in-reach to care homes** • **Tele-medicine video support for care homes to community matrons, UCT, on-call geriatrician and remote nursing support** • **Quality dashboard working in conjunction with the LA** • **Ongoing support by meds management** • **Care home improvement collaborative**	Extended access to clinicians. Co-ordination of service provision Potential to provide a wider range of services closer to home Holistic approach to patient care Better patient outcomes Better management of patients with long term conditions Improved care for patients in care homes by offering more intensive health treatment Reduction in hospital acquired complications	Reduced number of admissions from care homes Reduced length of stay for care home admissions Reduction in Hospital acquired infections Increase the number people dying in their preferred place of care by 1% Reduction in A&E attendances Avoid hospital admissions Better patient experience

Community Urgent Care
• **Acute GP home visiting scheme**
• **Integration of all community urgent care providers including the following**
  ○ **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**
• **Urgent care team input into care homes directly**
• **Increase number of community based**
	Improved access to primary care
	Care closer to home
	Reduced exposure to hospital acquired infections
	Co-ordinated response to urgent care
	Patients able to live more independently
	Patients stay at home longer
	Emotional, physical and social care needs assessed together
	Common patient record and IT system
		Reduced number of admissions from care homes
		Reduced length of stay for care home admissions
		Reduction in Hospital acquired infections
		Reduction in A&E attendances
		Avoid hospital admissions
		Better patient experience

intermediate care beds • Single entry and coordination for intermediate care • Rotation of therapists through acute trust, CICT, ward 35 • Patient alert system to community matrons, specialist teams, acute trust front end coordinator • Ratified pathway development for 14 ambulatory care conditions • Mobile access to EMIS for all staff • Consolidation of SPC including scoping health and social integration		

Integrated Care Pathways for LTCs
• For the following conditions
  ○ Diabetes
  ○ Heart Failure
  ○ COPD
  ○ Palliative care
  ○ Dementia & Frailty
• Consultant community hot clinics
• Consultant oversight for specialist nursing teams
• Develop role and opportunity of GPSI
• Seamless step-up step down
	Improved access to clinician
	Care closer to home
	Reduced exposure to hospital acquired infections
	Patients able to live more independently
	Patients stay at home longer
	Holistic approach to patient care
	Better patient outcomes
	Better management of patients with long term conditions
		Reduction in admissions
		Reduction in re-admissions
		Reduced length of stay
		Improve health outcomes
		Reduce Inequalities

Diagnostic Services • Urgent bloods wait time to 24h for domiciliary, treatment room and UCT	Develop more community specialty services to streamline intervention Ensure only appropriate conditions are referred to secondary care	Reduce A&E attendances Better patient experience Care closer to home Reduce referrals
End of Life • develop a locality based structure for all staff	Extended access to clinicians.	Increase number of people

delivering palliative care • ensure that those who wish to die in the community in their PPC have the support they require • improve access to EOL beds in the community for those where it is not possible to support their needs in their own home • commission additional bed capacity for EoL patients • support and improve integration of all EOL services to ensure that patients are able to die in their PPC • support an integrated programme of education for all of those delivering EOL care in the community • ensure that all EOL care in the community is of high quality and supported by the necessary expertise regardless of where this take place ie, private home, care home	Care closer to home Co-ordination of service provision Holistic approach to patient care Improve the quality of end of life care Appropriate increase in use of step up beds Promote awareness of dying, death and bereavement	dying in usual place of residence Reduced LoS Admission avoidance Reduction in unplanned admissions Increase in reablement
Cancer • to develop the virtual ward Macmillan coordinator role (vacant) • to scope the information and support needs of patients in South Sefton and recognise existing services to develop a directory/programme for survivorship • to improve the cancer knowledge of existing staff including primary care so that patients can/may receive their long term cancer follow up in the community (see primary care)	Increase awareness of Macmillan's services Communicate campaign messages Involve local people Improve the lives of people affected by cancer across the Sefton	Admission avoidance Reduction in unplanned admissions

Respiratory • **Develop patient led self-care pilot programme** • **Review current respiratory pulmonary rehab programme and develop new programme with Public Health and SCVS** • **Commission enhanced Home Oxygen Therapy Service** • **Set- up MUR programme to train local pharmacies correct inhaler technique**	Early detection Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
CVD • **Telehealth – consultant hotline pilot** • **Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.**	Increased access to clinician Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
Diabetes • **Review of community diabetes care** • **Work with current Acute Provider to explore benefits of joint clinics for patients with diabetes and kidney injury** • **Implementation of a primary care pathway for diabetes footcare, scope and potential cost and provider implications** • **Gestational diabetes – clinical pathway out to consultation outlining support before and during pregnancy**	Early detection Increased access to clinician Increased self management Care closer to home Holistic approach Reduce morbidity	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
Children • **Review children's community nursing team with a view to commissioning an integrated children's nursing model in 16/17** • **Reduce unplanned admissions for children with LTC: asthma, epilepsy, diabetes, CF**	Increased access to clinician Care closer to home	Admission avoidance LTC support Discharge Support Reduce A&E attendances

• Review community paediatric services • Review children's therapies • Replicate inhaler technique pilot for children • Palliative care review • End of Life review • Review complex children's nursing care		
Development of community/Tier 2 services • Ophthalmology community assessment service (OCAS) • ENT • Dermatology	Care closer to home	Reduce outpatient activity

INTERMEDIATE CARE

INITIATIVE	QUALITY BENEFIT	MEASURE
Enhanced intermediate care and reablement (BCF initiative)	Patients able to live more independently Patients stay at home longer Emotional, physical and social care needs assessed together	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Step up/down – patient flow (CC2H)	Appropriate increase in use of step up beds particularly requested by GPs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Integrated care at locality level building on virtual ward and care closer to home (BCF initiative)	Focus on Frail and elderly with LTCs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting

UNPLANNED CARE SOUTH SEFTON

INITIATIVE	QUALITY BENEFIT	MEASURE
Acute Visiting Scheme	Support for care home patients More patients being treated at home rather than being conveyed to hospital	Reduction in unnecessary attendances to hospital
Ambulatory Care Sensitive (ACS) Conditions • **CVD Heart failure – reconfiguration of acute heart failure team to work alongside consultant in AED** • **Respiratory – in reach of Community team**	Development of zero-stay ambulatory care condition pathways This would offer appropriate fast track diagnosis and treatment in an assessment area and discharge to the community to prevent admission Consultant reviews Initiation of treatment	Admission avoidance Reduction in admissions Admission avoidance Reduction in admissions
NWAS pathfinder acute visiting scheme	Ambulance service and other providers working together to improve decision-making before making transfers to urgent care settings More patients being treated at home/in the community rather than being conveyed to hospital	Increased availability of ambulances Reduce A&E attendances Reduce emergency admissions
Explore ambulance transportation requirements to support Walk in Centre as part of new model of care as an alternative to A&E	Reducing conveyance to A&E Referring to Primary Care/OOH if required	Reduction in non-elective activity
Integrated Discharge Team	Better patient and carer experience Reduction in hospital acquired complications Prompt and pro-active identification of end of life care	Increased discharges to home Reduced time from discharge to home Reduced patients in long term care Reduced length of stay
111 programme implementation	Provide advice for patients and appropriate use of services	Reduce A&E attendances

Review of Walk in Centre and impact of closure of Darzi practice – development of Urgent Care Centre	More patients being treated in the community rather A&E	Reduce A&E attendances
Self care/management • **easily accessible support for the self management of conditions delivered as part of the virtual ward and health and wellbeing board via the better care fund** • **Patient education**	Disease prevention Minor illness Improved signposting Targeted education Tailored self-care plan Assistive Technologies	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 Reduce readmissions
Development of the Community Voluntary Sector (CVS) - Bids from CVS to focus on urgent care to support patients to avoid admission	Ensure services are used appropriately and community Engagement and commissioning	
Proactive case management	To support self-care and early disease management	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 Reduce readmissions
Proactive case finding	To support self-care and early disease management	Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of

		unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Additional Community Geriatricians	To support the Community teams	Reduction in unplanned admissions Reduced Length of Stay
Cancer **Develop acute oncology to include outpatient clinic access for cancer of unknown primary 2/52 clinic, side effects of treatment**	Better patient and carer experience To support early diagnosis	Reduction in unplanned admissions Reduced Length of Stay

MENTAL HEALTH

INITIATIVE	QUALITY BENEFIT	MEASURE
Primary Care development and education	Raise awareness and understanding	Patient satisfaction Survey
Dementia	Holistic care for patient Improved screening Services wrapped around patient Access to voluntary services Develop service to meet patient need Extend memory services Enhance Alzheimer's Society Support Review use of anti psychotic drugs for Dementia	75% of identified population by 2015/16 90% of identified population by 2018/19
Child and Adolescent Mental Health Services (CAMHS)	Improve access and understanding of CAMHS services Ensure seamless transiton Increased patient experience	Reduce Tier 4 placements Improve response times
Brain Injury	Co-ordinated care for patient	Better patient experience
Outcomes and Activity Information	Introduction of Payment by Results (PbR) is a major organisational change for both providers and commissioners Financial modelling and profiling of risk to be undertaken	To be agreed with Mersey Care NHS Trust
Children • Review ADHD and ASD pathways • Develop Children's IAPT service	Improve access to services Increased patient experience	Reduce waiting times Early Identification Better patient experience
Cancer • Psychological support via Aintree cancer pathway		Better patient experience

APPENDIX TWO
INITIATIVES, BENEFITS AND MEASURES
SOUTHPORT CCG

PRIMARY CARE		
INITIATIVE	**QUALITY BENEFIT**	**MEASURE**
Collaboration across practices	Better patient access Care closer to home	Better patient experience
Co-commissioning – greater involvement	Co-ordination of service provision	Better patient experience
Workforce Planning and Development **Heath Care Assistant scheme in collaboration with Hugh Bird College**	In collaboration with NHS England/HENW Succession Planning	
Primary Care Infrastructure Fund	Potential to provide a wider range of services closer to home	Better patient experience Reduction in referrals
IT Data sharing / Interoperability	Holistic approach to patient care	Better patient experience
Increased access and patient choice	Extended access to clinicians. No closure in core hours, additional access outside of core hours.	Reduce A&E attendances
Early detection CVD • **Increased uptake of Health Checks.** • **Hypertension – recording, management and treatment** • **Atrial Fibrillation (AF) Management – improve case finding and management** • **Community cardiology services – review acute cardiology provision**	Prevention of multiple long term conditions Better patient outcomes Better management of patients with long term conditions Rapid access to diagnostics	Reduce A&E attendances Reduction in admissions Increased prevalence rates Better patient experience Reduced LoS
Early detection	Joint commissioning of rehabilitation facilities with Public Health and third sector Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Reduce A&E attendances Reduction in admissions Reduction in re-admissions Reduced length of stay Reduced number of admissions from care homes
Enhanced management of patients in care homes	Improved care for patients in care homes by offering more intensive health treatment	Reduced number of admissions from care homes

	Reduction in hospital acquired complications Maintain function level of patients Improve End of Life care	Reduced length of stay for care home admissions Reduction in Hospital acquired infections Increase the number people dying in their preferred place of care by 1%
End of Life • **Access to Community geriatrician team to support Primary Care Team in complex cases** • **Collaborative working with Public Health to raise awareness of 'Dying Matters'** • **Raise public awareness around care planning** • **Develop bereavement frameworks to effectively and efficiently provide bereavement support and signposting to avoid future psychological distress and morbidity** • **TRANSFORM Education programme**	Extended access to clinicians. Care closer to home Co-ordination of service provision Holistic approach to patient care Promote public awareness of dying, death and bereavement improve the quality of end of life care	Increase the number people dying in their preferred place of care by 1% Reduction in unplanned admissions
Children • **obesity – supporting primary care and public health**	Better Quality of Life Reduced morbidity	Reduction in referrals Reduction in admissions
Diabetes • **Prevention – Impaired Glucose Regulation (IGR)** • **Prevention – Increased awareness** • **Identify pilot areas to further develop pathways for IGR screening**	Early intervention can prevent, delay or reverse the onset of diabetes Evidence of clinical and cost effectiveness for lifestyle interventions Provide assistance with willpower, coping strategies and practical support.	Reduction in referrals Reduction in admissions Better patient experience

Cancer • Cancer Research UK – two posts in Merseyside and Cheshire undertaking practice visits • Programme of screening uptake • Embedding best practice via Macmillan GPs	Increased awareness Earlier diagnosis Increased screening uptake Management of late effects of cancer and cancer treatments	Reduce A&E attendances Avoid hospital admissions Better patient experience
Respiratory • Primary care education programme covering Asthma and COPD all ages • Roll out inhaler technique across all localities	Understand the impact the disease process regarding the quality of life of these patients and the importance of self management. Identifying the early detection of COPD. Increased self management	Reduce A&E attendances Avoid hospital admissions Better patient experience
Planned Care • Choose and Book utilisation • Choose and Book addition of community services • Choice	Increased patient choice Reduce DNAs Increased	Reduce waiting times Reduce referrals to incorrect speciality Reduce referrals to secondary care Reduction in unplanned admissions

COMMUNITY CARE		
New pathways of care introduced (CC2H)	**For diabetes, cardiology, respiratory, dementia, End of Life, Frail Elderly fully in place by April 2015**	**Reduce A&E attendances Reduction in admissions Improve health outcomes Reduce inequalities**
End of Life • **Commission TRANSFORM hospice based community team** • **Equitable and speedy access to EoL beds** • **Ensure that services are developed which provide holistic care regardless of the need. (eg dementia, LTC, cancer, frail elderly)** • **Access to a full compliment of staff within the community to prevent hospital admission** • **Seamless 24/7 access to care** • **Full integration of provider services** • **Audit of quality of Gold Standards Framework (GSF) registers** • **All care homes to complete Six Steps to Success programme or GSF care homes** • **All people identified as being EoL will be registered on GSF register, regardless of diagnosis or capacity** • **Mobile working for all community and SPCS staff** • **OOH – integration and improved handover processes of DN night service to OOH services and day DN services** • **Sharing of relevant information, including**	Extended access to clinicians. Care closer to home Co-ordination of service provision Holistic approach to patient care Improve the quality of end of life care Appropriate increase in use of step up beds Promote awareness of dying, death and bereavement	Increase number of people dying in usual place of residence Reduced LoS Admission avoidance Reduction in unplanned admissions Increase in reablement

care plans • Evaluate care home provision with a view to supporting equitable and sustainable EoL care across care homes		
Community Emergency Response Team	Improved access to primary care Care closer to home Reduced exposure to hospital acquired infections Co-ordinated response to urgent care Patients able to live more independently Patients stay at home longer Emotional, physical and social care needs assessed together Common patient record and IT system	Reduced number of admissions from care homes Reduced length of stay for care home admissions Reduction in Hospital acquired infections Reduction in A&E attendances Avoid hospital admissions Better patient experience
Children • Evaluate children's community nursing team • Reduce unplanned admissions for children with LTC: asthma, epilepsy, diabetes, CF • Review community paediatric services • Review children's therapies • Replicate inhaler technique pilot for children • Palliative care review • End of Life review • Review complex children's nursing care • Develop community audiology service	Increased access to clinician Care closer to home	Admission avoidance LTC support Discharge Support Reduce A&E attendances
Diabetes • Review of community diabetes care • Implement generic agreed pathways in collaboration with West Lancashire CCG • Implementation of a primary care pathway for diabetes footcare, scope and potential cost	Early detection Increased access to clinician Increased self management Care closer to home Holistic approach	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances

and provider implications • Gestational diabetes – clinical pathway out to consultation outlining support before and during pregnancy	Reduce morbidity	
CVD • Development of intermediate care beds in nursing homes for early supported discharge patients with stroke.	Increased access to clinician Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances
Cancer • Support community based Macmillan centre providing: ○ info and support ○ Survivorship ○ In-reach into Southport & Ormskirk Hospital ○ Wellness and Activity co-ordinator • Potential for new community recovery and support pathways for breast patients following service changes at Southport and Ormskirk Acute Trust	Increase awareness of Macmillan's services Communicate campaign messages Involve local people Improve the lives of people affected by cancer across the Sefton	Admission avoidance Reduction in unplanned admissions
Respiratory • Develop patient led self-care pilot programme • Review current respiratory pulmonary rehab programme and develop new programme with Public Health and SCVS • Commission enhanced Home Oxygen Therapy Service	Early detection Increased self management Care closer to home	Admission avoidance Reduction in unplanned admissions Reduce A&E attendances

INTERMEDIATE CARE		
Enhanced intermediate care and reablement (BCF initiative)	Patients able to live more independently Patients stay at home longer Emotional, physical and social care needs assessed together	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Step up/down – patient flow (CC2H)	Appropriate increase in use of step up beds particularly requested by GPs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting
Integrated care at locality level building on virtual ward and care closer to home (BCF initiative)	Focus on Frail and elderly with LTCs	Reduce hospital admissions Reduce re-admissions Reduce length of stay Ensure decisions about long term care are not made in an acute setting

UNPLANNED CARE		
End of Life • Speedy diagnostic and access to treatment to negate the need for transfer to a secondary care setting • Acute hospital to attain GSF accreditation and undertake national TRANSFORM programme • Appropriate and timely discharge	Care closer to home Improve the quality of end of life care Promote awareness of dying, death and bereavement	Reduce A&E attendances Reduce LoS Admission avoidance
Ambulatory Care Sensitive (ACS) Conditions **CVD** • Heart failure – possible reconfiguration of acute heart failure team to work alongside consultant in AED based on Aintree model • Stroke – link with Cheshire and Merseyside networks to explore the possibility of 3 hyper Acute Stroke Units across Cheshire and Merseyside to address and improve inconsistences of the quality of care **Diabetes** • In-reach diabetes nurse to identify and appropriately discharge in-patients with diabetes who no longer need to be in a hospital setting	This would offer appropriate fast track diagnosis and treatment in an assessment area and discharge to the community to prevent admission Access to Consultant reviews Timely initiation of treatment	Reduction in admissions Admission avoidance Reduce LoS Better patient experience
Cancer Develop acute oncology to include outpatient clinic access for cancer of unknown primary 2/52 clinic, side effects of treatment	Better patient and carer experience To support early diagnosis	Reduction in unplanned admissions Reduced LoS

NWAS CERT pathfinder	Ambulance service and other providers working together to improve decision-making before making transfers to urgent care settings More patients being treated at home/in the community rather than being conveyed to hospital	Increased availability of ambulances Reduce A&E attendances Reduce emergency admissions
Self care/management • **easily accessible support for the self management of conditions delivered as part of the virtual ward and health and wellbeing board via the better care fund** • **Patient education**	Patients will: • have knowledge of the condition and/or its management • adopt a self-management care plan agreed and negotiated in partnership with health professionals, significant others and/or carers and other supporters • actively share in decision-making with health professionals, significant others and/or carers and other supporters • monitor and manage signs and symptoms of the condition • manage the impact of the condition on physical, emotional, occupational and social functioning • adopt lifestyles that address risk factors and promote health by focusing on prevention and early intervention • have access to, and confidence in the ability to use support services	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 Reduce readmissions
Development of the Community Voluntary Sector (CVS) - Bids from CVS to focus on urgent care to support patients to avoid admission	Ensure services are used appropriately and community Engagement and commissioning	Reduce A&E attendances Better patient experience

111 Programme implementation	Provide advice for patients and appropriate use of services	Reduced attendance in A&E
Proactive case management	To support self-care and early disease management	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 Reduce readmissions
Proactive case finding	To support self-care and early disease management	Increase people's feeling of involvement and confidence to be involved Reduce the prevalence of unhealthy behaviours (poor diet, inactivity, smoking) Reduce hospital admissions Reduce readmissions
Community Geriatrician	To support the Community teams	Reduction in unplanned admissions Reduced LoS

MENTAL HEALTH		
Primary Care development and education	Raise awareness and understanding	Patient satisfaction Survey
Dementia	Holistic care for patient Improved screening Services wrapped around patient Access to voluntary services Develop service to meet patient need Extend memory services Enhance Alzheimer's Society Support Review use of anti psychotic drugs for Dementia	75% of identified population by 2015/16 90% of identified population by 2018/19
Child and Adolescent Mental Health Services (CAMHS)	Improve access and understanding of CAMHS services Ensure seamless transiton Increased patient experience	Reduce Tier 4 placements Improve response times
Brain Injury	Co-ordinated care for patient	Better patient experience
Outcomes and Activity Information	Introduction of Payment by Results (PbR) is a major organisational change for both providers and commissioners Financial modelling and profiling of risk to be undertaken	To be agreed with Mersey Care NHS Trust
Children • **Review ADHD and ASD pathways** • **Develop Children's IAPT service**	Improve access to services Increased patient experience	Reduce waiting times Early Identification Better patient experience
Cancer • **Psychological support via Aintree cancer pathway**		Better patient experience

APPENDIX THREE
LOCALITY PLANS

South Sefton CCG
Transformation Programmes
Governance and Reporting Structure

Management and External Scrutiny

The programme structure addresses The three priorities to:

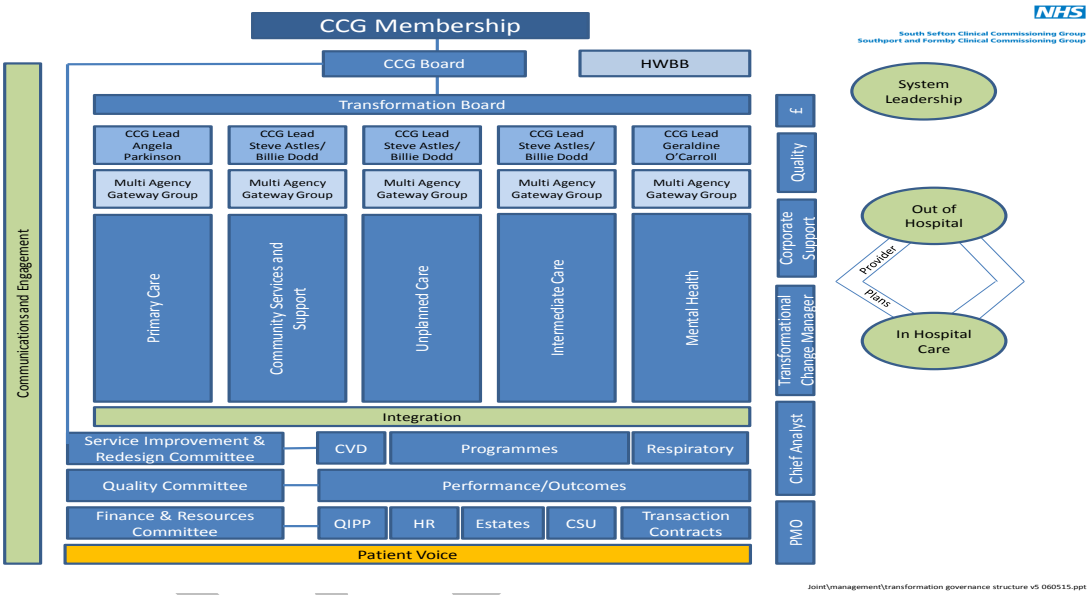
- Care for our older and Vulnerable residents
- Unplanned Care
- Develop and support Primary Care

Executive Management Team
Meets monthly and receives an overview report of activity, including any activity that requires authorisation

→ **Health and Wellbeing Board**

→ **Governing Body**

Governance



Blue-print Area

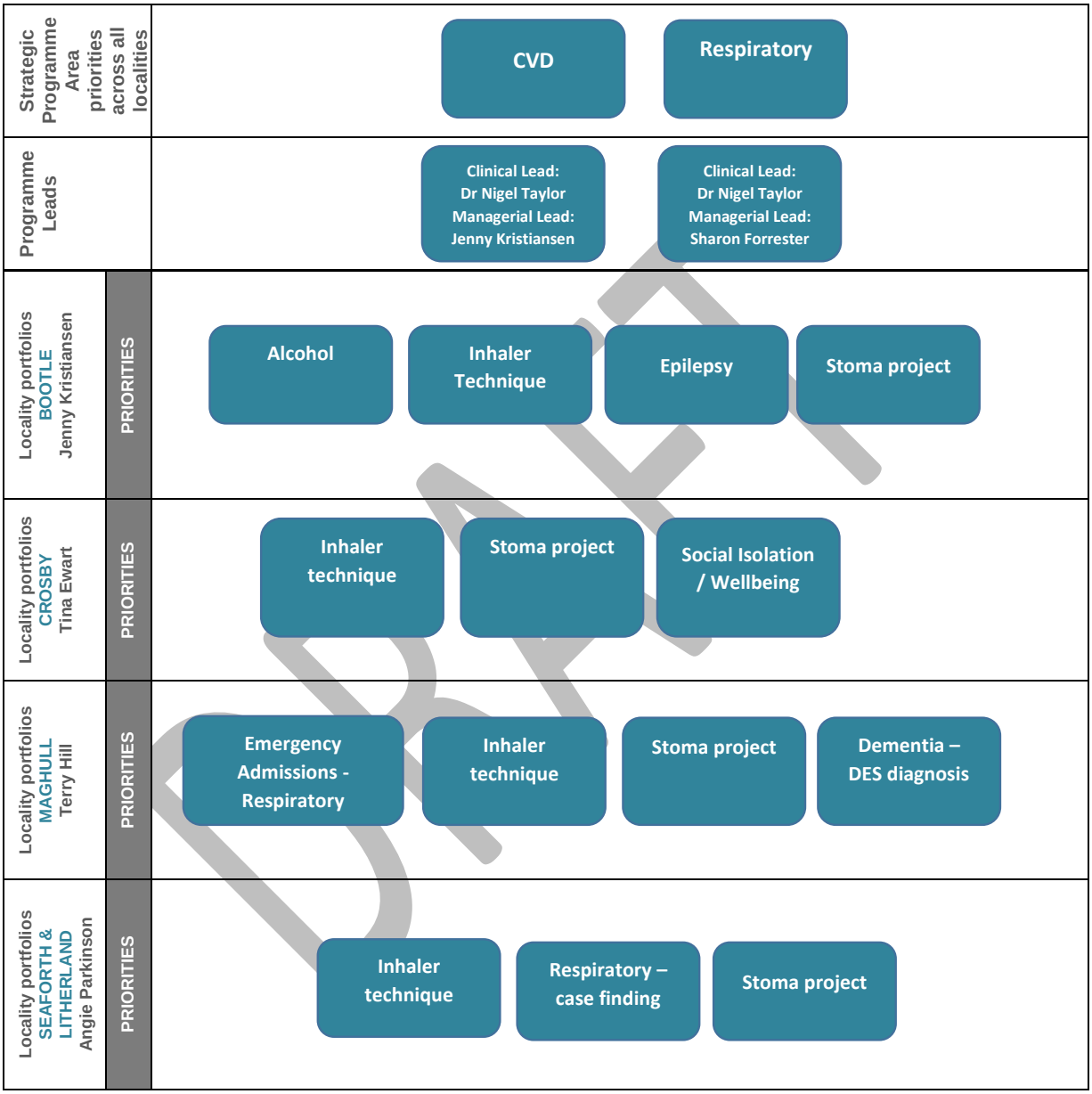
Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health

Blueprint Leads

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
Clinical Lead: Dr Craig Gillespie Managerial Lead: Angela Parkinson	Clinical Leads: Dr Ricky Sinha (Transactional) Dr Paul Thomas (Transformational) Managerial Lead:	Clinical Lead: Dr Daniel McDowell Managerial Lead: Melanie Wright	Clinical Lead: Dr Andy Mimnagh Managerial Lead: Steve Astles	Clinical Lead: Dr Sue Gough Managerial Lead: Geraldine O'Carrol

Blueprint top 5 priorities across all localities

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
Increased Access	Locality and virtual wards	Better Care Fund	Develop Urgent Care Centre	Dementia locality model
Enhanced Mngt of ptns over 75	Care Homes	Single entry co-ordination	Transportation review for WIC	Ageless service to include CAMHS
Workforce Succession Planning	Community urgent care team	Integrated care at locality level	Acute visiting Scheme	Primary and community training
Early detection	Integrated care pathways LTCs	Increased use of Step Up/Step down	NWAS pathfinder	Develop outcomes & activity dataset
Choose and Book utilisation	Review community tier 2 services	Stroke beds development	CVS bids	Brain Injury pathway


Strategic Programme Area priorities across all localities
CVD
Respiratory
Programme Leads
Clinical Lead: Dr Nigel Taylor Managerial Lead: Jenny Kristiansen
Clinical Lead: Dr Nigel Taylor Managerial Lead: Sharon Forrester
Locality portfolios BOOTLE Jenny Kristiansen
PRIORITIES
Alcohol
Inhaler Technique
Epilepsy
Stoma project
Locality portfolios CROSBY Tina Ewart
PRIORITIES
Inhaler technique
Stoma project
Social Isolation / Wellbeing
Locality portfolios MAGHULL Terry Hill
PRIORITIES
Emergency Admissions - Respiratory
Inhaler technique
Stoma project
Dementia – DES diagnosis
Locality portfolios SEAFORTH & LITHERLAND Angie Parkinson
PRIORITIES
Inhaler technique
Respiratory – case finding
Stoma project

Southport and Formby CCG
Transformation Programmes
Governance and Reporting Structure

Management and External Scrutiny

The programme structure addresses the three priorities to:

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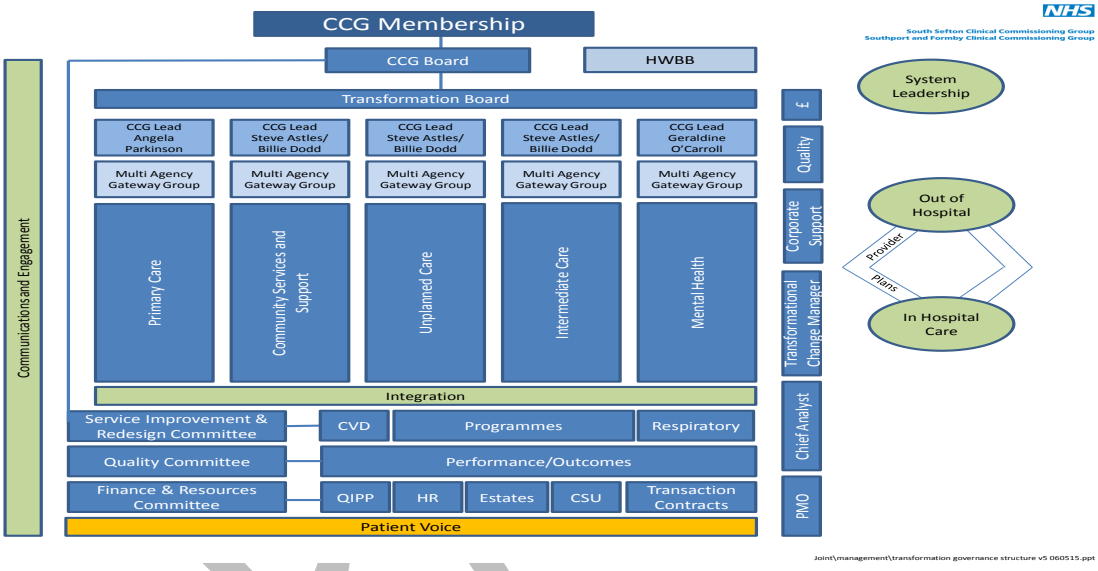
→ Governing Body

Governance



Blue-print Area

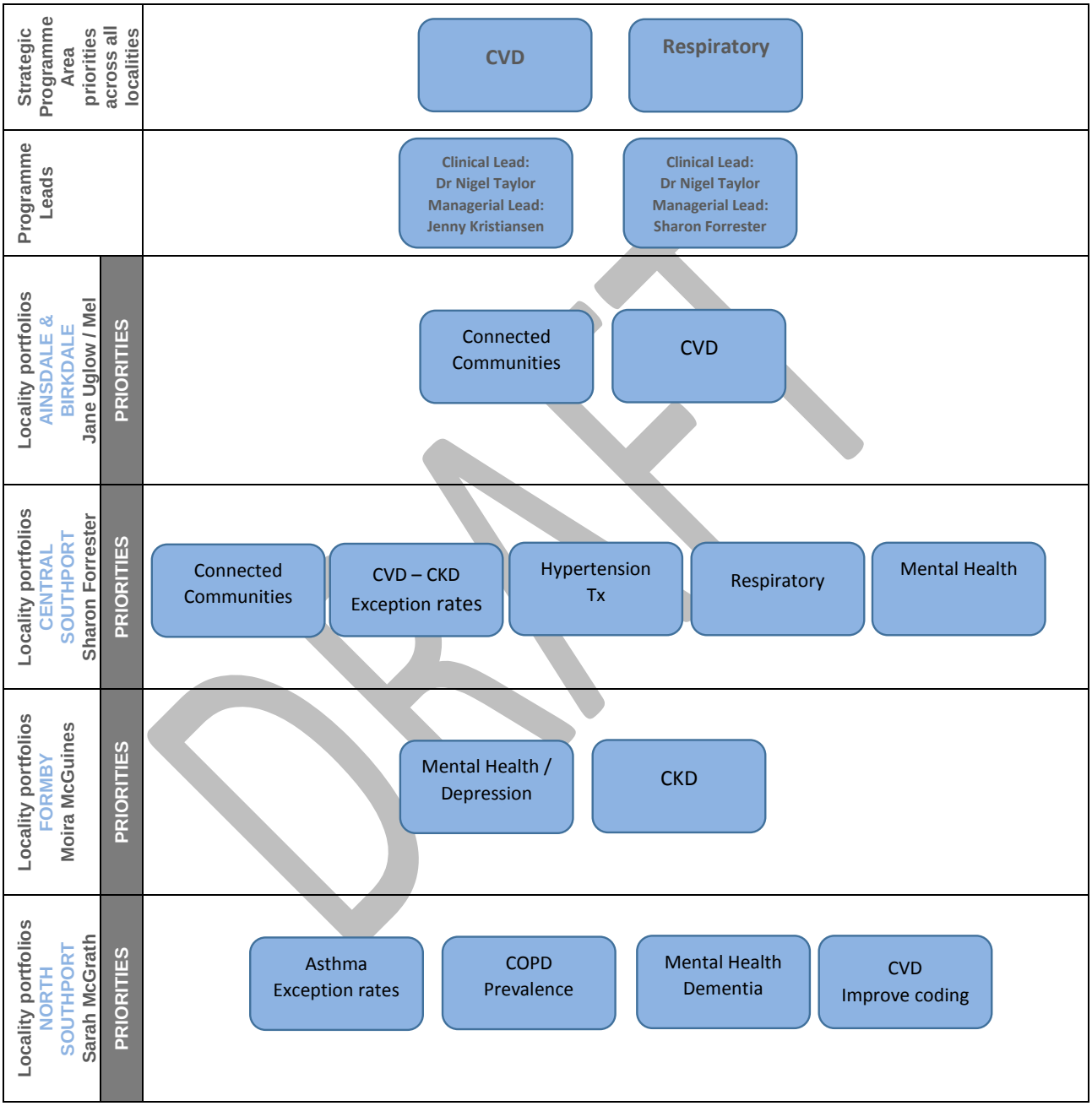
Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health

Blueprint Leads

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
Clinical Lead: Dr Niall Leonard Managerial Lead: Angela Parkinson	Clinical Lead: Dr Rob Caudwell Managerial Lead: Billie Dodd	Clinical Lead: TBC Managerial Lead: Melanie Wright	Clinical Lead: Dr Martin Evans Managerial Lead: Billie Dodd	Clinical Lead: Dr Hilal Mulla Managerial Lead: Geraldine O'Carrol

Blueprint top 5 priorities across all localities

Primary Care	Community Care	Intermediate Care	Unplanned Care	Mental Health
Increased Access	Integrated Community Services	Better Care Fund	Primary Care Engagement	Dementia locality model
Enhanced Mngt of ptns over 75	Care Homes	Tender of Intermediate care	Transportation review for WIC	Ageless service to include CAMHS
Workforce Succession Planning	Community urgent care team	Integrated care at locality level	Acute visiting Scheme	Primary and community training
Early detection	Integrated care pathways LTCs	Increased use of Step Up/Step down	NWAS pathfinder	Develop outcomes & activity dataset
Choose and Book utilisation	Review community tier 2 services	Stroke beds development	CVS bids	Brain Injury pathway


Strategic Programme Area priorities across all localities
CVD
Respiratory
Programme Leads
Clinical Lead: Dr Nigel Taylor Managerial Lead: Jenny Kristiansen
Clinical Lead: Dr Nigel Taylor Managerial Lead: Sharon Forrester
Locality portfolios AINSDALE & BIRKDALE Jane Uglow / Mel
PRIORITIES
Connected Communities
CVD
Locality portfolios CENTRAL SOUTHPORT Sharon Forrester
PRIORITIES
Connected Communities
CVD – CKD Exception rates
Hypertension Tx
Respiratory
Mental Health
Locality portfolios FORMBY Moira McGuines
PRIORITIES
Mental Health / Depression
CKD
Locality portfolios NORTH SOUTHPORT Sarah McGrath
PRIORITIES
Asthma Exception rates
COPD Prevalence
Mental Health Dementia
CVD Improve coding

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/97	**Author of the Paper:** Fiona Clark Chief Officer Email: fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: May 2015	

Title: Shaping Sefton Update

Summary/Key Issues:

This paper presents the Governing Body with an update on Shaping Sefton.

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.

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

Shaping Sefton - Start Well, Stay Well & Age Well May 2015

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

1. Introduction

The need for better integrated joined-up working across health and social care is now seen as unequivocal.

The mechanisms for achieving this have focussed on the provision and latterly, on the commissioning of the care as the means to successful delivery.

Since their inception in April 2013, both NHS Southport and Formby CCG and NHS South Sefton CCG have been working to define their strategies and plans to implement this ambition successfully.

Working closely with the Health and Wellbeing Board, the CCGs' strategy has been closely aligned. The CCGs' identify three key aims in transforming care and the local system:

(i) Frail/Elderly Care
(ii) Primary Care; and
(iii) the Unplanned Care System.

The CCGs have now developed blueprints for each of these areas. Crucially, the programmes of work have been mapped through in order to maximise delivery of the CCGs' strategic aims. The identified programmes include:

(i) Respiratory;
(ii) Cardiovascular Disease;
(iii) Cancer;
(iv) Diabetes;
(v) Mental Health;
(vi) End of Life;
(vii) Dementia;
(viii) Children's Health.

Much activity has been undertaken to understand local needs, care and support, together with future care requirements.

Transforming Health and Social Care and support in Sefton will be challenging, given the financial backdrop of both the CCG and the Local Authority.

Arguably a 45% reduction or £170m less spending power by the local authority alongside the minimal allocation of 1.94% for the CCGs has somewhat challenged the local health and social care economy, thus the need to find creative solutions to enable transformational change is vital. This change has to be led across the local system, by the leaders of the local system in order to find the right solutions for Sefton to meet the economic, financial, demographic, workforce and infrastructure challenges it faces.

> "Be the change that you wish to see in the world."
>
> - Mahatma Gandhi

2. The Health and Wellbeing Board (HWBB)

Health and wellbeing boards are an important feature of the reforms introduced by the Health and Social Care Act 2012. All upper-tier local authorities set up shadow boards in April 2012, which became fully operational on 1 April 2013.

The boards are intended to bring together bodies from the NHS, public health and local government, including Healthwatch, as the patient's voice, jointly to plan how best to meet local health and care needs and to commission services accordingly (Humphries & Galea, 2013).

The Sefton HWBB believes everyone in Sefton should have a healthy and fulfilling life. Since becoming a formal committee of Sefton Council in April 2013, Sefton's Health and Wellbeing Board has brought together those who buy services across the NHS, public health, social care and children's services, plus Elected Councillors and service user representatives, to jointly consider local needs and plan the right services for the population of Sefton.

The main statutory functions of the Health and Wellbeing Board are:-

- to assess the needs of the local population through the Joint Strategic Needs Assessment process;
- to produce a local Health and Wellbeing Strategy as the overarching framework within which commissioning plans are developed for health services, social care, public health and broader wellbeing services;
- to promote integration and partnership, including joint commissioning, integrated provision and pooled budgets, where appropriate.

In addition to the above statutory functions, the Board's role is to provide system leadership for change across care, health and wellbeing. This role requires the involvement of a wide range of leaders from not only the Council and the two Clinical Commissioning Groups' Governing Bodies, but other public sector organisations, such as hospitals and community based health care providers, Merseyside Police, Merseyside Fire and Rescue, Merseyside Probation Service, Schools and Colleges, Merseytravel and housing providers and, of course, our voluntary community and faith sector groups and organisations. These are just some of the organisations that the Board works alongside and there are a whole range of other organisations which have a stake in Sefton, too many to list, but which are just as important within the wider system. The Board has created a sub-structure to engage as wide range of partners, stakeholders and organisations as possible to ensure Sefton has the delivery infrastructure to achieve the best care, health and wellbeing outcomes for people in Sefton, through integrated, collaborative working.

The Adult, Early Life and Wider Determinants Forums provide opportunities for wider stakeholders, partners and representatives to come together to look at how by listening to local people, the right services can be commissioned and delivered to achieve the outcomes outlined within this Strategy. Importantly, as resources within the public sector decrease, the role of the Forums becomes even more important, as through this sub-structure the Board engages with people in communities, to build independence, resilience and tackle loneliness and isolation together. The shift from 'dependence' to 'independence' is crucial to the work of the Board if it is to rise to the challenges presented by our demography, levels of inequality and a reducing public sector resource base. Representatives from a wide range of organisations influence the debate at the Forums and bring their expertise, knowledge and specialism to better inform decision making – for example, understanding the positive impact being in employment can have on a person's health or how a home impacts on mental wellbeing. This way of working (a leadership collaborative) takes the Board beyond its statutory function, to that which is needed to achieve change - collective systems leadership.

The overall aim of the Board in providing system leadership for change is to ensure that the broadest range of partners, stakeholders and organisations are joining together to help shape Sefton, through the care, health and wellbeing of its people - our aspiration for Sefton by 2020.

By working together and aligning our resources, by 2020 we aim to improve the care, health and wellbeing of all Sefton residents and narrow the gap between those communities with the best and worst health and wellbeing outcomes. We will promote independence and help build personal and community resilience. We will work with parents and carers so that all children and young people have opportunities to become healthy and fulfilled adults and create a place where older people can live, work and enjoy life as valued members of the community. We will seek to improve opportunities and support residents to make choices so that people are able to live, work and spend their time in a safe and healthy environment and provide early support so that people can remain independent for longer (Sefton Health & Wellbeing Board, 2014).

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

3. Local Provider Landscape

The provider landscape is complex in Sefton. There are currently two acute providers, one integrated care organisation, one mental health provider, one community provider, and five specialist providers of children's, women's, cardiac, cancer and neurological care. Some of these providers have gained Foundation Trust status and are regulated by Monitor, some are in the Foundation Trust pipeline with the Trust Development Authority (TDA) and others are exploring the future options. Whilst co-terminus with the Local Authority, the two CCGs have a very differing demography.

Both the Dalton Review started in February 2014 and the Five year Forward view published in November 2014 describe the need for change and potential future models. Sir David Dalton's review of the role of chains of hospitals and services explores one particular approach with a focus on how high-performing NHS organisations might lend their support to providers in difficulty.

The NHS has dramatically improved over the past fifteen years. Cancer and cardiac outcomes are better; waits are shorter; patient satisfaction much higher. Even during the global recession and hardship, progress has continued thanks to protected funding and the commitment of NHS staff. However, the quality of care that people receive can be changeable, preventable illness is widespread and health inequalities are deep-rooted. Our patients' needs are changing, new treatment options are emerging, and we face particular challenges in areas such as mental health, cancer and support for frail older patients the service pressures are building (NHS England, 2014).

Fortunately, there is now agreement on what a better future should be. The Five Year Forward View sets out a clear direction for the NHS – showing why change is needed and what it will look like. Some of what is needed can be brought about by the NHS itself; other actions need new partnerships with local communities, local authorities and employers. Some important decisions – for example about money, on various public health measures and on local service changes – will need firm support from the next government.

The Five Year Forward view argues that public health and prevention should be at the heart of any future system. Fundamentally, there is not a 'one size fits all' approach and new creative solutions to enable new models of care need to be promulgated. This change should involve a process of discovery and not design. There should be a commitment to real-time evaluation and learning throughout the process (NHS England, 2014).

Work also needs to be undertaken at a national level to implement new forms of commissioning and contracting. It would help if NHS England and Monitor accelerate the development of new payment systems such as capitated budgets, pooled budgets and integrated personal commissioning. In Sefton we will look to influencing this element of change (Ham & Murray, 2015).

4. Sefton Strategic Needs Assessment (SSNA)

The Sefton Strategic Needs Assessment (SSNA) clearly outlines the suggested themes below, which have been derived from analysis of the evidence of data and information within the SSNA The themes reflect the key areas of need across the Borough, however the suggestion of priority themes is a guide to assist the Health & Wellbeing Board in deciding on the priorities for the Borough going forward are not meant to be an exhaustive or definitive priority list.

- **Lifestyles** – recognise the major impact of common lifestyle behaviours, which often start in childhood and continue throughout life.
- **Obesity** (childhood and adult) - child poverty, alcohol misuse and smoking, promoting physical activity, plus mental wellbeing which can have an impact on long term conditions.
- **Alcohol Related Conditions** – respond to high levels of alcohol consumption, alcohol specific hospital admissions, chronic liver disease, alcohol specific mortality
- **Child Health & Young People** – focus on ensuring a positive start to life for children, given the growing evidence of the impact this will have throughout their lives. Promoting breastfeeding initiatives, childhood obesity, underage under 18 alcohol related hospital admissions, emergency hospital admissions (asthma & injury) .
- **Older People** – plan now for the significant forecast growth in the number of older people in Sefton over the next 20 years by prioritising needs and requirements of an aging population. Tackling health issues for elderly, including dementia and reconfigure services to support older people to live in a community setting as long as possible.
- **Supporting Carers** - there are believed to be in excess of 30,000 carers across Sefton, who reduce the burden on both health & local authority services, however impact on the local economy through having to give up work to provide care.
- **Mental Health Issues** – to promote individual and community resilience and mental health including community engagement. Dementia is prevalent amongst the older population and depression amongst those in more deprived areas.
- **Long Term Conditions** – this also links to lifestyle as determinant lifestyle choices can have a direct impact on coronary heart disease (CHD) / heart failure, hypertension, cancers etc. Promoting early intervention and prevention through improved screening uptake and health checks.
- **Health & Social Inequalities** – current social and health inequalities and trends in Sefton have a significant impact on local people's health and wellbeing. Reducing the health inequality gaps between the most deprived and most affluent families/ communities, reducing deprivation and worklessness and improving skills.
- **Vulnerable Groups** - within Sefton there a number of vulnerable groups whose health status typically reveals inequalities and difficulties in accessing health and other public services. Interventions to reduce inequalities for these groups in particular need to focus long term and require a joined-up approach if they are to be tackled appropriately.

The health of people in Sefton is mixed compared with the England average. Deprivation is higher than average and about 10,000 children live in poverty. Life expectancy for both men and women is lower than the England average. Life expectancy is 11.9 years lower for men and 9.4 years lower for women in the most deprived areas of Sefton than in the least deprived areas. Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen but the former is worse than the England average.

About 20.7% of Year 6 children are classified as obese, higher than the average for England. Levels of alcohol-specific hospital stays among those under 18, breast feeding initiation and smoking in pregnancy are worse than the England average. The level of teenage pregnancy is

better than the England average. An estimated 19.6% of adults smoke and 23.9% are obese. Rates of smoking related deaths and hospital stays for alcohol related harm are worse than the England average. Rates of sexually transmitted infections and road injuries and deaths are better than the England average (Sefton MBC, 2014).

5. Delivering Change

In order to deliver the required change at pace, the CCGs and Local Authority must work even more closely across the strategic landscape in Sefton working with the providers. The financial pressures must be used as a force for change to help to shape new models of care in Sefton.

Chis Ham described at the Shaping Sefton event on the 12th February 2015, 'the soft stuff is the hard stuff'.

- System leadership
- Trusting relationships
- Collaborative behaviours
- A willingness to cede sovereignty for the greater good
- Leaders who collaborate as well as compete.

Pace now needs to be injected into the delivery of Shaping Sefton - Start Well, Stay Well, Age Well. There will also be opportunities for learning as we discover new and creative solutions and we will use our membership contact with such bodies as the Advancing Quality Alliance (AQuA), the Kings Fund, NHS Leadership Academy, Academic Health Science network, Health Education England, Local Government Association, local colleges and Universities and NHS Clinical Commissioners to share the Sefton experiences.

The changes as identified and developed will be formally project managed and reported through the Transformation Board and ultimately held to account through the various Boards. We will continue to work really closely with our CCG colleagues in West Lancashire CCG, Knowsley CCG and Liverpool CCG and also learning across the wider Cheshire & Merseyside footprint.

6. Systems Leadership

Ham (2014) suggests that strengthening leadership within the NHS holds the key to providing patients with access to high-quality care wherever they live. He argues that leadership needs to be collective and distributed, as important in the frontline teams delivering care as in the boards responsible for running NHS organisations. It needs to be developed across organisations and areas where networks and chains are involved. And there needs to be much greater continuity of leadership in place of the constant chopping and changing that has bedevilled the NHS in recent times.

The task now is to identify the skills, knowledge and behaviours that this new breed of system leaders will need if they are to be successful and to consider how such an approach to developing leadership – which is likely to be different to that found inside many of our institutions – can best be fostered.

System leadership is equally important at a local level, where organisational changes following from the Health and Social Care Act 2012 have left a vacuum that commissioners and providers are seeking to fill through partnership arrangements of various forms. At a time of growing pressures within the NHS, the absence of a designated system leader places the onus on commissioners and providers to agree how this vacuum should be filled. Much then hinges on the quality of relationships between organisations and their leaders and their willingness to seek common cause to deal with the challenges facing the health and care system (Ham & Murray, 2015).

They go on to say that new kinds of leadership will be needed to make a reality of new models of care. Specifically, leaders of different organisations will need to work together to provide leadership across local systems of care, however these are defined. The challenge this presents is that most NHS leaders are first and foremost organisational leaders rather than system leaders, and they will have to learn new skills to operate effectively in the NHS of the future.

Leaders must learn to operate without the might of the hierarchy behind them and use their individual skills rather than their formal position to achieve results. They must be able to compete in a way that enhances rather than undercuts the competition and to do this these leaders must become successful collaborators. Leaders who conduct their business to the highest ethical standards; trust is crucial to successful alliance-building, develop a process focus – concentrating not only on what is to be achieved but how it is done (Fillingham & Weir, 2014).

Within Sefton a place based approach to leadership is underway, with sponsorship of the system leadership challenge by the consortium led by Chris Lawrence-Petronie. Over the next 12 months, the local leadership will be challenged and supported to create a social movement of change to deliver the emergent models of care, identified through the work of the Transformation Board.

7. Governance to Underpin Delivery

The governance must be clear and structured for delivery. The proposed governance structure can be found at Appendix 1. The Board itself will comprise of senior local system leaders. Each of the five work streams will be clinically led by the CCGs and provider clinicians, supported by various leaders in the variety of organisations across Sefton, both statutory and the community, voluntary and faith sector.

The desire is that this work will be underpinned by the work of Healthwatch and the development of a citizen's voice linking in with the work of the Engagement Patient Experience Group (EPEG). The Transformation Board and supporting work streams will be established during May 2015. It will report to both CCGs' Governing Bodies and work is underway with the Chief Executive of Sefton Council to clarify the relationship with the HWBB.

8. Future sessions

Two further sessions are planned to cover Unplanned Care and Primary Care, to compliment the work of Dr David Oliver on Elderly Care. The sessions will be developed in conjunction with the work stream clinicians and may include the following:

8.1. Unplanned care
- To cover work to assess the role of the SRGs in delivering successfully in past 12 months and explore future possibilities
- To explore the opportunities to develop an alternative model of care for unplanned networks
- To take best practice and benchmarking and develop future commissioning intentions to deliver across the urgent care/unplanned pathway.

8.2. Primary Care
- To build on emergent models of primary care
- To tie into the Local Quality Framework for affordability and delivery
- To take best practice from Prime Ministers Challenge Fund areas.

8.3. Elderly Care
- To cover work to assess the success of currently commissioned pathways
- To explore further options for managing the elderly wellness and health/social care agenda
- To take best practice and benchmarking and develop future commissioning intentions to deliver across the elderly care pathway.

9. Next Steps

9.1. Three further dates identified with the Kings Fund - 16 June 2015, July 2015 and one further date to be confirmed.

9.2. Define governance structures, develop terms of reference and invite strategic leaders to the Transformation Board and work streams.

9.3. Ensure clinical leadership is shaping and driving the future models within the five work streams supporting the Transformation Board.

9.4. Create the programme of system leadership to support place based delivery.

9.5. Identify project lead to support transformation/integration project agenda.

10. Recommendations

10.1. The Governing Body is asked to receive this report and support the direction of travel for Shaping Sefton transformation.

References

Department of Health (2014)
Filingham, D. & Wier, B. (2014) System leadership Lessons and learning from AQuA's Integrated Care Discovery Communities.
Ham, C. (2014) Future organisational models for the NHS Perspectives for the Dalton review.
Ham, C. & Murray, R. (2015) Implementing the NHS five year forward view: aligning policies with the plan
Humphries, R. & Galea, A. (2013) Health and wellbeing boards One year on. Kings Fund, London.
NHS England (2014) Five Year Forward View.
Sefton Health & Wellbeing Board (2014) Living Well in Sefton-Health & Wellbeing Strategy 2014-2020.
Sefton Metropolitan Borough (2014) Sefton Strategic Needs Assessment 2012-13.

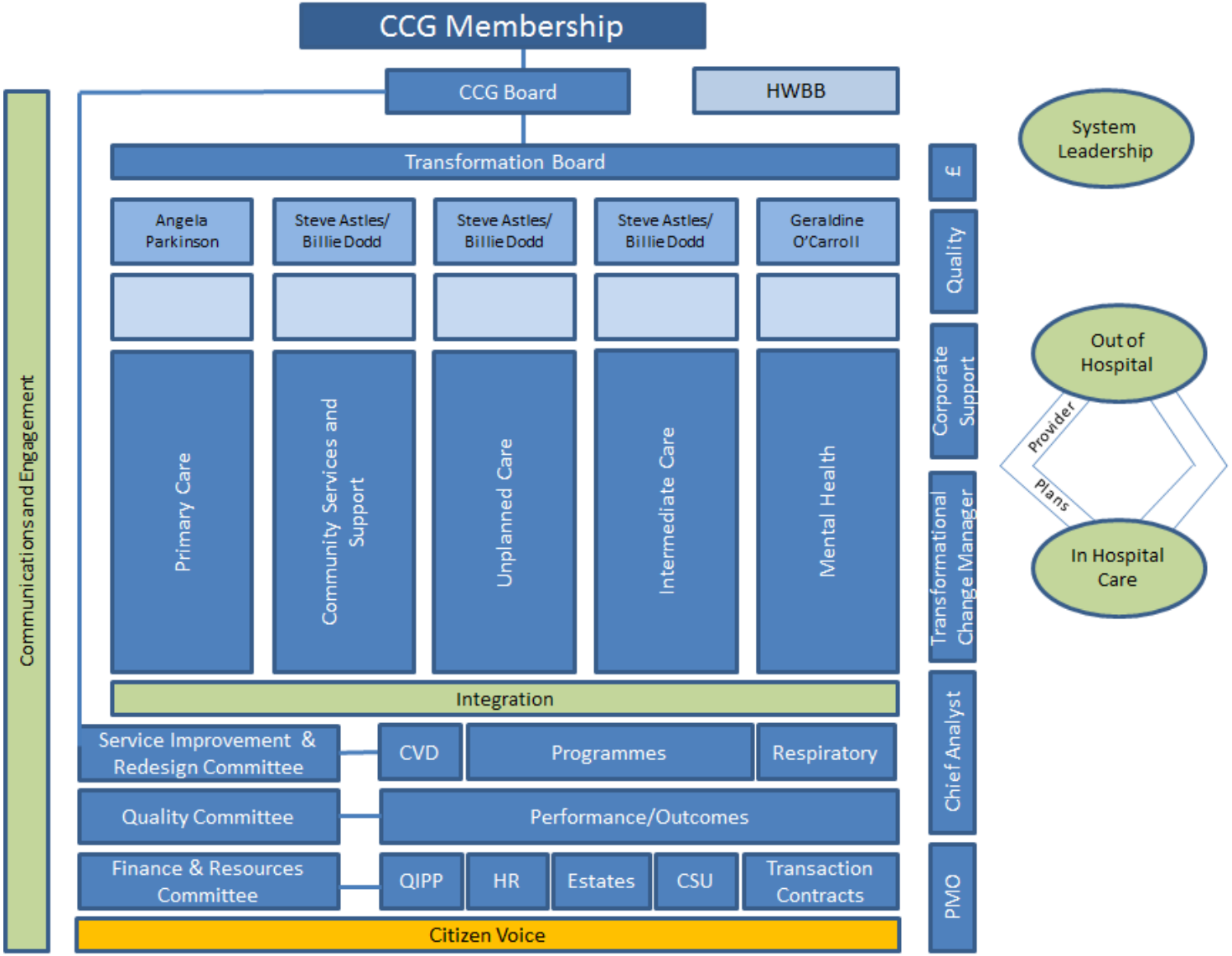
Appendices

Appendix 1 - Draft Shaping Sefton - Transformational Governance Framework

Fiona Clark
Chief Officer
May 2015

Appendix 1
Shaping Sefton - Transformational Governance Framework

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



Southport & Formby Clinical Commissioning Group

Integrated Performance Report

NHS
Southport and Formby
Clinical Commissioning Group

NWCSU
A partner in our clients' future

Contents

List of Tables and Graphs

1. Executive Summary

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

CCG Key Performance Indicators

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

Yearly measures - no new update

Patient Recorded Outcomes Measures for elective procedures: Groin Hernia	CCG	
Patient reported outcomes measures for elective procedures: Hip replacement	CCG	
Patient reported outcomes measures for elective procedures: Knee replacement	CCG	

Key Information from this report

The financial position is £4.583m overspent on operational budget areas before the application of reserves. The CCG has experienced significant financial pressures during the financial year, and a management action plan was agreed to achieve the planned £1.750m surplus. All of the actions identified have been delivered, and the CCG delivered the planned surplus and the business rules required by NHS England. However, there are risks in the reported financial position that may materialise in the new financial year.

Ambulance Activity: The year end targets for the entire NWAS service across the Red response times have not been achieved, and a number of actions are being carried out by the provider which are detailed in this report.

A&E waits: Although the CCG failed the 95% target for this indicator with the actual for March at 92.80%, they achieved the target year to date reaching 95.07% and are flagged GREEN. The CCG has failed the target in month from October onwards for 2014-15. Southport & Ormskirk are reporting 92.23% for March, this equates to 729 attendances out of 9379, were not admitted, transferred or discharged within 4 hours. The Trust has failed this target every month from October 2014 with the year to date figure recorded as 94.60% just under the 95% target. The wider urgent care action plan is addressing significant health economy issues, many of which are long-term objectives.

Cancer Indicators: Year to date the CCG achieved all the cancer indicators apart from two, which were 2 week breast symptom, year to date they achieved 92.5% in month (Feb) they achieved 93% which is the target. Also 62 day screening year to date they achieved 85.4%, in month (Feb) 51.1%, out of 7 patients there were 3 patient breaches (target 90%). Southport & Ormskirk achieved all indicators apart from 62 day screening achieving 63.6% year to date. Performance is hampered by low numbers with only one patient breach often leading to failure against the target. In February there was a half patient breach out of a total of 1 accountable patient.

CPA: The CCG have failed the target of 95% in Q3 reaching 88.90%, a fall from previous quarter. This equates to 40 out of 45 patients on CPA being followed up within 7 days after discharge from psychiatric inpatient care. The Trust reports this KPI on a monthly basis but the consequence of the breach is based on the quarterly response.

Emergency Admissions Composite Measure: The CCG is over the monthly plan and had 523 more admissions than the same period last year. The elements of the composite contributing to over-performance are as follows:Emergency Admissions that should not usually require hospital admission- The CCG is over plan and has had an increase in actual admissions of 362 above the same period last year. Unplanned hospitalisation asthma, diabetes, epilepsy under 19's - The CCG is over plan, the increase in actual admissions is 39 more than same period last year. Unplanned hospitalisation for chronic ambulatory care - The CCG is over plan, the increase in actual admissions is 163 more than the same period last year. A number of practices are analysing patient level data to understand trends and possible actions via localities and Finance and Resource Committee.

HCAI – C difficile: The CCG are achieving the target for C difficile, remaining under the planned target (actual 34 / plan 43) and have achieved the target for 2014-15. However Southport & Ormskirk reported 4 new cases in March taking them to 35 cases against a plan of 27, as such the Trust are over target for this indicator and have failed the target for 2014-15.

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

IAPT Prevalence: The CCG did not achieve the 3.75% in Q4 recording 3.07%% (585 patients entering psychological therapies). Although this represents an improvement on Q1, Q2 and Q3, year to date they are at 10.73% which is still far from the 15% target. The target was changed during the year requiring 3.75% in the final quarter of the year which the CCG failed to meet. To have achieved the target in Q4 the service would have needed to see 131 more patients enter psychological therapies in Q4.

IAPT Recovery Rate: The CCG did not achieve the 50% target reaching 47.5% cumulatively to March, but did achieve in month (March) reaching 50.9% this year the target was achieved in May, June Feb and March. The CCG have not achieved the annual target. A new IAPT service provider takes over the contract in 2015/16.

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

RTT 18 Weeks – Admitted patients: Southport & Formby CCG failed to achieve the 90% target in March recording 85.28%, this is the 3rd time the CCG has failed the target in 2014-15. This month's activity equates to 116 patients out of 788 not being seen within 18 weeks. Also Southport & Ormskirk reported below the 90% target in February achieving 80.4%, this being the 4th consecutive time this year the trust has failed the target, February's performance equates to 14 patients out of 837 not being seen within 18 weeks. A number of actions are being taken byb the Trust which are described in this report; the most significant one being further data validation following the Trust's IT system upgrade meaning the data should be treated with caution.

RTT 18 Weeks – Non Admitted patients: Southport & Formby CCG narrowly failed to achieve the target of 95% in March, achieving 94.74%. This is the first time this year the CCG has failed the non-admitted target overall. This month's activity equates to 164 patients out of 3,119 not being seen within 18 weeks. Also Southport & Ormskirk reported below the target of 95% in February, achieving 93.8%. This is the second consecutive month the Trust has failed the target and a further drop in performance. This month's performance equates to 261 patients out of 4,225 not being seen within 18 weeks. A number of actions are being taken byb the Trust which are described in this report; the most significant one being further data validation following the Trust's IT system upgrade meaning the data should be treated with caution.

Stroke: In March Southport & Ormskirk failed the target recording 75.0%, with 27 patients out of 36 spending 90% of their time on a stroke unit (9 breaches). This is the 5th time the target has been breached in 2014-15 but an improvement on last month's performance. The CGG has established a concerted piece of work on the configuration for HAS, building on the work that has been undertaken by the clinical network. This is being progressed in conjunction with Liverpool CCG to determine the service construct for Liverpool and Sefton. A timetable for this work is being developed across 2015 and more immediate support solutions explored with Stroke leads.

2. Financial Position

2.1 Summary

This report focuses on the Year End financial performance of Southport and Formby CCG as at 31 March 2015 (Month 12). The financial position is £4.583m overspent on operational budget areas before the application of reserves.

The CCG has experienced significant financial pressures during the financial year, and a management action plan was agreed to achieve the planned £1.750m surplus. All of the actions identified have been delivered, and the CCG delivered the planned surplus and the business rules required by NHS England (as demonstrated in Figure 1 below).

However, there are risks in the reported financial position that may materialise in the new financial year.

Figure 1 Financial Dashboard

Report Section	Key Performance Indicator		This Month	Prior Month
1	Business Rule (Forecast Outturn)	1% Surplus	✓	✓
		0.5% Contingency Reserve	✓	✓
		2.5% Non-Recurrent Headroom	✓	✓
3	Surplus	Financial Surplus / (Deficit) before the application of reserves - £'000	-4,583	-4,298
4	QIPP	Unmet QIPP to be identified > 0	0	160
5	Running Costs (Forecast Outturn)	CCG running costs < National 2014/15 target of £24.78 per head	✓	✓
6	BPPC	NHS - Value YTD > 95%	98.4%	98.2%
		NHS - Volume YTD > 95%	91.5%	91.2%
		Non NHS - Value YTD > 95%	90.1%	91.1%
		Non NHS - Volume YTD > 95%	92.0%	91.2%

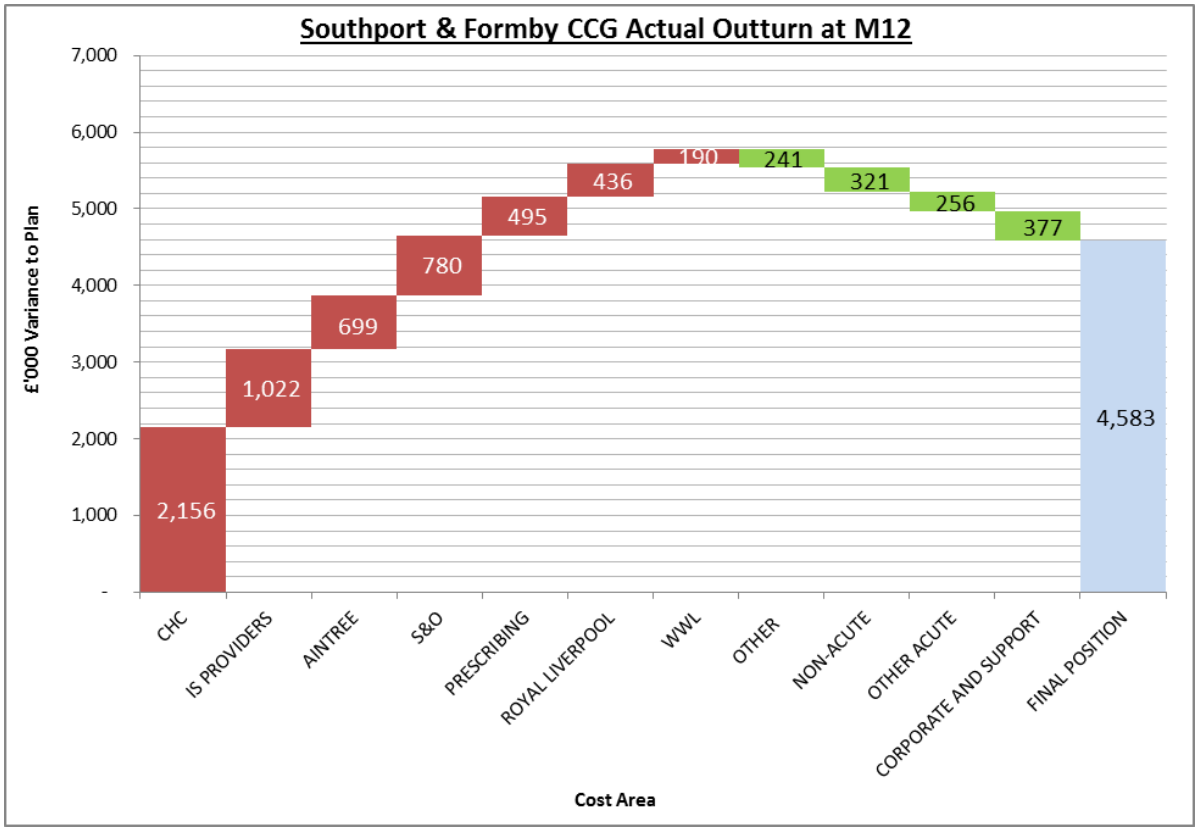
2.2 Resource Allocation

There were no changes to the RRL allocation in Month 12.

2.3 Position to Date

The main cost pressures are shown below in Figure 2, notably Continuing Healthcare, Independent Sector and Acute Care.

Figure 2 Financial Position to Date



Whilst the financial reporting period relates to the end of March, the CCG has based its reported position on activity information received from Acute Trusts to the end of February 2015. Where year-end financial settlements have been agreed, the financial position has been based upon this.

Southport and Ormskirk NHS Trust

The forecast overspend at Southport and Ormskirk is based upon the agreed year end settlement. This applied a forecast as at month 10, with a partial impact of the application of the Marginal Rate Emergency Threshold. None of the IT funding requested by the Trust was paid. Activity has now been received for both month 11 and month 12. Month 11 showed a lower than planned level of activity in both emergency and planned care. Month 12 activity was consistent with the plan.

A year end summary is outlined below, with a number of consistent patterns identified throughout the year:

- Emergency activity was significantly higher during the year, with increases in A&E attendances and emergency admissions:

- A&E attendances were 6% higher than plan, costing an additional £0.211m.
- Same day emergency admissions (typically seen in Ambulatory Emergency Care) were 22% higher than budgeted, at an additional cost of £0.168m.
- Short stay emergency admissions (1-2 days) were 16% higher than plan, with an additional cost of £0.161m.

- Longer stay emergency admissions were 5% higher than plan, costing the CCG £0.944m more than was budgeted.

- Planned inpatient care was £0.731m lower than the plan representing a reduction of 6% from the planned levels.

- Outpatients – we saw a shift from new outpatient attendances to outpatient procedures as the Trust changed the coding associated with a number of orthopaedic attendances. We also saw a shift from Southport to Aintree in respect of Breast services.

- Maternity pathway payments were 25% lower than plan, with a cost saving of £0.516m. This resulted from a lower number of bookings, and a lower complexity of patients that originally envisaged by the Trust.

Continuing Health Care (Adult)

This area continues to be a major risk for the CCG, with overspends of £2.156m for the financial year. A working group involving both the CCG and the Commissioning Support Unit meets regularly to review progress and risks.

The budget was increased by 4% from last year's expenditure levels, but the current data shows growth levels closer to 33%. Independent benchmarking has been carried out, and a comparison has been undertaken with a peer group of the 10 most similar CCGs, in relation to demographics as defined nationally. The results of this were reported to the Committee in February and show that although the CCG is in the top quintile for activity nationally, it is not an outlier against its peers. This has been reflected in the longer term financial strategy for the CCG.

In addition to the activity increases in continuing healthcare, the CCG has also identified that some providers are insisting on charging higher prices. The Framework under which prices are charged expired at the end of February 2015, and there is a risk that prices will increase further once a new framework is agreed.

Independent Sector Providers

The overspend for Independent Sector providers is £1,022k at Month 12. The majority of this is with Ramsay Healthcare (£752k) and Spire Healthcare (£116k).

Higher than anticipated activity can be seen indicating an overall increase in planned care. This suggests that general demand for planned inpatient services is increasing. The overspends are in the area of orthopaedic surgery, general surgery and ophthalmology. Independent Sector providers are reporting daycase activity that exceeds contracted levels by £0.566m (44%). New outpatient activity at independent sector providers is 17% higher than plan for the year.

Royal Liverpool and Broadgreen University Hospitals (RLBUH)

The overspend for RLBUHT is estimated at £436k for the year. The CCG has not agreed a year-end settlement with the Trust, and this figure could change once the full year activity is known.

Activity at RLBUH is higher than planned in the following areas:

- Critical Care – at Month 11, critical care expenditure at RLBUH is **£0.112m** higher than contracted levels. This is 85% higher than the contract, with a number of long stay critical care patients.

Critical care has seen a sharp increase for a number of commissioners, and the host commissioner will be reviewing in 2015/16.

- Wet ARMD – growth in Wet ARMD continues the trend identified in previous years. Costs in this area are **£0.081m** higher than contract. This reflects growth of 18%.

- Elective excess bed days – The expenditure to month 11 is **£0.053m** higher than plan, with one long stay patient discharged in the first quarter of the year. Records indicate that a patient who came in for an elective procedure developed pneumonia.

- Unbundled Diagnostics – The Trust was issued with a contract query in Feb 2014 as they had been failing the diagnostic wait time target since October 2013. Since that date there has been a significant increase in activity. It had been expected to plateau, but overspends have been consistently high throughout the year. To month 11, this equates to **£0.097m**.

Aintree University Hospital

The overspend at Aintree Hospital is based on an agreed financial settlement for the year. This was based on month 10 activity, with the application of CQUIN and penalty reductions. Increases in outpatient attendances have been a significant driver of the overspend, particularly in the area of Breast services which have shifted from Southport and Ormskirk Trust. The overspends in the year to date are in the following areas:

- ARMD – This exceeds the plan by **£0.118m**.
- Excluded Drugs – The overspend to date is valued at **£0.114m**, and the main area of pressure is in cytokine modulators.
- Outpatient procedures – The costs are **£0.113m** higher than plan, with interventional radiology and breast surgery being the main specialties with higher than anticipated costs.
- Elective surgery – This exceeds our contract by **£0.142m**, and is mainly in the area of breast surgery and orthopaedic surgery.

2.4 QIPP

Southport and Formby CCG has a QIPP savings target of £6.257m in 2014/15. The QIPP savings can be achieved through a reduction in either programme or running costs.

The CCG has carried out a review of the savings and costs avoided through the implementation of a number of its QIPP schemes, this indicates that the full QIPP target has now been identified.

2.5 CCG Running Costs

The CCG is currently operating within its running cost target which forms part of this budget area. The financial position for the year is an underspend on Running Costs and other Corporate and Support Services. This is because of a significant number of non-recurrent benefits. There have also been a number of vacancies in the staffing structure, and it is expected that some of these will be filled during Q4.

It is important to note that although the CCG is operating below the 14/15 national target of £24.78 per head of population, this will be reduced to £22.11 per head in 2015/16. There are plans in place to meet this target for 2015/16 and these were agreed by the Governing Body in February 2015.

2.6 Evaluation of Risks and Opportunities

The 2014/15 accounts have been closed and are now subject to external audit. There are a number of areas that are based on estimates, which could pose a risk in 2015/16 if those estimates are found to be insufficient. These are outlined below:

- Acute cost per case contracts – Where the CCG does not have a full and final settlement agreed, there is a risk that activity in month 12 will be higher than estimated. The CCG will work with the host commissioner to ensure that activity is validated and CQUIN/sanctions are applied before year end balances are agreed.

- Continuing Healthcare Costs – The CCG has experienced significant pressures on the growth of CHC cases this year. The position is based on estimates up to month 11. If claims in March exceed current estimates, the excess will be borne by the CCG in the new financial year.

- Continuing Healthcare restitution claims – CCGs were notified in December of a forecast underutilisation against the national pool and resource of £0.394m was returned to the CCG in Month 10. There will be a national reconciliation exercise carried out to determine whether further returns / funding requests will be required to balance the payments nationally.

- Estates – Latest estimates have now been received from both NHS Property Services and the organisation that administers the LIFT buildings. The CCG now has estimated charges for all premises, and has sufficient reserves to meet its financial obligations. However, these are not final charges, and the values could fluctuate.

- Prescribing / Drugs costs - The prescribing data is two months in arrears. The costs for February and March may differ from the amounts accrued, with the difference being accounted for in 2015/16.

2.7 Reserves and Management Action Plan

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

At the end of Month 4, it was recognised that the forecast costs exceeded the available reserves and subsequently a Management Action Plan was devised. This plan has been delivered during the financial year and has supported the CCG to achieve the financial surplus.

Figure 3 Reserves and agreed actions

	£000
Forecast overspend	4,583
Available reserves	(1,834)
Forecast pressures	**2,749**
Management actions implemented:	
Deferral of Mandate spend	(236)
Quality Premium	(279)
Technical adjustments	(478)
CHC Restitution	(394)
Estates	(200)
NPFiT funding	(450)
Cheshire / Mersey rehab	(200)
Locality Money	(200)
LCH Baseline	(312)
Remaining shortfall	**0**

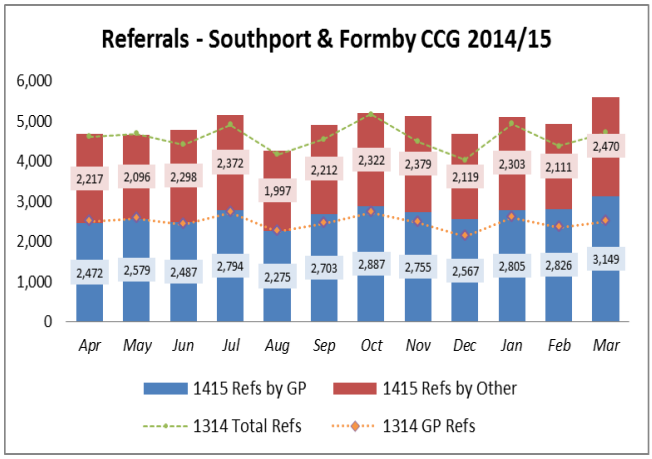
It should be noted that most of the management actions identified are non-recurrent, whereas the current financial pressures being seen are likely to impact on 15/16. It is therefore imperative that the CCG develops a sustainable plan for recurrent balance.

3. Referrals

The following section provides an overview of referrals to secondary care to March 2015. Analysis also includes comparisons of 1415 referrals to the previous 2 financial years.

3.1 Referrals by source

Figure 4 Number of GP and 'other' referrals for the CCG across all providers for 2014/15



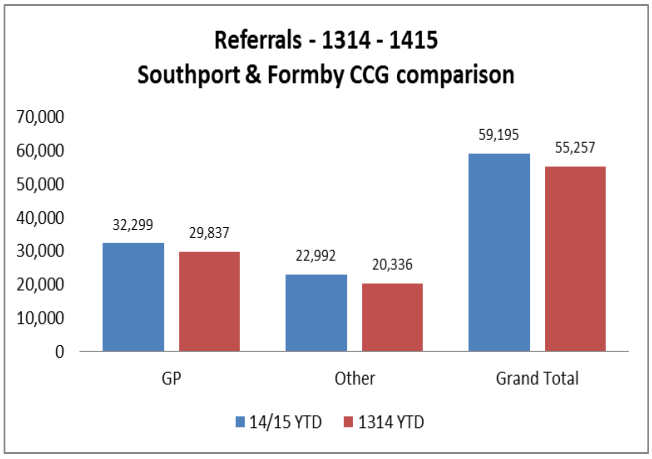


Figure 5 Monthly Average in 2014/15 compared to previous 2 years

Provider Monthly Average

Provider Name	1213 Average	1314 Average	1415 Average	% of total
Southport & Ormskirk	2,829	3,443	3,627	75%
Aintree Hospital	205	230	294	6%
Royal Liverpool & Broadgree	203	216	232	5%
Ramsay Healthcare	-	270	323	5%
Alder Hey	139	147	151	3%
Liverpool Heart and Chest	116	104	113	3%
Liverpool Womens	71	96	104	2%
Isight	-	60	60	1%
ST Helens & Knowsley	21	22	25	1%
Spire Liverpool	-	14	19	0%
Warrington & Halton	2	2	2	0%
Fairfield	2	1	2	0%
Mid Cheshire	1	1	0	0%
Grand Total	3,588	4,606	4,953	

Source of Referral Monthly Average

Source of Referral	1213 Average	1314 Average	1415 Average	% of total
01	173	191	110	4%
02	1	0	14	0%
03	1,987	2,486	2,691	55%
04	219	223	238	5%
05	650	672	790	16%
06	77	95	111	2%
07	0	1	1	0%
-1	25	424	343	6%
10	6	12	13	0%
11	64	60	55	1%
12	0	0	0	0%
13	2	2	2	0%
14	9	20	132	1%
15	0	53	55	1%
16	-	-	-	0%
17	12	6	29	0%
92	145	137	136	3%
93	1	2	2	0%
97	214	219	229	5%
Grand Tota	3,587	4,605	4,951	

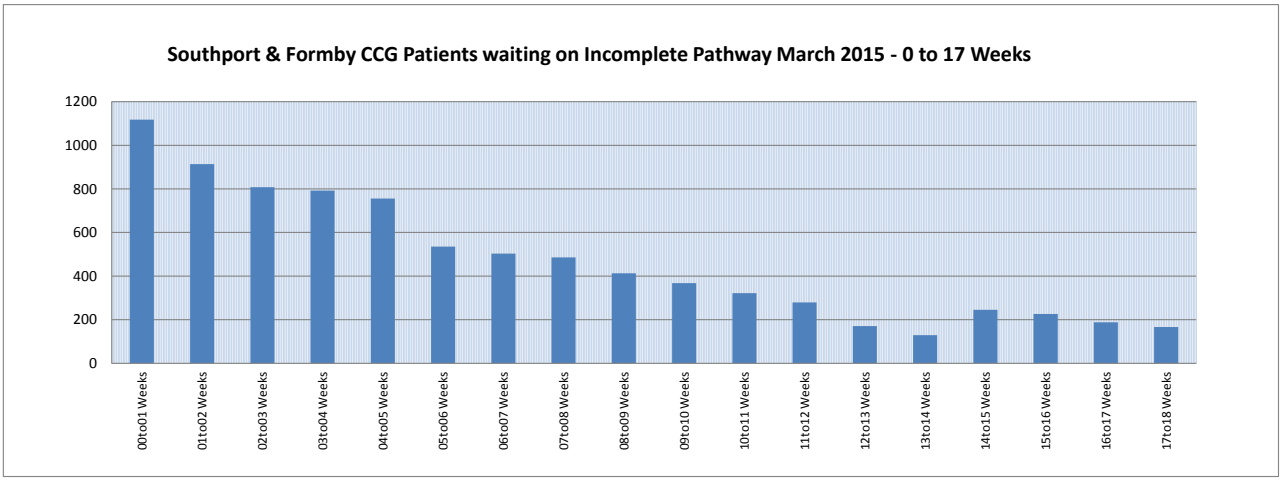
Figure 6 The number of GP and 'other' referrals for the CCG across all providers comparing 2013/14 and 2014/15 by month

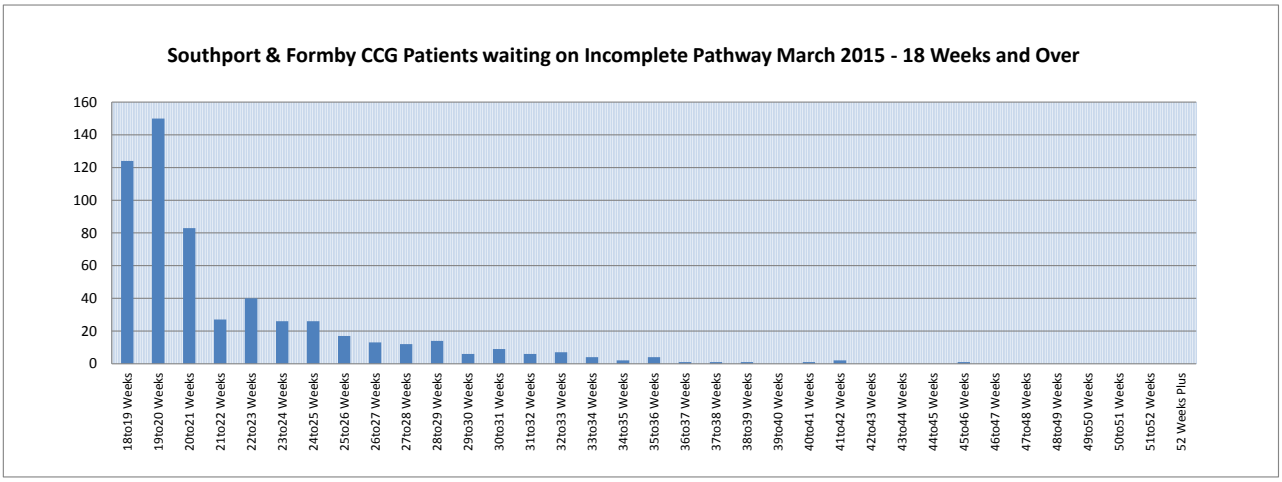
Referral Type	DD Code	Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	14/15	1314	Variance	% Variance
GP	03	GP Ref	2,472	2,579	2,487	2,794	2,275	2,703	2,887	2,755	2,567	2,805	2,826	3,149	32,299	29,837	2,462	8%
GP Total			2,472	2,579	2,487	2,794	2,275	2,703	2,887	2,755	2,567	2,805	2,826	3,149	32,299	29,837	2,462	8%
Other	01	following an emergency admission	196	174	211	200	181	188	132	7	6	10	8	12	1,325	2,292	-967	-73%
	02	following a Domiciliary Consultation					1	2	7	27	36	25	37	33	168	5	163	97%
	04	An Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)	228	203	253	240	239	247	270	266	219	221	204	266	2,856	2,674	182	6%
	05	A CONSULTANT, other than in an Accident and Emergency Department	725	674	677	747	640	695	879	936	870	952	798	874	9,467	8,069	1,398	15%
	06	self-referral	93	106	106	104	81	99	109	116	131	134	121	134	1,334	1,143	191	14%
	07	A Prosthetist		1	1	2	1	4			1	1			11	13	-2	-18%
	10	following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)	12	10	13	19	14	14	8	11	17	7	14	12	151	149	2	1%
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	58	50	77	71	50	68	44	53	43	54	43	40	651	717	-66	-10%
	12	A General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)				1							1		2	1	1	50%
	13	A Specialist NURSE (Secondary Care)	2	1	2		4	4	1	3	3	2	6	1	29	22	7	24%
	14	An Allied Health Professional	140	150	127	199	127	112	86	136	103	122	125	154	1,581	242	1,339	85%
	15	An OPTOMETRIST	84	37	72	47	59	71	48	48	29	47	53	61	656	635	21	3%
	16	An Orthoptist						1						24	25	3	22	88%
	17	A National Screening Programme	30	29	23	23	21	15	32	28	33	29	24	52	339	74	265	78%
	92	A GENERAL DENTAL PRACTITIONER	122	137	144	135	121	143	144	148	147	131	116	142	1,630	1,646	-16	-1%
	93	A Community Dental Service		3	2		2	2	2	2	4		2	1	20	22	-2	-10%
	97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	232	204	230	238	209	229	239	257	222	233	216	238	2,747	2,629	118	4%
Other Total			1,922	1,779	1,938	2,026	1,750	1,894	2,001	2,038	1,864	1,968	1,768	2,044	22,992	20,336	2,656	12%
Unknown (All are Renacres SOR coding error)			295	317	360	346	247	318	321	341	255	335	343	426	3,904	5,084	-1,180	-30%
Grand Total			**4,689**	**4,675**	**4,785**	**5,166**	**4,272**	**4,915**	**5,209**	**5,134**	**4,686**	**5,108**	**4,937**	**5,619**	**59,195**	**55,257**	**3,938**	**7%**

4. Waiting Times

4.1 NHS Southport and Formby CCG patients waiting

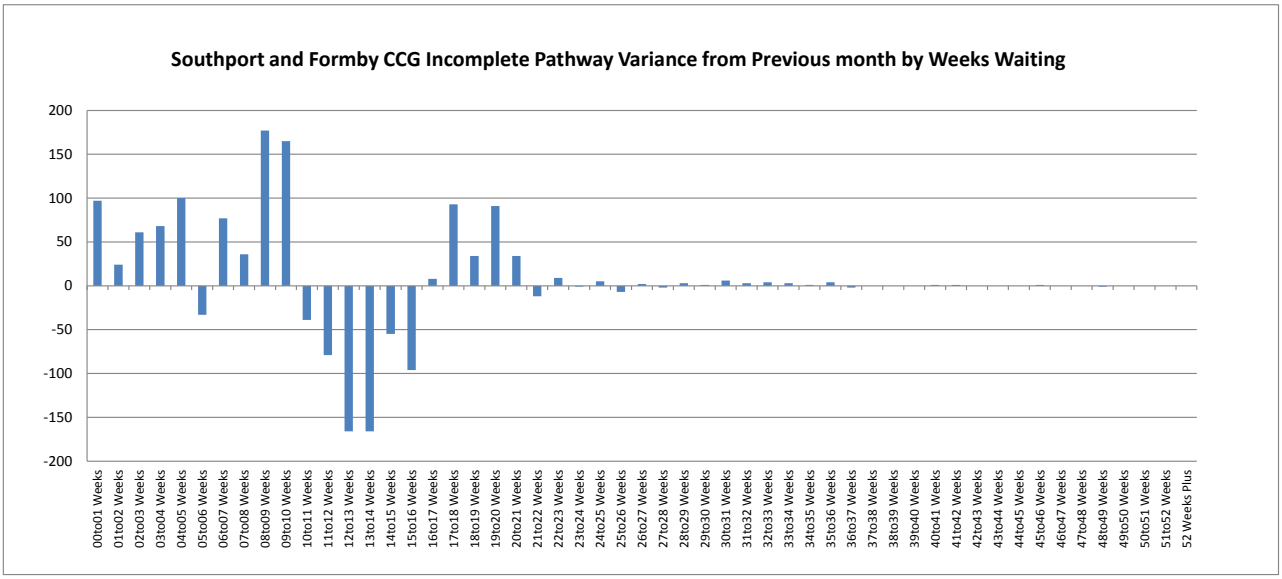
Figure 7 Patients waiting on an incomplete pathway by weeks waiting





There were 577 patients (6.4%) waiting over 18 weeks on Incomplete Pathways at the end of March 2015 an increase of 178 patients (44.6%) from Month 11.

There were no patients Waiting over 52 weeks in February 2014 or March 2015.



There were 8,996 patients on the Incomplete Pathway at the end of March 2015 an increase of 450 patients (5.3%) since February 2015.

4.2 Top 5 Providers

Figure 8 Patients waiting (in bands) on incomplete pathway for the top 5 Providers

Trust	0to10 wks	10to18 wks	Total 0 to 17 Weeks	18to24 wks	24to30 wks	30+ wks	Total 18+ Weeks	Total Incomplete
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	5150	1456	6606	420	69	24	513	7119
RENACRES HOSPITAL	448	23	471	0	0	0	0	471
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	318	56	374	4	3	1	8	382
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	282	57	339	11	6	7	24	363
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	75	27	102	1	0	0	1	103
Other Providers	420	107	527	14	10	7	31	558
Total All Providers	6693	1726	8419	450	88	39	577	8996

4.3 Provider assurance for long waiters

Figure 9 Southport RTT caseload:

As in previous periods the overall number of patients treated with a wait experience over 18 weeks has been increasing as the Trust continues to list patients in chronological order. The total number of patients waiting over 18 weeks remains greater than the number of clock stops. This is focused in a small number of specialties which the Trust is addressingValidation work continues to be carried out across all pathways. As a result of this work the Trust has a larger backlog than planned. A comprehensive training programme has been delivered by the organisation that owns the Trust's new IT system. RTT weekly data meetings continue with an emphasis on delivering a comprehensive action plan, with twice weekly monitoring to senior operational managers. Compliance is expected from July.

5. Planned Care

5.1 All Providers

Performance for 2014/15 against planned care elements of the contracts held by NHS Southport & Formby CCG show an over-performance of circa £1.6m.This over-performance is primarily driven by increases at Aintree Hospital (£385k), Royal Liverpool and Broadgreen University Hospitals (£343k) and Renacres (£757k). Wrightington Wigan and Leigh contract continues to over perform with a cost variance of £244k.

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

Figure 10 All Providers

Other Providers (PBR & Non PBR)	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	10,652	10,652	11,857	1,205	11.31%	£2,256	£2,256	£2,641	£385	17.06%
Alder Hey Childrens NHS F/T	4,509	4,509	4,935	426	9.45%	£720	£720	£662	-£59	-8.14%
Countess of Chester Hospital NHS Foundation Trus	0	0	77	77	0.00%	£0	£0	£6	£6	0.00%
East Cheshire NHS Trust	0	0	5	5	0.00%	£0	£0	£0	£0	0.00%
Liverpool Heart and Chest NHS F/T	1,243	1,243	1,571	328	26.39%	£783	£783	£894	£111	14.13%
Liverpool Womens Hospital NHS F/T	2,088	2,088	2,041	-47	-2.25%	£730	£730	£689	-£41	-5.59%
Royal Liverpool & Broadgreen Hospitals	11,947	11,947	13,564	1,617	13.53%	£2,636	£2,636	£2,979	£343	13.00%
ST Helens & Knowsley Hospitals	3,593	3,593	3,840	247	6.88%	£822	£822	£952	£130	15.87%
Wirral University Hospital NHS F/T	290	290	284	-6	-2.07%	£100	£100	£78	-£22	-22.13%
Central Manchester University Hospitals Nhs Foun	220	220	265	45	20.45%	£42	£42	£62	£21	49.58%
Fairfield Hospital	61	61	98	37	60.66%	£13	£13	£28	£15	115.54%
ISIGHT (SOUTHPORT)	2,518	2,518	3,019	501	19.90%	£582	£582	£702	£120	20.61%
Renacres Hospital	7,308	7,308	10,868	3,560	48.70%	£2,302	£2,302	£3,059	£757	32.87%
SPIRE LIVERPOOL HOSPITAL	480	480	792	312	64.96%	£128	£128	£225	£97	75.84%
University Hospital Of South Manchester NHS FT	191	191	188	-3	-1.57%	£35	£35	£42	£7	18.84%
Wrightington, Wigan And Leigh Nhs FT	1,927	1,927	2,576	649	33.68%	£748	£748	£992	£244	32.63%
	47,025	**42,928**	**50,130**	**7,202**	**16.78%**	**£11,898**	**£10,868**	**£12,485,445**	**£1,618**	**14.89%**

5.2 Southport and Ormskirk Hospital NHS Trust

Figure 11 Month 12 Planned Care- Southport and Ormskirk Hospital NHS Trust by POD

S&O Hospital Planned Care (PbR ONLY)	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	12,058	12,058	11,786	-272	-2.26%	£6,606	£6,606	£6,714	£107	1.63%
Elective	1,851	1,851	1,595	-256	-13.83%	£5,069	£5,069	£4,251	-£819	-16.15%
Elective Excess BedDays	392	392	296	-96	-24.49%	£90	£90	£72	-£18	-20.46%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	1,054	1,054	936	-118	-11.20%	£150	£150	£132	-£18	-11.71%
OPFASPCL - *Outpatient first attendance single professional consultant led*	23,023	23,023	19,304	-3,719	-16.15%	£3,355	£3,355	£2,809	-£547	-16.29%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	2,156	2,156	1,982	-174	-8.07%	£210	£210	£199	-£12	-5.57%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	48,179	48,179	46,929	-1,250	-2.59%	£4,137	£4,137	£4,080	-£57	-1.38%
Outpatient Procedure	14,692	14,692	18,681	3,989	27.15%	£2,407	£2,407	£3,353	£946	39.29%
Grand Total	**103,405**	**103,405**	**101,509**	**-1,896**	**-1.83%**	**£22,026**	**£22,026**	**£21,609**	**-£417**	**-1.89%**

5.2.1 Southport & Ormskirk Hospital Key Issues

There has been an underspend at Southport & Ormskirk trust for 2014/15 for planned care with an evident shift in activity to both the independent sector and other NHS providers. Within Planned Care, Outpatient Procedures is showing a £946k (39%) over performance which is offset by a -£819k (16%) underspend in Elective admissions. The increase in outpatient procedures is primarily as a result of coding changes made by the trust. Some of these are agreed i.e. transfer of cystoscopies from day case to outpatient setting, and some of these are under discussion namely dermascopes (shift from outpatients to outpatient procedures) and increased depth of coding in T&O particular in the fracture clinic.

5.3 Royal Liverpool & Broadgreen Hospitals

Figure 12 Month 12 Planned Care- Royal Liverpool & Broadgreen Hospitals by POD

Royal Liverpool & Broadgreen Hospitals Planned Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	744	744	907	163	21.91%	£575	£575	£656	£81	14.04%
Elective	278	278	303	25	8.99%	£923	£923	£926	£4	0.40%
Elective Excess BedDays	48	48	522	474	987.50%	£11	£11	£117	£106	962.01%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	126	126	204	78	61.90%	£20	£20	£31	£11	55.90%
OPFANFTF - *OP 1st Attendance Multi-Professional Outpatient First. Attendance Non face to Face*	0	0	6	6	0.00%	£0	£0	£0	£0	0.00%
OPFASPCL - *Outpatient first attendance single professional consultant led*	1,523	1,523	1,652	129	8.47%	£238	£238	£261	£23	9.68%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	248	248	189	-59	-23.79%	£27	£27	£17	-£11	-38.72%
OPFUPNFTF	166	166	188	22	13.25%	£4	£4	£4	£1	13.25%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	8,044	8,044	8,268	224	2.78%	£718	£718	£761	£44	6.10%
Outpatient Procedure	770	770	1,325	555	72.08%	£121	£121	£204	£84	69.48%
Grand Total	**11,947**	**11,947**	**13,564**	**1,617**	**13.53%**	**£2,636**	**£2,636**	**£2,979**	**£343**	**13.00%**

5.3.1 Royal Liverpool & Broadgreen Hospitals Key Issues

The main area of planned care over-performance in 2014/15 for NHS Southport & Formby CCG at Royal Liverpool Broadgreen University Hospital is elective excess bed days, daycases and outpatient procedures. In terms of Speciality, the Daycase and Outpatient Procedure over performance is focused around 3 specialties – Ophthalmology, Dermatology and Gastroenterology.

The Trust has been issued with an information query notice relating to over-performance reported throughout 2014/15. The Co-ordinating Commissioner has engaged external consultants to undertake an audit of clinical coding, and provide assurance regarding payment, which is currently underway. Preliminary findings have been shared by Capita with Co-ordinating Commissioners and further refinement against the original specification is being discussed. NWCSU will continue to liaise with the Co-ordinating Commissioner to ensure that outcomes can be shared with co-commissioners when available.

6. Unplanned Care

Performance for 2014/15 against unplanned care elements of the contracts held by NHS Southport & Formby CCG shows an over-performance of circa £1.6m. Over-performance is primarily driven by increases at Southport & Ormskirk Hospital, with smaller but significant elements of over-performance also seen Alder Hey.

6.1 All Providers

Figure 13 Month 12 Unplanned Care – All Providers

Other Providers (PBR & Non PBR)	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	1,467	1,467	1,414	-53	-3.61%	£826	£826	£844	£18	2.16%
Alder Hey Childrens NHS F/T	664	664	766	102	15.30%	£277	£277	£413	£135	48.76%
Countess of Chester Hospital	0	0	40	40	0.00%	£0	£0	£8	£8	0.00%
East Cheshire NHS Trust	0	0	12	12	0.00%	£0	£0	£3	£3	0.00%
Liverpool Heart and Chest NHS F/T	157	157	125	-32	-20.38%	£370	£370	£389	£19	5.22%
Liverpool Womens Hospital NHS F/T	207	207	246	39	18.84%	£179	£179	£205	£26	14.49%
Royal Liverpool & Broadgreen Hospitals	1,285	1,285	1,111	-174	-13.54%	£724	£724	£584	-£140	-19.34%
ST Helens & Knowsley Hospitals	289	289	347	58	20.05%	£163	£163	£186	£22	13.68%
Wirral University Hospital NHS F/T	112	112	92	-20	-17.86%	£45	£45	£42	-£3	-6.61%
Central Manchester University Hospitals	88	88	105	17	19.32%	£30	£30	£24	-£6	-20.67%
University Hospital Of South Manchester	47	47	35	-12	-25.53%	£8	£8	£9	£1	15.07%
Wrightington, Wigan And Leigh	62	62	66	4	6.45%	£53	£53	£28	-£25	-46.91%
Grand Total	**4,378**	**4,004**	**3,999**	**-5**	**-0.13%**	**£2,674**	**£2,447**	**£2,505**	**£58**	**2.37%**

6.2 Southport and Ormskirk Hospital NHS Trust

Figure 14 Month 12 Unplanned Care – Southport and Ormskirk Hospital NHS Trust by POD

S&O Hospital Unplanned Care (PbR ONLY)	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A and E	32,878	32,878	35,411	2,533	7.70%	£3,429	£3,429	£3,640	£211	6.16%
NEL/NELSD - *Non Elective/Non Elective IP Same Day*	10,554	10,554	11,241	687	6.51%	£18,636	£18,636	£19,755	£1,119	6.01%
NELNE - *Non Elective Non-Emergency*	1,181	1,181	1,918	737	62.40%	£1,947	£1,947	£2,029	£82	4.23%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	169	169	252	83	49.11%	£49	£49	£70	£21	41.62%
NELST - *Non Elective Short Stay*	1,436	1,436	1,727	291	20.26%	£995	£995	£1,156	£161	16.19%
NELXBD - *Non Elective Excess Bed Day*	4,979	4,979	5,389	410	8.23%	£1,093	£1,093	£1,191	£98	8.94%
Grand Total	**51,197**	**46,684**	**50,939**	**4,255**	**9.11%**	**£26,149**	**£23,875**	**£25,387**	**£1,512**	**6.33%**

6.3 Southport and Ormskirk Hospital NHS Trust Key Issues

For non- elective, increases in A&E attendances resulted in increases in the number of medical admissions from A&E. Continuing growth in non-elective admissions particularly in the specialties of A&E, General Medicine, Paediatrics and Geriatrics continues to be investigated by NWCSU. Specifically, further investigation is taking place into excessive over performing HRGs, particularly in the Specialties mentioned previously. Southport & Ormskirk Hospital month 12 Provider Report highlights those HRGs being queried.

7. Mental Health

7.1 Mersey Care NHS Trust Contract

Figure 15 NHS Southport and Formby CCG – Shadow PbR Cluster Activity

PBR Cluster	NHS Southport and Formby CCG			
	2014/15 Plan	Caseload (Mar-2015)	Variance from Plan	% Variance
0 Variance	32	39	7	22%
1 Common Mental Health Problems (Low Severity)	35	19	(16)	-46%
2 Common Mental Health Problems (Low Severity with greater need)	45	27	(18)	-40%
3 Non-Psychotic (Moderate Severity)	162	185	23	14%
4 Non-Psychotic (Severe)	128	140	12	9%
5 Non-psychotic Disorders (Very Severe)	29	27	(2)	-7%
6 Non-Psychotic Disorder of Over-Valued Ideas	25	26	1	4%
7 Enduring Non-Psychotic Disorders (High Disability)	96	119	23	24%
8 Non-Psychotic Chaotic and Challenging Disorders	62	64	2	3%
10 First Episode Psychosis	52	63	11	21%
11 On-going Recurrent Psychosis (Low Symptoms)	282	287	5	2%
12 On-going or Recurrent Psychosis (High Disability)	151	156	5	3%
13 On-going or Recurrent Psychosis (High Symptom & Disability)	105	111	6	6%
14 Psychotic Crisis	18	16	(2)	-11%
15 Severe Psychotic Depression	7	5	(2)	-29%
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	6	7	1	17%
17 Psychosis and Affective Disorder – Difficult to Engage	35	27	(8)	-23%
18 Cognitive Impairment (Low Need)	365	253	(112)	-31%
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	465	709	244	52%
20 Cognitive Impairment or Dementia Complicated (High Need)	159	200	41	26%
21 Cognitive Impairment or Dementia (High Physical or Engagement)	50	52	2	4%
Reviewed Not Clustered	30	64	34	113%
No Cluster or Review	46	96	50	109%
Total	2,385	2,692	307	13%

Figure 16 CPA – Percentage of People under followed up within 7 days of discharge

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

Figure 17 CPA Follow up 2 days (48 hours) for higher risk groups

		Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
CPA Follow up 2 days (48 hours) for higher risk groups are defined as individuals requiring follow up within 2 days (48 hours) by CRHT, Early Intervention, Assertive Outreach or Homeless Outreach Teams.	95.0%	100.0%	100.0%	100.0%	100.00%	100.00%	91.67%	87.50%	85.00%	81.82%	100.00%	100.00%	100.00%

7.2 Inclusion Matters Sefton Contract

Figure 18 PHQ13_6 Proportion of people who complete treatment who are moving to recovery

Sefton	Target	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Oct	Nov	Dec	Q3	Jan	Feb	Mar	Q4	Total
Entered (KPI4)		284	461	414	1159	404	308	390	1102	520	518	460	1498	540	461	465	1466	5225
Entered (KPI4) HSCIC		**290**	**345**	**390**	**1025**	**380**	**335**	**390**	**1105**									2130
Completed (KPI5)		289	324	249	857	374	272	343	986	412	316	251	979	369	303	334	1006	3836
Completed (KPI5) HSCIC		**245**	**295**	**220**	**760**	**380**	**270**	**345**	**995**									1755
Moved to recovery (KPI6)		107	154	100	361	162	112	144	416	166	114	92	372	144	124	151	419	1570
Moved to recovery (KPI6) HSCIC		**95**	**145**	**90**	**330**	**140**	**85**	**135**	**360**									690
Entered Below Caseness (KPI6b)		31	22	17	70	26	23	28	77	28	22	18	68	18	22	18	58	273
Entered Below Caseness (KPI6b) HSCIC		**20**	**20**	**15**	**55**	**30**	**25**	**30**	**85**									140
Prevalence	15%	0.65%	1.06%	0.95%	2.67%	0.93%	0.71%	0.90%	2.54%	1.20%	1.19%	1.06%	3.45%	1.24%	1.06%	1.07%	3.38%	12.05%
Recovery	50%	41.5%	51.0%	43.1%	45.9%	46.6%	45.0%	45.7%	45.8%	43.2%	38.8%	39.5%	40.8%	41.0%	44.1%	47.8%	44.2%	44.1%
Prevalence HSCIC	15%	**0.67%**	**0.80%**	**0.90%**	**2.36%**	**0.88%**	**0.77%**	**0.90%**	**2.55%**									**4.91%**
Recovery HSCIC	50%	**42.2%**	**52.7%**	**43.9%**	**46.8%**	**40.0%**	**34.7%**	**42.9%**	**39.6%**									**42.7%**

IAPT Prevalence: The CCG did not achieve the 3.75% in Q4 recording 3.07%% (585 patients entering psychological therapies). Although this represents an improvement on Q1, Q2 and Q3, year to date they are at 10.73% which is still far from the 15% target. The target was changed during the year requiring 3.75% in the final quarter of the year which the CCG failed to meet. To have achieved the target in Q4 the service would have needed to see 131 more patients enter psychological therapies in Q4.

IAPT Recovery Rate: The CCG did not achieve the 50% target reaching 47.5% cumulatively to March, but did achieve in month (March) reaching 50.9% this year the target was achieved in May, June Feb and March. The CCG have not achieved the annual target.

A new provider will deliver IAPT services in 2015/16.

8. Community Health

8.1 Southport and Ormskirk Community Health

District Nurses: Referrals to District Nurses remain above plan at month 12 and this is linked to "Care Closer to Home".

Chronic Care Coordinators: Upward trend in referrals received and a corresponding increase in the number of contacts seen.

Wheelchair Service: The activity year to date at month 12 remains over planned levels. There was a dip in activity in November to January which is possibly due to seasonal factors but this month contacts have returned to previous levels.

Podiatry Non AQP-referrals year to date for podiatry at month 12 are below indicative plan levels. Referrals into the service are also down. Community contacts are within tolerance levels while clinic contacts remain below plan which shows a shift in where activity is occurring. Overall clinic and community activity is below plan. Comparison of activity on the Podiatry block and AQP 2013/14 and AQP and Block 2014/15 combined for March to date show that overall activity is at a lower level to the same time period last year.

Waiting Times
18 week waiters – Work is on-going to set appropriate wait targets by service as the national RTT targets are inappropriate for community services.

The CCG are working with the Trust to review Community KPIs and Quality Contract Measures and develop a new suite of indicators for inclusion in the 15/16 Contract. This will be picked up via the Information Sub Group.

Any Qualified Provider

Adult Hearing AQP is +4% above the annual budget at month 12. Adult Hearing AQP activity year to date is up on the same time period last year.

MSK AQP 86% of the budget has been spent at month 12. Activity is slightly down on the same time period last year

The Podiatry AQP is underperforming by 8% against budget at month 12. Activity is down on the same time period last year

Bridgewater
Paediatric Audiology
This is a relatively new service that commenced in September 2014
Bridgewater is in the process of transferring a member of staff from the previous provider, and are about to recruit another two members of staff.
DNAs - Initial Appointments (Threshold 10%): 24.1% in March .This is a worse position than last month.
DNAs - Follow-up Appointments (Threshold 7%) 22.2% in March. This is a worse position than last month.

Longest wait was 9 weeks in October reduced to 3 weeks in Feb. In March all patients are waiting under 11 weeks.

Liverpool Community Health Trust

Overall adult services demand and activity is above planned levels at month 12.

Community Cardiac Nurses: Domiciliary visits are above plan and this is due to staffing levels and the ability to see more patients potentially more frequently.

Children's services demand is above plan with activity closed to planned levels.

Paediatric continence is above planned levels with increased demand flowing into increased activity. Waiting times are within target.

TB nursing: Activity at month12 is well above planned levels but this is due to one extremely complex active case.

Paediatric Dietetics: Increased activity is due to more frequent contacts with patients. Experienced locum cover has been found and will provide additional support.

Paediatric OT: Demand and have activity have increased resulting in a small number of children waiting over 18 weeks. The service is targeting the longest waiters.

Waiting times are not being recorded for several services: Community Cardiac/Heart Failure, IV Therapy.

9. Third Sector Contracts

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

10. Quality and Performance

10.1 NHS Southport and Formby CCG Performance

		Current Period				
Performance Indicators	**Data Period**	**Target**	**Actual**	**Direction of Travel**	**Exception Commentary**	**Actions**
IPM						
Treating and caring for people in a safe environment and protecting them from avoidable harm						
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(CCG)**	14/15 - March	43	34	↑	There were 6 new cases reported in March 2015, 34 cases reported YTD compared to a cumulative plan of 43 cases. Of the 34 cases reported YTD, 29 were reported by Southport and Ormskirk Hospital (15 apportioned to acute and 14 apportioned to community), 3 cases reported by Aintree Hospital (1 apportioned to acute, 2 apportioned to community) and 2 case reported by Royal Liverpool Hospital (apportioned to acute). The CCG have achieved the yearly target for C.Difficile for 2014-15.	
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Southport & Ormskirk)**	14/15 - March	27	35 (19 following appeal)	↑	There were 4 new cases reported in March 2015, 35 cases reported YTD compared to a annual plan of 27 cases. All 4 cases were reported at Southport and Formby CCG. Of the 35 cases reported YTD, 15 cases reported against Southport and Formby CCG patients, 17 cases against West Lancs CCG patients, 1 case reported against a Chorley and South Ribble CCG, 1 case reported against Eastern Cheshire CCG and 1 at Ipswich and East Suffolk CCG. The Trust have failed the year target for C.Difficile for 2014-15.	The Trust reported 35 cases in14/15; 16 have been successfully appealed, taking the local reported total cases to 19 attributable cases against the 14/15 annual target of 27. Since October 2014, the Trust has performed below trajectory on a monthly basis, not taking into account appeals. However in March 2015 there were 4 cases putting the Trust over the monthly trajectory of 2.25, reviews have been completed on these cases and some will be considered for the appeals process. The annual target for 15/16 is 36 attributable cases. The focus continues to be appropriate antimicrobial prescribing which remains good, early identification of symptomatic patients including their isolation, sample acquisition and treatment, and the maintenance of the Bristol Stool Chart, including recording the Bristol Stool number on sample request forms. *Please Note - Data has been taken from the National HCAI Database - this is updated centrally therefore not all local appeals will be reflected in the table.*
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	14/15 - March	0	2	↔	No new cases reported in March 2015, 2 cases reported YTD. Both cases were reported by Southport and Ormskirk Hospital in July 2014 (1 apportioned to acute and 1 apportioned to community).	The CCG currently has two year-to-date MRSA cases related to Southport & Formby CCG Patients - 1 apportioned to acute and 1 apportioned to community - as community providers cannot be held accountable for HCAIs the CCG has had the community MRSA case attributed to them. The CCG is monitoring all Trust acquired cases of MRSA through Southport & Ormskirk Hospital's Quality & Safety Committee and the monthly CQPG.
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Southport & Ormskirk)**	14/15 - March	0	2	↔	No new cases have been reported in March 2015, 2 cases reported YTD. 1 in July 2014 relating to a Southport and Formby CCG patient and 1 in September related to a West Lancashire CCG patient.	After closing the 14/15 year with 2 MRSA bacteraemias (the last one being in September 2014), unfortunately the Trust have had their first case in April for 15/16 against an annual trajectory of zero. The CCG and Public Health England have been informed and the Post Infection review (PIR) will be held shortly. The Trust continues to focus on improvement in MRSA pathway compliance. Other highlights include: Blood culture contamination results in A&E has decreased; commode cleanliness audits have been exceptional (in February 15 the best figures since this has been recorded); increase in peripheral venous catheters while a decrease in the number of Peripherally Inserted Central Catheters (PICCs).

Enhancing quality of life for people with long term conditions						
Patient experience of primary care i) GP Services	Jan-Mar 14 and Jul-Sept 14		3.18%	New Measure		
Patient experience of primary care ii) GP Out of Hours services	Jan-Mar 14 and Jul-Sept 14		10.51%	New Measure		
Patient experience of primary care i) GP Services ii) GP Out of Hours services (Combined)	Jan-Mar 14 and Jul-Sept 14	6%	4.03%	New Measure		
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s(Cumulative)	14/15 - March	499.74	666.30	New Plans	The agreed plans are based on activity for the same period last year. The increase in actual admissions is 39 above the same period last year.	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	14/15 - March	1068.38	1,201.82	New Plans	The agreed plans are based on activity for the same period last year. The increase in actual admissions is 163 higher the same period last year.	
Emergency Admissions Composite Indicator(Cumulative)	14/15 - March	2377.24	2,982.45	New Plans	This measure now includes a monthly plan, this is based on the plan set within the Outcome Measure framework and has been split using last years seasonal Performance. Admissions have increased by 523 compared with the same period last year.	
IAPT - Prevalence (Quarterly)	14/15 - Qtr4	3.75%	3.07%	↑	Quarter 4 has not achieved above the required 3.75% target. Previous quarters recording 2.56% for Q1, 2.19% for Q2 and 2.92 for Q3. January recorded 1.14% (218 patients), February recorded 0.95% (181 patients) and March 0.97% (186 patients) . To have achieved the 3.75% target in Q4 the service would needed to see at 131 more patients enter psychological therapies in Q4.	
IAPT - Prevalence (Cumulative)	14/15 - March	15.00%	10.73%	↑	The CCG are not achieving the 15% target, reaching 10.73% year to date.	Identified issue with provider not applying nationally mandated definition of KPI. Action plan in place to ensure target met by end Q4 2014/15.
IAPT - Recovery Rate (Cumulative)	14/15 - March	50%	47.50%	↑	The CCG are not achieving the 50% target reaching 47.5% year to date, but are achieving in month (March) reaching 50.9% . The target was reached in May, June, February and March in 2014/15.	
Helping people to recover from episodes of ill health or following injury						
Patient reported outcomes measures for elective procedures: Groin hernia	2012/13	Eng Ave 0.085	0.08	Refreshed data	The CCG failed to improve on previous years outcome for Groin Hernia procedures and did not achieve a rate greater than the England average.	The CCG is very close to the England Average for PROMs data, discussions are currently taking place at CCG level to establish ownership of PROMs measure and to develop an improvement plan.
Patient reported outcomes measures for elective procedures: Hip replacement	2012/13	Eng Ave 0.438	0.43	Refreshed data	The CCG improved on the previous years rate but failed to achieve a score higher than that of the England average.	
Patient reported outcomes measures for elective procedures: Knee replacement	2012/13	Eng Ave 0.318	0.31	Refreshed data	The CCG improved on the previous years rate but failed to achieve a score higher than that of the England average.	
Emergency readmissions within 30 days of discharge from hospital (Cumulative)	14/15 - March		16.47	↔		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	14/15 - March	350.25	320.35	New Plans		
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	14/15 - March	1421.24	1,717.59	New Plans	The agreed plans are based on activity for the same period last year. This indicator is above the same period last year by 362 admissions.	

% who had a stroke & spend at least 90% of their time on a stroke unit **(CCG)**	14/15 - March	80%	84.00%	↑		
% who had a stroke & spend at least 90% of their time on a stroke unit **(Southport & Ormskirk)**	14/15 - March	80%	75.00%	↑	Southport & Ormskirk have failed the target in March, with 27 patients out of 36 spending 90% of their time on a stroke unit (9 breaches). This is the 5th time the target has been breached in 2014-15 but an improvement on last month's performance.	The Trust narrowly missed the 90% stay on stroke ward target reporting performance of 75% against the 80% target. The two main themes relate to pressures in the availability of beds across the Trust and atypical presentations which may cause delays to diagnosis. Actions - The Royal College of Physicians have reviewed the Trust's Stroke Services and the Trust is awaiting a formal report. High-level feedback received following the review has been developed into an action plan delivered via the Stroke Operational Group. Further details will be provided following receipt of the report. Forecast - There continues to be a risk around atypical presentations causing delays to diagnosis and during periods of increased bed pressures which impact on performance. The Trust has robust procedures in place to diagnose and treat patients effectively.
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(CCG)**	14/15 - March	60%	77.78%	↑		
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Southport & Ormskirk)**	14/15 - March	60%	84.62%	↑		
Mental health						
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative) **(CCG)**	14/15 - Qtr3	95%	88.90%	↓	The CCG has failed the target in Q3, with 40 out of 45 patients on CPA who being followed up within 7 days after discharge from psychiatric inpatient care. Early indications show (from local un-validated data) that the target should be met in Q4 as January and February have recorded 100%.	
Preventing people from dying prematurely						
Under 75 mortality rate from cancer	2013		120.20			
Under 75 mortality rate from cardiovascular disease	2013		57.50			
Under 75 mortality rate from liver disease	2013		15.80			
Under 75 mortality rate from respiratory disease	2013		22.30			
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Person)	2013	2,646.00	1,933.40	↑		The annual variation is significant and the CCG is working with Public Health locally and regionally to understand this. Indications at present are that the PYLL is significantly susceptible to fluctuations due to changes such as young deaths, which introduces major swings, particularly at CCG level.

Cancer waits – 2 week wait						
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(CCG)**	14/15 - February	93%	96.26%	↓		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Southport & Ormskirk)**	14/15 - February	93%	95.93%	↓		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(CCG)**	14/15 - February	93%	92.52%	↑	Southport & Formby CCG achieved the 93% target in month (Feb) but failed year to date due to previous months failing the target. The breaches were mainly down to patient cancellation, patient choice.	Southport & Formby CCG narrowly missed the 93% target due to a small number of breaches (patient choice), initital forecasts for Quarter 4 14/15 indicates that the 93% target will be met. Unvalidated cancer data indicates that Aintree Hospital has met it's 14/15 target, Southport & Ormskirk Hospital's breast service is no longer open to new patients but continued to run clinics and some surgery for follow-up patients finally ceasing all services from 1 April 2015.
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(Southport & Ormskirk)**	14/15 - February	93%	95.00%	↑	The Trust didn't submit data between October and February but reported 1 patient in March.	Provider Comments: We closed our breast services down for new patients but continued to run clinics and some surgery for follow-up patients finally ceasing all services from 1 April. This patient was toward the end of her five year follow-up cycle that breast cancer patients are placed on post treatment. A mammogram screening at the trust had found something that needed further investigation but was not suspected as cancer. The protocol for any further follow-ups of the breast symptomatic is that they are classed as a "new" two week referral, when in fact they are a follow-up patient that requires further investigation.
Cancer waits – 31 days						
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	14/15 - February	96%	98.85%	↓		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Southport & Ormskirk)**	14/15 - February	96%	99.72%	↑		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	14/15 - February	94%	96.84%	↑		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Southport & Ormskirk)**	14/15 - February	94%	100%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	14/15 - February	94%	99.15%	↑		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Southport & Ormskirk)**	14/15 - February	94%	98.94%	↑		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	14/15 - February	98%	99.19%	↑		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Southport & Ormskirk)**	14/15 - February	98%	100%	↔		

Cancer waits – 62 days						
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set (Cumulative) **(CCG)**	14/15 - February		94.83%	↑		
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set (Cumulative) **(Southport & Ormskirk)**	14/15 - February		91.03%	↑		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	14/15 - February	90%	85.42%	↓	The CCG failed the target in February reaching 57.1% in month and 85.42 year to date. In February there were 3 patient breaches out of a total of 7 patients.	The CCG failed to achieve the target in February (see below for Southport & Ormskirk Hospital's narrative). Aintree Hospital also failed their Screening Target, the Cancer Network are currently reviewing cancer screening breaches across the Health Economy, to improve the process for late referrals and breach allocations.
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(Southport & Ormskirk)**	14/15 - February	90%	63.64%	↓	The Trust failed the target in February reaching 50% and 63.64% year to date. In February there was only 1 patient and 0.5 patient breached the target. Year to date there have been a total of 11 patients and 4 patient breaches.	The breach relates to one patient (of two in the denominator) who was treated at the Trust following referral from a screening provider. The patient was referred late to the Trust which resulted in the patient breaching the 62 day standard. Despite every effort to reduce the time between key stages on the patient pathway the Trust was unable to stop this patient breaching. Screening patients continue to be monitored by the MDT co-ordinator from receipt of referral into the Trust to ensure their pathway runs smoothly. The particular problem associated with late referrals from screening units is scheduled for discussion with CCGs and the Cancer Network. Due to the Trust's reliance on referrals from other providers the 62 day screening referral to treatment target remains at risk. Preliminary information based on the patients treated in March indicates that the Trust will be compliant against all indicators for the month and have delivered compliance for the year and Q4 excluding 62 day screening referral to treatment.
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	14/15 - February	85%	85.82%	↑		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Southport & Ormskirk)**	14/15 - February	85%	86.07%	↑		
Mixed Sex Accommodation Breaches						
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(CCG)**	14/15 - March	0.00	0.00	↔		
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(Southport & Ormskirk)**	14/15 - March	0.00	0.00	↔		
Referral To Treatment waiting times for non-urgent consultant-led treatment						
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(CCG)**	14/15 - March	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(Southport & Ormskirk)**	14/15 - February	0	0	↔		

The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(CCG)**	14/15 - March	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(Southport & Ormskirk)**	14/15 - February	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	14/15 - March	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Southport & Ormskirk)**	14/15 - February	0	0	↔		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(CCG)**	14/15 - March	90%	85.28%	↓	Southport & Formby CCG failed to achieve the target of 90% for the second consecutive month, achieving 85.28%. This is the third time the CCG has failed the target this year and is the lowest performance recorded YTD. This month's activity equates to 116 patients 788 not being within 18 weeks. Breaches occurred in the following specialties T&O (39), General Surgery (19), Ophthalmology (15), ENT (10), Urology (6), General Medicine (1), Cardiology (2) and All Other (24). At CCG level four trusts failed this target; Southport & Ormskirk achieved 77.39% (equates to 97 out of 429 patients), Alder Hey achieved 68.42% (equates to 6 out of 19 patients), Aintree achieved 88.57% (4 patients out of 35) and Liverpool Heart & Chest achieved 83.33% (2 patients out of 12).	See below for detailed narrative outlining the reasons for under performance in Southport & Ormskirk Hospital. The CCG is liasing with Liverpool CCG to discuss the breaches occuring at Alder Hey and Liverpool Heart & Chest Hospital.
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(Southport & Ormskirk)**	14/15 - February	90%	80.38%	↓	The Trust failed to achieve the target of 90% in February achieving 80.38%. This equates to 164 patients out of 836 not been seen within 18 weeks. These breaches were in the following specialities:- General Surgery (31), Urology (5), T&O (47), Ophthalmology (24), ENT (10), Oral Surgery (18), General Medicine (2), Gynaecology (4) and 'All other' (23). 1 patient waited over 40 weeks and was seen between 43-44 weeks in General Surgery.	The Trust continues to treat patients in chronological order from the longest waiter first excluding any patients that are urgent or have another priority status, for example military veterans. During March the Trust continued to utilise national funding to run waiting list initiatives focusing on reducing the number of patients with a wait longer than 18 weeks. A significant volume of patients were treated during the month from both the admitted and non-admitted pathways. This has been acknowledged by the TDA who have thanked the Trust for the reduction in the number of patients waiting. The Trust has also undertaken a significant validation exercise to ensure that the waiting list data is accurate. A number of patients had been incorrectly assigned to non-RTT pathways. Theses have been validated and are now reported against the correct RTT pathways. This has caused an increase to the backlog position across both admitted and non-admitted pathways. **Actions** • The Trust continues to assign resources to the validation process. • A comprehensive training programme has been delivered by the organisation that owns the Medway system. • Weekly RTT data meetings continue with an emphasis on delivering a comprehensive action plan. • Revised twice-weekly monitoring to senior operational managers. • The Trust is revising all Standard Operating Procedures including RTT. Validation work continues to be carried out across all pathways. As a result of this work the Trust has a larger backlog than planned. The total number of patients waiting over 18 weeks remains too great a proportion of clock stops to deliver compliance against the operational standards. This is focused in a small number of specialities which the Trust is addressing. As a result the Trust will continue to breach the admitted and non-admitted standards until the position improves. A deadline has been set to deliver compliance in July.

Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(CCG)**	14/15 - March	95%	94.74%	↓	Southport & Formby CCG narrowly failed to achieve the target of 95%, achieving 94.74%. This is the first time this year the CCG has failed the non-admitted target overall. This month's activity equates to 164 patients out of 3,119 not being seen within 18 weeks. Breaches occured in T&O (13), General Surgery (8), Ophthalmology (16), ENT (24), Urology (4), General Medicine (8), All Other (29), Cardiology (7), Rheumatology (2), Respiratory Medicine (3), Gynaecology (6), Geriatric Medicine (2), Gastroenterology (10) and Dermatology (32). At CCG level, 3 Trust's failed the target; S&O at 93.66% (155 patients out of 2,445), Alder Hey at 90.91% (3 patients out of 33) and Liverpool Heart & Chest at 80% (2 patients out of 10).	See below for detailed narrative outlining the reasons for under performance in Southport & Ormskirk Hospital. The CCG is liasing with Liverpool CCG to discuss the breaches occuring at Alder Hey and Liverpool Heart & Chest Hospital.
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(Southport & Ormskirk)**	14/15 - February	95%	93.82%	↓	The Trust narrowly failed to achieve the target of 95% in February achieving 93.82%. This equates to 261 patients out of 4,224 not been seen within 18 weeks. These breaches were in General Surgery (12), Urology (6), T&O (21), Ophthalmology (19), ENT (12), Oral Surgery (9), Gastroenterology (11), Cardiology (11), Dermatology (95), Rheumatology (1), Geriatric Medicine (1), Gynaecology (9) and Other (45).	The Trust continues to treat patients in chronological order from the longest waiter first excluding any patients that are urgent or have another priority status, for example military veterans. During March the Trust continued to utilise national funding to run waiting list initiatives focusing on reducing the number of patients with a wait longer than 18 weeks. A significant volume of patients were treated during the month from both the admitted and non-admitted pathways. This has been acknowledged by the TDA who have thanked the Trust for the reduction in the number of patients waiting. The Trust has also undertaken a significant validation exercise to ensure that the waiting list data is accurate. A number of patients had been incorrectly assigned to non-RTT pathways. Theses have been validated and are now reported against the correct RTT pathways. This has caused an increase to the backlog position across both admitted and non-admitted pathways. Actions • The Trust continues to assign resources to the validation process. • A comprehensive training programme has been delivered by the organisation that owns the Medway system. • Weekly RTT data meetings continue with an emphasis on delivering a comprehensive action plan. • Revised twice-weekly monitoring to senior operational managers. • The Trust is revising all Standard Operating Procedures including RTT. Validation work continues to be carried out across all pathways. As a result of this work the Trust has a larger backlog than planned. The total number of patients waiting over 18 weeks remains too great a proportion of clock stops to deliver compliance against the operational standards. This is focused in a small number of specialities which the Trust is addressing. As a result the Trust will continue to breach the admitted and non-admitted standards until the position improves. A deadline has been set to deliver compliance in July.
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(CCG)**	14/15 - March	92%	95.39%	↑		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(Southport & Ormskirk)**	14/15 - February	92%	95.21%	↓		

A&E waits						
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG)**	14/15 - March	95.00%	95.07%	↓		
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Southport & Ormskirk)**	14/15 - March	95.00%	94.60%	↓	Southport & Ormskirk have failed the target narrowly year to date reaching 94.60%. In month (Mar) they achieved 92.23%. 729 attendances out of 9,379 where not admitted, transferred or discharged within 4 hours. The Trust have failed the target each month since October 2014.	There has been an increase in attendances at all sites. Proportion of majors significantly higher compared to the same month last year and to the average over 2014-15. The Trust continues to experience a higher level of activity than at the same period in the previous year. Attendances at all sites together were over 4% higher than in March 14. Over the whole of 14/15 attendances are over 5% greater than in 13-14. Total attendances for 14/15 are 5,140 higher than in 13/14. A&E admissions are up 22% in month and 20% over the year. Compared to the same periods in 13/14, totalling in 3,661 additional admissions. The pattern of attendances has also changed during the year. We have seen an increase in the length of stay highlighting the complexity of patients admitted to the Trust. We have also seen a rise in the number of short stays or same day admissions as the resilience-funded schemes allow certain cohorts of patients to be discharged sooner. This compounds the average length of stay figures as the more complex and acutely sick patients remain in hospital longer whilst those who can be treated in the community see reductions in their individual length of stay. The rise in the number of frail and elderly patients attending the Trust continues to rise showing a significant increase since October. Site compliance remains a challenge, the Trust failed to achieve Q3 and 4 and the year. Significant pressure across the region, and nationally, puts the achievement of the 95% target at risk. The wider urgent care action plan is addressing significant health economy issues, many of which are long-term objectives. Currently the Trust is non-compliant against the four hour A&E target for April.
Diagnostic test waiting times						
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	14/15 - March	1.00%	0.59%	↑		
% of patients waiting 6 weeks or more for a Diagnostic Test **(Southport & Ormskirk)**	14/15 - February	1.00%	0.33%	↓		

Category A ambulance calls						
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	14/15 - March	75%	68.96%	↑	The CCG failed to achieved the 75% year to date target. In month (Mar) the CCG recorded a percentage of 80% therefore achieving the target for the first time since December. Before this the CCG had only achieved the target in May and Aug in 2014-15.	Overall NWAS activity at the year-end was 2.2% over plan . Merseyside activity was 0.8% over plan at year-end. Southport and Formby was 2.6% up. Southport and Formby Red activity is up 14.3% at year end against plan. Green activity remains down on plan, finishing the year at 1.4% under plan. NWAS attended a Board to Board with the Trust Development Authority on the 24th April. Subsequent to the meeting, NWAS have put in place a number of internal measures to focus staff on being able to meet performance in Quarter 1 of 2015/16. For the Trust this means working in such a way as if they were managing a major incident (suspending mandatory training and attendance at some meetings), although it should be stressed that they have not declared a major incident and remain at REAP 3. Following the meeting NWAS performance has improved significantly and the Trust provided Commissioners with assurances of meeting Q1 performance at the Strategic Partnership Board held 7th May 2015. Agreement on the contractual arrangements for 2015/16 has been reached following mediation with the Trust, avoiding the need for formal arbitration. County Lead Commissioners have agreed to invest circa £10m into NWAS for 15/16. This includes base lining funding for some of the Trusts initiatives targeted at deflecting incidents (including Paramedic Pathfinder, Complementary Resources and Frequent Callers).
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	14/15 - March	75%	66.20%	↑	The CCG failed to achieved the 75% year to date target. In month (Mar) the CCG recorded a percentage of 67.94%. Although this shows an improvement on the past 3 months, the CCG hasn't achieved the target for any months in 2014/15.	
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	14/15 - March	95%	88.03%	↑	The CCG failed to achieve the 95% year to date and also did not achieve the target in month (Mar) recording 89.21%. Although this is an improvement on the past 5 months, the CCG hasn't achieved the target for any months in 2014/15.	
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	14/15 - March	75%	69.13%	↓	NWAS failed to achieve the 75% year to date and also did not achieve the target in month (Mar) recording 68.27%. April remains the only month they have achieved the target.	
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	14/15 - March	75%	69.43%	↓	NWAS failed to achieve the 75% year to date and also did not achieve the target in month (Mar) recording 65.72%. April remains the only month they have achieved the target.	
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	14/15 - March	95%	93.13%	↓	NWAS failed to achieve the 95% year to date and also did not achieve the target in month (Mar) recording 91.16%. NWAS have failed for the past 5 months.	
Local Measure						
Diabetes Care Processes **(CCG)**	14/15 - Qtr3	59.3%	48.2%	New Measure	This measure makes up part of the quality premium and will be measures quarterly. Current figures show the CCG is under performing against plan and performance has also dropped from quarter 2 which recorded at 49.6%	

10.2 Friends and Family – Southport and Ormskirk Hospital NHS Trust

Figure 19 Friends and Family – Southport and Ormskirk Hospital NHS Trust

Clinical Area	Response Rate (RR) Target	RR Actual (Mar 2015)	RR - Trajectory From Previous Month (Feb 15)	Percentage Recommended (England Average)	Percentage Recommended (Mar 2015)	PR Trajectory From Previous Month (Feb 15)	Percentage Not Recommended (England Average)	Percentage Not Recommended (Mar 2015)	PNR Trajectory From Previous Month (Feb 15)
Inpatients	30%	29.5%	↑	95%	94%	↑	2%	3%	↔
A&E	20%	10.1%	↓	87%	82%	↓	6%	10%	↓
Q1 - Antenatal Care	N/A	-	-	95%	97%	↓	1%	0%	↔
Q2 - Birth	N/A	16.0%	↓	97%	92%	↑	1%	3%	↑
Q3 - Postnatal Ward	N/A	-	-	93%	94%	↑	2%	3%	↔
Q4 - Postnatal Community Ward	N/A	-	-	98%	100%	↑	1%	0%	↑

Where cell contains "-" no denominator data available

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

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

The Trust failed to achieve the A&E response rate target and achieved 10.1% in March against a target of 20%, there has also been a decline in performance from the February position. They Trust reported below the England Average percentage recommended and they saw a further decline in monthly performance against the February position.

The Trust saw an improvement in performance relating to Inpatient response rate target, achieving 29.5% against a target of 30%, they also reported below England Average percentage recommended by 1%, however this was an improvement on the February position.The Trust remain in line with national tolerance for antenatal care and they have seen a slight decrease in the response rate for Birth, but an improvement in the percentage recommended / not recommended rates (although they are still below national averages).

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

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

10.3 Complaints

Complaints are only reported on a Quarterly basis (in line woth Quality Contract guidance), Quarter 4 data will be available in June following approval by the Trust's Board.

10.4 Serious Untoward Incidents (SUIs)

SUIs Reported at Southport & Formby CCG level

For Southport & Formby CCG there has been one serious incidents reported in March 2015 - Sub-optimal care of the deteriorating patient, 33 Incidents reported YTD.

Number of Never Events reported in period

0 never events reported in March 15, 3 never events reported in 2014/15.
1xSurgical Error (May – Alder Hey)
1xSerious Incident by Inpatient (not in receipt) (June – Royal Liverpool)
1xDrug Incident (general) (July – Southport & Ormskirk)

NHS Southport and Formby CCG reported Serious Untoward Incidents

32 incidents reported YTD against Southport & Formby CCG patients

Type of Incident	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Suspected suicide		1			1	1					2		5
Delayed diagnosis			1				1	1					3
Unexpected Death of Community Patient (in receipt)		1				1				1			3
Confidential Information Leak				1			1				1		3
Child Death					1	1							2
Unexpected Death (general)									2				2
Attempted Suicide by Outpatient (in receipt)		1						1					2
Pressure ulcer - (Grade 3)							1	1					2
Surgical Error		1											1
Hospital Transfer Issue								1					1
Allegation Against HC Professional					1								1
Abscond						1							1
Sub-optimal care of the deteriorating patient												1	1
Radiology/Scanning incident	1												1
Admission of under 18s to adult mental health ward	1												1
Safeguarding Vulnerable Child			1										1
Drug Incident (general)				1									1
Serious Incident by Inpatient (not in receipt)			1										1
Slips/Trips/Falls							1						1
Grand Total	**2**	**4**	**3**	**2**	**3**	**4**	**4**	**4**	**2**	**1**	**3**	**1**	**33**

Red indicates Never Event

Number of Southport & Formby CCG Incidents reported by Provider

Please not the data comes from Datix and not StEIS, as such differences in the figures reported for Liverpool community health and Mersey Care will be notable. These known data issues are being worked though with the Providers and the differing data sets.

Provider / Type of Incident	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Alder Hey Children's NHS Foundation Trust													
Surgical Error		1											1
Allegation Against HC Professional					1								1
Lancashire Teaching Hospitals NHS Foundation Trust													
Unexpected Death (general)									1				1
Liverpool Community Health NHS Trust													
Child Death					1	1							2
Mersey Care NHS Trust													
Suspected suicide		1			1	1					2		5
Unexpected Death of Community Patient (in receipt)		1				1				1			3
Abscond						1							1
Admission of under 18s to adult mental health ward	1												1
Attempted Suicide by Outpatient (in receipt)		1						1					2
Royal Liverpool and Broadgreen University Hospitals NHS Trust													
Serious Incident by Inpatient (not in receipt)			1										1
Southport and Ormskirk Hospital NHS Trust													
Confidential Information Leak				1			1				1		3
Delayed diagnosis			1				1	1					3
Radiology/Scanning incident	1												1
Safeguarding Vulnerable Child			1										1
Slips/Trips/Falls							1						1
Drug Incident (general)				1									1
Pressure ulcer - (Grade 3)							1	1					2
Hospital Transfer Issue								1					1
Unexpected Death (general)									1				1
Sub-optimal care of the deteriorating patient												1	1
Grand Total	**2**	**4**	**3**	**2**	**3**	**4**	**4**	**4**	**2**	**1**	**3**	**1**	**33**

For Southport & Ormskirk Hospital there has been 4 serious incidents reported in March 2015, 32 Incidents reported in 2014/15.

- Communicable Disease and Infection Issue
- Delayed diagnosis
- Pressure ulcer - (Grade 3)
- Sub-optimal care of the deteriorating patient

To note the reporting methodology has changed slightly for incidents reported within 48hrs, figures now in exclude weekends and bank holidays.

Number of Never Events reported in period

0 never events reported in March 15, 2 never events reported year to date both occurring in July (one has now been down graded by the CCG, however still appears on National Database).

Number of incidents reported split by type

32 incidents reported YTD by the provider.

Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Pressure ulcer - (Grade 3)							3	1	3			1	8
Delayed diagnosis			1	1			2	1				1	6
Confidential Information Leak				1			1				1		3
Unexpected Death (general)									2				2
Adverse media coverage or public concern about the organisation or the wider NHS					1	1							2
Screening Issues									1				1
Radiology/Scanning incident	1												1
Sub-optimal care of the deteriorating patient												1	1
Drug Incident (Chemotherapy)				1									1
Safeguarding Vulnerable Child			1										1
Communicable Disease and Infection Issue												1	1
Slips/Trips/Falls							1						1
Hospital Transfer Issue								1					1
Attempted Suicide by Inpatient (in receipt)							1						1
Allegation against HC non-Professional								1					1
Drug Incident (general)				1									1
Grand Total	**1**	**0**	**2**	**4**	**1**	**1**	**8**	**4**	**6**	**0**	**1**	**4**	**32**

Number of Incidents reported by CCG

CCG Name / Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Southport and Formby CCG													
Confidential Information Leak				1			1				1		3
Delayed diagnosis			1				1	1					3
Drug Incident (general)				1									1
Hospital Transfer Issue								1					1
Pressure ulcer - (Grade 3)							1	1					2
Radiology/Scanning incident	1												1
Safeguarding Vulnerable Child			1										1
Slips/Trips/Falls							1						1
Unexpected Death (general)									1				1
Sub-optimal care of the deteriorating patient												1	1
West Lancashire CCG													
Adverse media coverage or public concern about the organisation or the wider NHS					1	1							2
Attempted Suicide by Inpatient (in receipt)							1						1
Delayed diagnosis				1			1					1	3
Drug Incident (Chemotherapy)				1									1
Pressure ulcer - (Grade 3)							2		3			1	6
Screening Issues									1				1
Unexpected Death (general)									1				1
Communicable Disease and Infection Issue												1	1
Not Applicable													
Allegation against HC non-Professional								1					1
Grand Total	**1**	**0**	**2**	**4**	**1**	**1**	**8**	**4**	**6**	**0**	**1**	**4**	**32**

All incident investigations and action plans are discussed in details at the CCG's Monthly SUI Management Group Meetings.

11. Primary Care

11.1 Background

The primary care dashboard has been developed during the summer of 2014 with the intention of being used in localities so that colleagues from practices are able to see data compared to their peers in a timely and consistent format. From this, localities can use this data to request further analysis, raise queries with providers, determine local priorities for action, understand demand, and monitor improvement. The tool is to aid improvement, not a performance management tool.

11.2 Content

The dashboard is still evolving, but at this stage the following sections are included: Urgent care (A&E attendances and emergency admissions for children under 19, adults aged 20-74 and older people aged 75 and over separately), Demand (referrals, Choose & Book information, cancer and urgent referrals), and Prescribing indicators. Recent new additions are expected to observed disease prevalence (QOF), and forthcoming additions include financial information, and public health indicators.

11.3 Format

The data is presented for all practices, grouped to locality level and RAG rated to illustrate easily variation from the CCG average, where green is better than CCG average by 10% or more, and red is worse than CCG average. Amber is defined as better than CCG average but within 10%. Data is refreshed monthly, where possible and will have a 6 week time lag from month end for secondary care data and prescribing data, and less frequent updates for the likes of annual QOF data. The dashboards have been presented to Quality Committee and to localities, and feedback has been positive. The dashboards will be available on the new Cheshire & Merseyside Intelligence Portal (CMiP).

11.4 Summary of performance

Figure 20 Summary of Primary Care Dashboard – Urgent Care Summary

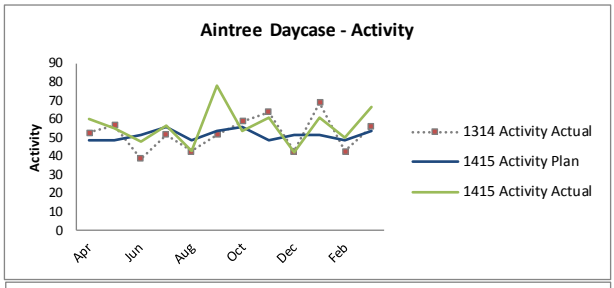
Southport & Formby CCG
Urgent Care Practice Scorecard 2014/15

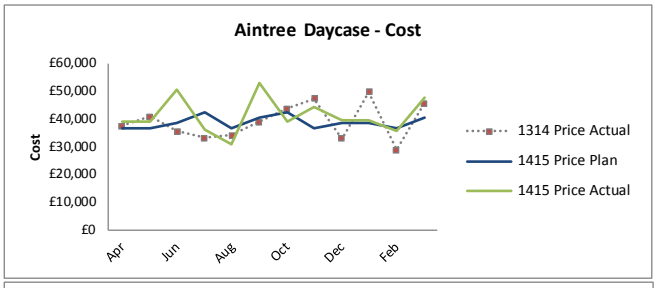
Indicator		A&E Attendance rate per 1000 for under 19's (12 Mths to Dec-14)			A&E Attendance rate per 1000 for over 19's (12 Mths to Dec-14)			Emergency Admission rate per 1000 for under 19's (12 Mths to Dec-14)			Emergency Admission rate per 1000 for over 19's (12 Mths to Dec-14)		
Code	Practice	Period	Result	Score	Period	Result	Score	Period	Result	Score	Period	Result	Score
N84012	AINSDALE MEDICAL CENTRE	Dec-14	49.98	0	Dec-14	123.35	3	Dec-14	28.69	3	Dec-14	54.83	3
N84014	AINSDALE VILLAGE SURGERY	Dec-14	39.55	3	Dec-14	130.87	2	Dec-14	33.66	3	Dec-14	57.12	3
N84024	GRANGE SURGERY	Dec-14	39.15	3	Dec-14	147.69	0	Dec-14	37.54	3	Dec-14	68.58	0
N84037	LINCOLN HOUSE SURGERY	Dec-14	59.97	0	Dec-14	159.25	0	Dec-14	41.16	2	Dec-14	68.46	0
N84625	THE FAMILY SURGERY	Dec-14	43.77	2	Dec-14	156.59	0	Dec-14	59.69	0	Dec-14	67.75	0
N84005	CUMBERLAND HOUSE SURGERY	Dec-14	36.37	3	Dec-14	151.36	0	Dec-14	45.59	0	Dec-14	65.43	0
N84013	CURZON ROAD MEDICAL PRACTICE	Dec-14	62.44	0	Dec-14	167.56	0	Dec-14	51.62	0	Dec-14	67.69	0
N84021	ST MARKS MEDICAL CENTRE	Dec-14	50.91	0	Dec-14	187.85	0	Dec-14	54.90	0	Dec-14	79.61	0
N84617	KEW SURGERY	Dec-14	43.49	2	Dec-14	153.18	0	Dec-14	41.73	0	Dec-14	56.73	3
Y02610	TRINITY PRACTICE	Dec-14	30.32	3	Dec-14	223.13	0	Dec-14	55.37	0	Dec-14	99.99	0
N84006	CHAPEL LANE SURGERY	Dec-14	58.78	0	Dec-14	110.75	3	Dec-14	34.11	3	Dec-14	53.99	3
N84018	THE VILLAGE SURGERY FORMBY	Dec-14	42.02	2	Dec-14	109.00	3	Dec-14	36.57	3	Dec-14	52.97	3
N84036	FRESHFIELD SURGERY	Dec-14	45.92	0	Dec-14	106.75	3	Dec-14	37.21	3	Dec-14	53.48	3
N84618	THE HOLLIES	Dec-14	51.35	0	Dec-14	110.90	3	Dec-14	35.08	3	Dec-14	52.38	3
N84008	NORWOOD SURGERY	Dec-14	36.04	3	Dec-14	133.87	2	Dec-14	40.30	2	Dec-14	61.58	2
N84017	CHURCHTOWN MEDICAL CENTRE	Dec-14	34.18	3	Dec-14	153.99	0	Dec-14	37.57	2	Dec-14	78.18	0
N84032	SUSSEX ROAD SURGERY	Dec-14	63.12	0	Dec-14	147.42	0	Dec-14	47.82	0	Dec-14	63.38	2
N84611	ROE LANE SURGERY	Dec-14	48.31	0	Dec-14	133.23	2	Dec-14	27.75	3	Dec-14	55.51	3
N84613	THE CORNER SURGERY (DR MULLA)	Dec-14	37.73	3	Dec-14	124.69	3	Dec-14	34.08	3	Dec-14	58.11	3
N84614	THE MARSHSIDE SURGERY (DR WAINWRIGH	Dec-14	45.55	0	Dec-14	140.85	2	Dec-14	58.70	0	Dec-14	63.85	2
	Southport & Formby Average		44.50			144.35			41.71			65.15	

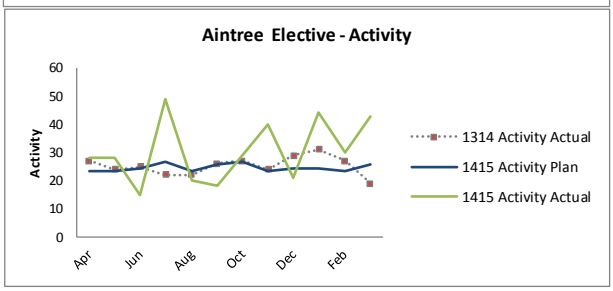
Appendix 1 Main Provider Activity & Finance Comparisons

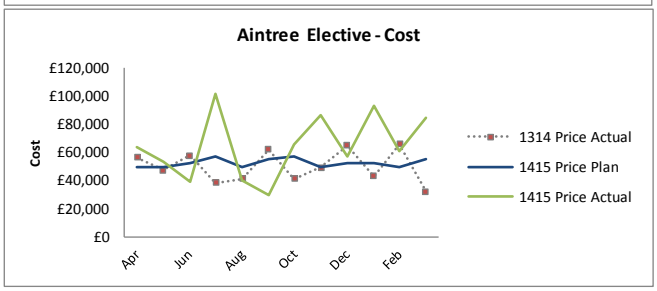
Figure 21 Month 12 Planned Care Aintree Hospital NHS Trust (13/14 and 14/15 comparison)

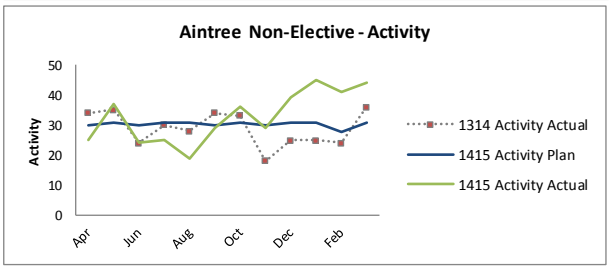
Aintree Hospital Southport & Formby CCG			2014/15											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	49	49	51	56	49	54	56	49	51	51	49	54
		1415 Activity Actual	60	55	48	57	43	78	54	61	42	61	50	67
	Price	1415 Price Plan	£36,975	£36,975	£38,823	£42,521	£36,975	£40,672	£42,521	£36,975	£38,823	£38,823	£36,975	£40,672
		1415 Price Actual	£39,067	£39,166	£50,783	£36,422	£30,858	£53,211	£39,158	£44,585	£39,493	£39,667	£35,882	£47,590
Elective	Activity	1415 Activity Plan	23	23	24	27	23	26	27	23	24	24	23	26
		1415 Activity Actual	28	28	15	49	20	18	29	40	21	44	30	43
	Price	1415 Price Plan	£50,066	£50,066	£52,569	£57,575	£50,066	£55,072	£57,575	£50,066	£52,569	£52,569	£50,066	£55,072
		1415 Price Actual	£64,095	£52,993	£39,161	£101,361	£39,806	£30,127	£66,065	£86,628	£57,566	£92,863	£61,316	£84,371
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	30	31	30	31	31	30	31	30	31	31	28	31
		1415 Activity Actual	25	37	24	25	19	29	36	29	39	45	41	44
	Price	1415 Price Plan	£55,035	£56,870	£55,035	£56,870	£56,870	£55,035	£56,870	£55,035	£56,870	£56,870	£51,366	£56,870
		1415 Price Actual	£63,084	£93,058	£45,066	£42,774	£28,554	£50,471	£61,185	£62,611	£68,657	£71,310	£53,539	£77,262
AandE	Activity	1415 Activity Plan	64	66	64	66	66	64	66	64	66	66	59	66
		1415 Activity Actual	65	69	75	71	82	77	67	77	64	74	75	64
	Price	1415 Price Plan	£6,615	£6,836	£6,615	£6,836	£6,836	£6,615	£6,836	£6,615	£6,836	£6,836	£6,174	£6,836
		1415 Price Actual	£6,912	£7,065	£7,935	£7,232	£8,729	£8,361	£6,954	£7,453	£7,103	£8,440	£7,563	£7,148

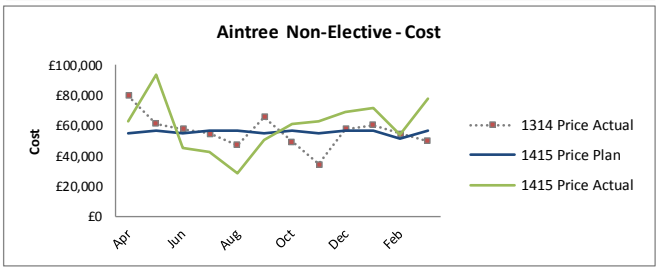


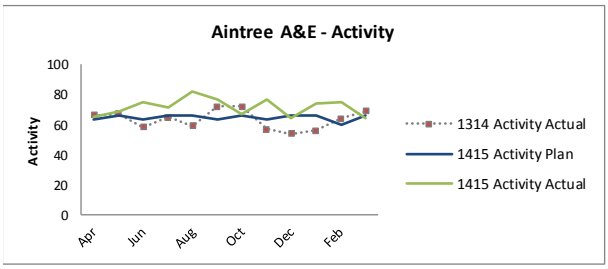












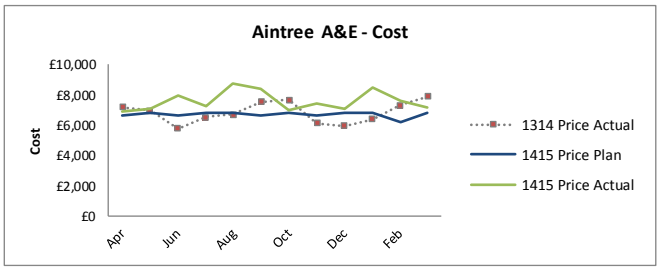
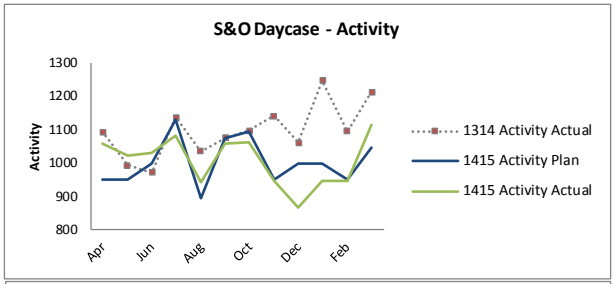
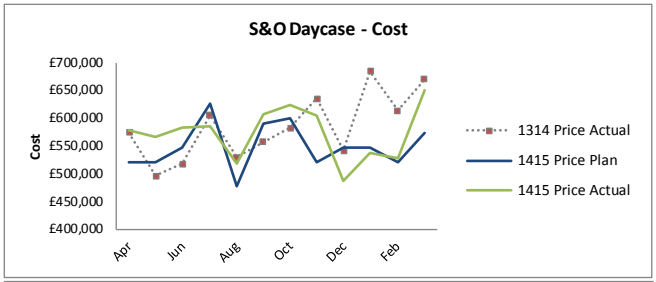
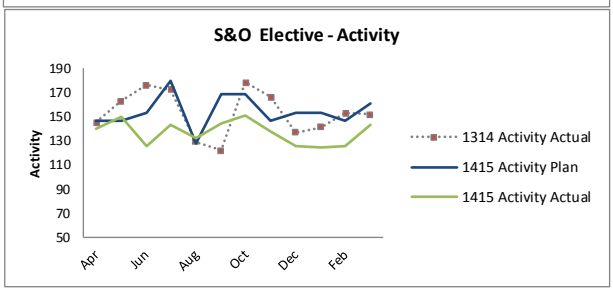


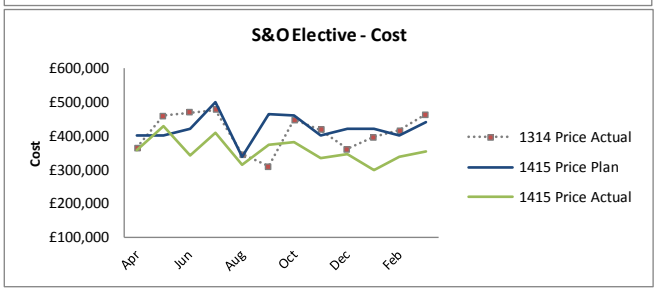
Figure 22 Month 12 Planned Care Southport and Ormskirk Hospital NHS Trust (13/14 and 14/15 comparison)

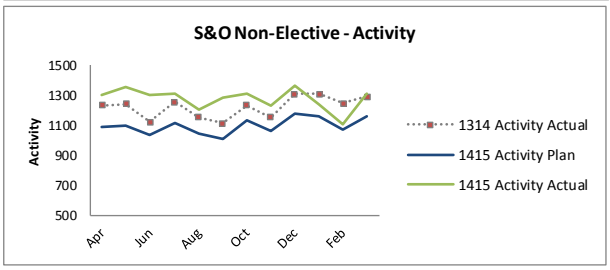
Southport & Ormskirk Hospital Southport & Formby CCG			2014/15											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	953	953	1001	1131	894	1073	1096	953	1001	1001	953	1049
		1415 Activity Actual	1060	1024	1031	1084	942	1059	1064	946	867	946	946	1114
	Price	1415 Price Plan	£522,238	£522,238	£548,350	£626,091	£479,156	£592,026	£600,574	£522,238	£548,350	£548,350	£522,238	£574,462
		1415 Price Actual	£578,305	£566,859	£584,630	£586,402	£519,706	£606,915	£624,558	£604,125	£488,573	£539,007	£529,264	£651,241
Elective	Activity	1415 Activity Plan	146	146	154	179	128	168	168	146	154	154	146	161
		1415 Activity Actual	140	150	125	143	132	144	151	138	125	124	125	143
	Price	1415 Price Plan	£400,734	£400,734	£420,771	£498,505	£337,966	£465,915	£460,844	£400,734	£420,771	£420,771	£400,734	£440,808
		1415 Price Actual	£359,883	£427,076	£343,770	£407,316	£316,007	£375,257	£381,182	£335,502	£344,322	£297,244	£338,808	£352,328
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	1092	1099	1035	1119	1047	1012	1133	1066	1175	1159	1073	1161
		1415 Activity Actual	1304	1356	1300	1314	1200	1284	1306	1231	1364	1239	1105	1313
	Price	1415 Price Plan	£1,816,601	£1,822,149	£1,721,693	£1,868,207	£1,745,465	£1,626,736	£1,855,415	£1,734,051	£1,881,886	£1,900,093	£1,716,814	£1,888,746
		1415 Price Actual	£1,951,726	£1,989,344	£1,953,566	£2,041,613	£1,865,604	£1,906,128	£2,079,169	£1,875,651	£2,080,839	£2,005,664	£1,716,033	£2,032,092
AandE	Activity	1415 Activity Plan	2815	2745	2722	2965	2686	2544	2725	2653	2863	2610	2508	3042
		1415 Activity Actual	2896	2983	2982	3163	2815	2918	3133	3001	3186	2813	2656	3214
	Price	1415 Price Plan	£293,572	£286,319	£283,934	£309,222	£280,158	£265,353	£284,232	£276,680	£298,590	£272,259	£261,577	£317,320
		1415 Price Actual	£306,334	£313,890	£314,997	£325,578	£297,546	£304,587	£316,268	£291,032	£313,634	£294,263	£275,983	£326,068

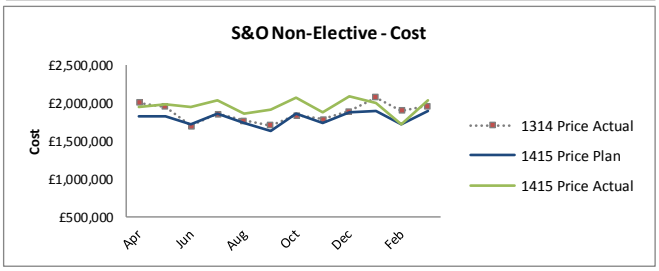


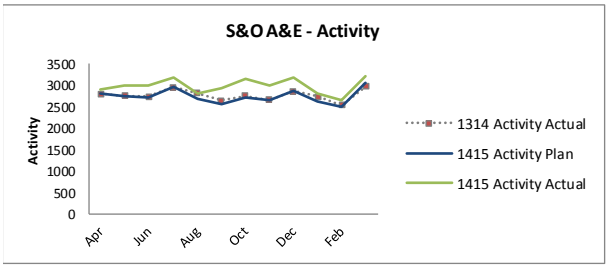












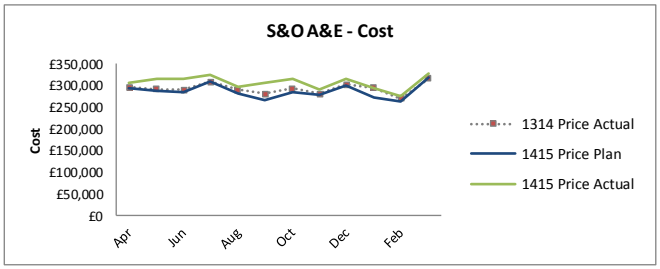
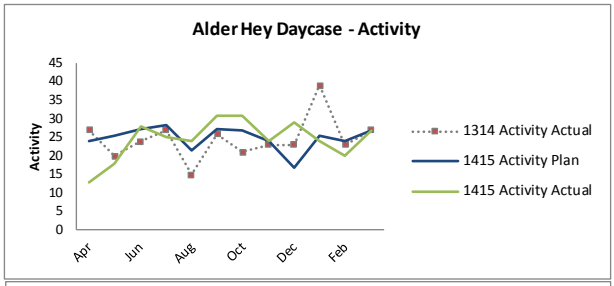
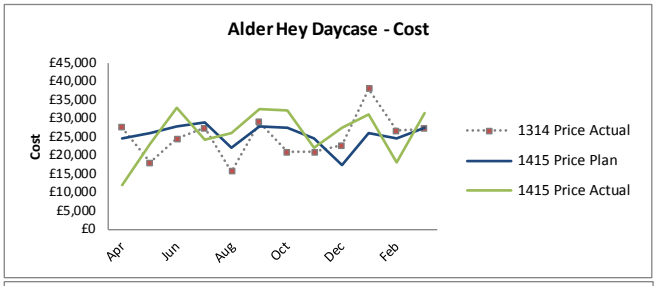
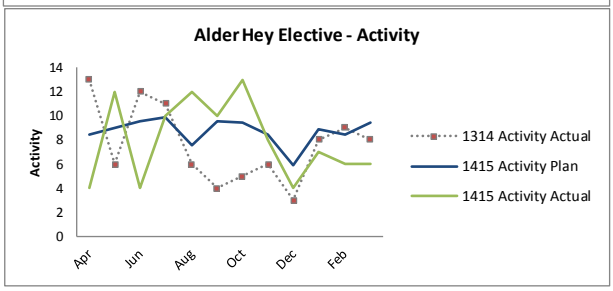


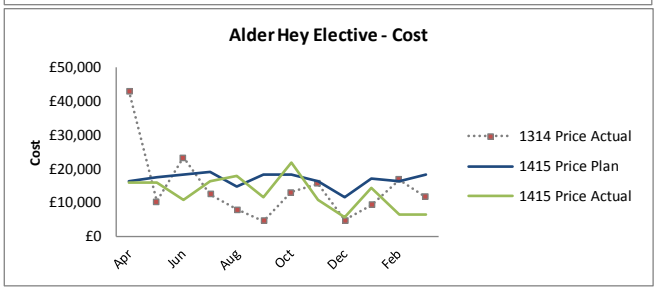
Figure 23 Month 12 Planned Care Alder Hey Childrens Hospital (13/14 and 14/15 comparison)

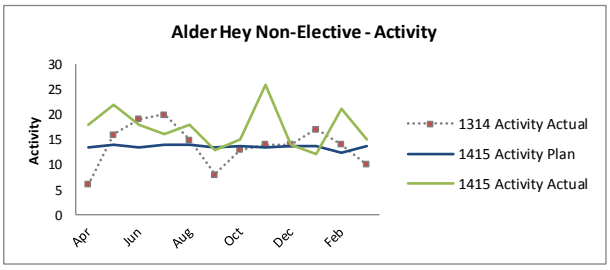
Alder Hey Childrens Hospital Southport & Formby CCG			2014/15											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	24	26	27	28	21	27	27	24	17	25	24	27
		1415 Activity Actual	13	18	28	25	24	31	31	24	29	24	20	27
	Price	1415 Price Plan	£24,760	£26,289	£27,817	£29,040	£22,009	£27,817	£27,511	£24,760	£17,424	£25,983	£24,760	£27,511
		1415 Price Actual	£12,118	£23,067	£32,886	£24,401	£26,189	£32,420	£32,348	£22,232	£27,721	£30,993	£18,319	£31,594
Elective	Activity	1415 Activity Plan	8	9	10	10	8	10	9	8	6	9	8	9
		1415 Activity Actual	4	12	4	10	12	10	13	8	4	7	6	6
	Price	1415 Price Plan	£16,434	£17,449	£18,463	£19,275	£14,608	£18,463	£18,260	£16,434	£11,565	£17,246	£16,434	£18,260
		1415 Price Actual	£15,930	£15,809	£10,834	£16,527	£17,887	£11,790	£21,914	£10,927	£5,853	£14,428	£6,420	£6,504
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	13	14	13	14	14	13	14	13	14	14	12	14
		1415 Activity Actual	18	22	18	16	18	13	15	26	14	12	21	15
	Price	1415 Price Plan	£18,156	£18,810	£18,156	£18,810	£18,810	£18,156	£18,219	£17,566	£18,219	£18,219	£16,477	£18,219
		1415 Price Actual	£23,510	£41,406	£29,179	£29,179	£46,456	£16,219	£25,295	£35,028	£31,285	£16,026	£44,478	£22,782
AandE	Activity	1415 Activity Plan	36	37	36	35	35	33	37	36	37	39	36	39
		1415 Activity Actual	42	42	39	46	32	44	42	64	45	48	43	53
	Price	1415 Price Plan	£3,035	£3,146	£3,035	£2,960	£2,960	£2,849	£3,146	£3,035	£3,146	£3,331	£3,035	£3,331
		1415 Price Actual	£3,488	£3,701	£3,323	£3,928	£2,705	£3,775	£3,595	£5,394	£3,828	£4,156	£3,641	£4,568

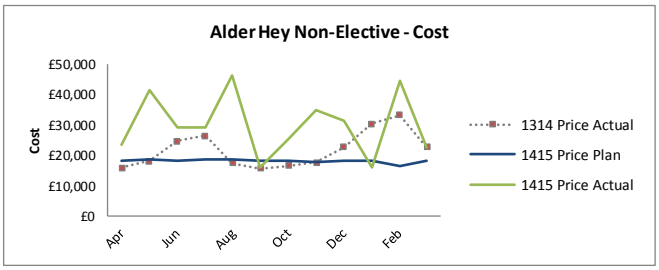


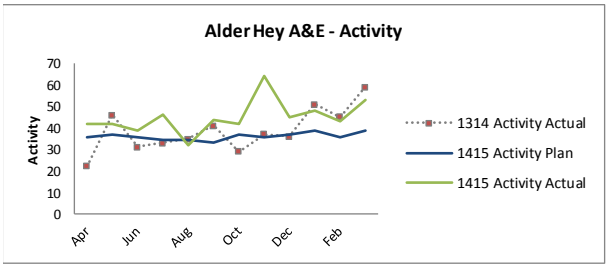


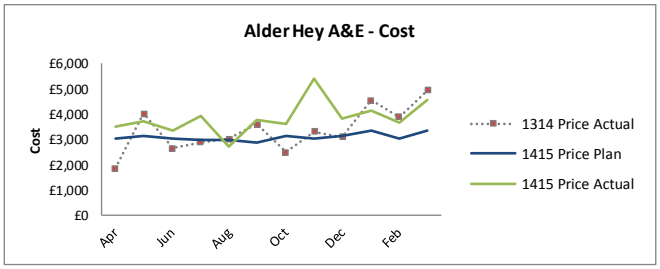












NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/99	**Author of the Paper:** Debbie Fagan Chief Nurse & Quality Officer NHS South Sefton CCG Email: debbie.fagan@southportnadformbyccg.nhs.uk Brendan Prescott Deputy Chief Nurse / Head of Quality & Safety NHS South Sefton CCG E mail: brendan.prescott@southportandformbyccg.nhs.uk Tel: 0151 247 7000
Report Date: May 2015	

Title: Overview, Quality and Performance – Southport & Ormskirk Hospitals NHS Trust (ICO)

Summary/Key Issues :

This paper presents the Governing Body with a brief overview of the areas of concern that the CCG has identified for Southport & Ormskirk Hospitals NHS Trust. These areas have been clearly identified through a range of assessment and assurance reviews and processes that the CCG has undertaken in its role as lead commissioner for this provider.

An outline of the key actions that the CCG is undertaking is set out in relation to the areas highlighted.

In addition a synopsis of the outcome of the Care Quality Commission (CQC) Chief Inspector of Hospitals Inspection Visit, undertaken in November 2014, which went into the public domain on 13 May 2015, is included.

The Governing Body are asked to note that these issues are being managed by Southport & Formby CCG with input from the joint CCG Senior Management Team.

Recommendation

The Governing Body is asked to receive this report.

Receive	X
Approve	
Ratify	

Overview, Quality and Performance at S&O

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

Process	Yes	No	N/A	Comments/Detail
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	Wider Forum Quality 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

1. Executive Summary

1.1 This paper presents the Governing Body with an overview of the quality and performance areas of concern emerging for the CCG with regard to Southport & Ormskirk Hospitals NHS Trust. The key actions that Southport and Formby CCG has undertaken against these areas are also set out.

1.2 In addition, a synopsis of the outcome of the Care Quality Commission (CQC) Chief Inspector of Hospitals Inspection Visit undertaken in November 2014 which went into the public domain on 13 May 2015.

2. Identified Areas of Concern

2.1 The following services have been identified as areas of concern for the CCG:

- Breast;
- Cardiology;
- Stroke;
- Acute Medicine;
- Gastroenterology.

2.2 Further concerns have emerged as a result of:

- Serious incident reporting (SIs);
- Staffing Reports / Staff Experience Reports;
- Patient Experience;
- Mortality Performance;
- Safeguarding Performance;
- Recent Peer Reviews – Cancer and Trauma;
- Referral to Treatment (RTT) / PAS System;
- A&E performance / ambulance turnaround times;
- Orthopaedics.

3. Overview of Key CCG Actions CQC

Breast Services

3.1 Southport and Formby CCG has undertaken a public engagement exercise in conjunction with West Lancashire CCG with regard to the provision of Breast Surgery at Southport & Ormskirk Hospital NHS Trust (S&O). In addition work has been undertaken with neighbouring providers to ensure that the existing clinical pathway is maintained and that all new referrals for Breast surgery are managed according to national standards and waiting times. Provision has also been made to ensure the adequacy of both short-term and long-term follow up of patients. The CCG is now addressing the need for the future of sustainable provision of breast services for the residents of Southport & Formby CCG.

Cardiology

3.2 The CCG has reviewed cardiology services, including activity, compliance against NICE guidance. The CCG has assessed current and future workforce solutions and explored provider support to S&O. The CCG has developed a revised model of care and is pursuing a solution to the long term provision of cardiology services.

Stroke

3.3 The CCG has assessed stroke performance against a range of national performance and clinical indicators. A working group is in place to develop Early Supportive Discharge to support the current service. The CCG is working jointly with the clinical network in conjunction with Liverpool CCG and West Lancashire CCG to review the need for Hyper acute and rehabilitation provision across Liverpool and Sefton.

Acute Medicine

3.4 The CCG has established a joint commissioner and ICO work stream on sustainability, to support the Trust. Current recruitment plans are being reviewed and assessed by the CCG for assurance purposes.

Gastroenterology

3.5 The CCG is supporting discussions between S&O and AUHT to explore a collaborative solution to the provision of services.

Further Concerns

3.6 Further concerns have emerged based on the recent Cancer and Trauma peer review recommendations and contract performance and quality information which have been triangulated with soft intelligence.

4. CQC Inspection

4.1 The Care Quality Commission (CQC) undertook a Chief Inspector of Hospitals Inspection Visit in November 2014. A Quality Summit was held on 7 May 2015 at which the outcome of the inspection was presented to the Trust, NHS England, NHS Trust Development Authority, Southport & Formby CCG, West Lancashire CCG, Sefton Local Authority and representation from Health Watch. The report went into the public domain on 13 May 2015.

4.2 The outcome of the inspection was as follows:

Overall judgement = Requires Improvement

The five domains:

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)

4.3 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 = Good

4.4 The CQC report also included areas that require improvement in relation to Maternity Services and the Spinal Injury Unity (Spinal Injury Unit is commissioned via Specialised Commissioning / NHSE). Good practice was noted around End of Life Care.

4.5 The Trust is required to develop appropriate action plans and submit them to the CQC. The CCG will be working with Southport and Ormskirk NHS Trust and West Lancashire CCG with the CQC and TDA to ensure the action plans are implemented.

5. Summary of Actions Taken by the CCG

5.1 The issues detailed in this paper have been the subject of discussion at the CCG Quality Committee and escalated to the Governing Body as appropriate for purposes of assurance. The CCG has also discussed issues of concern at the Contract Review / Quality Contract Meetings as part of the formal contract management process with the Trust.

5.2 A formal Board-to-Board meeting was held with the Trust and Southport and Formby CCG as commissioner on 29th April 2015 prior to the CQC Quality Summit. At the time of writing this report the CCG is awaiting the formal written response from the Trust in response to the issues raised.

5.3 The CCG has been working collaboratively with West Lancashire CCG regarding performance and quality issues at the Trust and is an active member of the Strategic Partnership Board that is in place with attendance from SFCCG, WLCCG, S&O, NHSE, SMBC, other partners and the Trust themselves.

5.4 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.

5.5 The CCG have discussed the challenges being faced at the Trust as part of the regular Checkpoint Assurance Meetings with NHSE along with the action being undertaken by the CCG.

6. Conclusion

6.1 Southport and Formby CCG have taken the responsibility for commissioning high standards of patient quality and safety through the required Governance arrangements.

6.2 The Board of Southport and Ormskirk NHS Trust are now very aware of the CCG concerns and the CCG is awaiting a response and will report back to the Governing Body.

7. Recommendations

The Governing Body is asked to receive this report.

Debbie Fagan
Chief Nurse & Quality Officer

Brendan Prescott
Deputy Chief Nurse/ Head of Quality & Safety

May 2015

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
May 2015

Agenda Item: 15/100	**Author of the Paper:** Martin McDowell Chief Finance Officer Email: martin.mcdowell@southportandformbyccg.nhs.uk Tel: 0151 247 7065
Report date: May 2015	

Title: Revised 2015/16 Financial Budgets

Summary/Key Issues:

This paper presents the Governing Body with the revised 2015/16 Financial Budgets for Southport & Formby CCG.

Recommendation

The Governing Body is asked to:

- Approve the revised financial budgets for the financial year 2015/16;
- Note that unidentified QIPP is valued at £6.151m.

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

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

Receive	X
Approve	X
Ratify	

Revised Budgets

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

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

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

Report to the Governing Body
May 2015

1. Summary

1.1 The opening financial budgets for 2015/16 were approved at the Governing Body Meeting in March 2015. The March meeting noted that there remained uncertainties in some areas and that an update report would be presented to the Governing Body meeting in May 2015.

1.2 This paper provides details of the CCG's 2015/16 proposed revised financial budgets for consideration and approval.

1.3 The financial budgets have been prepared in conjunction with budget holders and reflect all available planning guidance and metrics requirements. A summary of the proposed revised 2015/16 Financial Budget is presented in **Table 1**.

Table 1 - Summary 2015/16 Revised Financial Budgets

Budget Area	2015/16		
	Rec	Non Rec	Total
	£m	£m	£m
Resources			
Base Allocation	165.610		165.610
Growth	3.213		3.213
Better Care Fund allocation	2.884		2.884
Running Cost Allowance	2.606		2.606
Enhanced Tariff Option		0.554	0.554
Surplus b/f		1.750	1.750
Available Resources	**174.313**	**2.304**	**176.617**
Commissioning Budgets			
NHS Commissioned Services	113.153	3.078	116.231
Corporate & Support Services: admin	2.584	0.022	2.606
Corporate & Support Services: programme	1.829	0.037	1.866
Independent Sector	4.205	0.104	4.309
Medicines Management	23.457	0.120	23.577
Primary Care	2.302	0.263	2.565
Non NHS Commissioning	19.386	0.061	19.447
Sub total Operational budgets	**166.916**	**3.684**	**170.600**
Reserves			
QIPP requirement	(6.151)		(6.151)
Non Recurrent schemes		1.566	1.566
Transformation Fund		1.800	1.800
Better Care Fund investment	3.251		3.251
Other Committed Plans	2.871		2.871
Contingency	0.880		0.880
Sub total Reserves	**0.851**	**3.366**	**4.217**
Total Anticipated Spend	**167.767**	**7.050**	**174.817**
Forecast Surplus/ (Deficit)	**6.546**	**(4.746)**	**1.800**
Expressed as %			**1%**

2. Changes from Opening Budgets

2.1 Overview

There has been an increase in operational budgets of £0.274m as a result of contract negotiations and the review of Opening Budgets. This has been met by a corresponding reduction in Reserves. In addition, a Transformation Fund reserve of £1.800m has been established, and an additional contract risk reserve of £0.926m. The impact of these changes has increased the QIPP requirement to £6.151m. **Table 2** outlines how the unidentified QIPP has changed since the report to the Governing Body in March 2015.

Table 2 – Unidentified QIPP

	£m
Opening unidentified QIPP balance (March 2015)	3.339
Transformation Fund	1.800
Contract risks	0.926
Other minor changes	0.086
	6.151

Following these revisions, the CCG continues to deliver a planned surplus of 1% (£1.8m). The detail by cost centre is included at Appendix 1.

The major movements are described under the relevant sections below.

2.2 Resource Allocations and Surplus

The Resource allocation has increased by £0.554m since the March report, to a total Allocation for 2015/16 of **£176.617m**. This increase relates to non-recurrent funding from NHS England in respect of the costs associated with the enhanced tariff.

2.3 Operational Budgets

NHS Commissioned Services

Overall the budget for NHS Commissioned Services has increased by £1.966m since the March report. It was noted in the March report that the CCG had not reached agreements with all providers and that this area could change significantly. These increases were anticipated in 'leakage' and other contract reserves.

However, there are a number of contract negotiations that are still ongoing, and the CCG has established an additional reserve to fund anticipated increases in costs. Further detail of these cost pressures is provided in **Table 3** below. These have been included in the revised budgets.

Table 3 – Cost Pressures - NHS Commissioned Services

Budget	£
Alder Hey - Realignment of community block	£75,250
S&O - Community urology	£300,000
S&O - Non-PbR: Direct Access Pathology	£450,000
S&O - Non-PbR: Direct Access Radiology	
S&O - Non-PbR: Rehabilitation	
S&O - Non-PbR: Critical Care	
S&O - Non-PbR: Other	
Liverpool Community Health - Community Equipment	£101,250
Total	**£926,500**

There are a number of non-PbR service lines at Southport & Ormskirk where the CCG has agreed a transitional move to Cost per Case arrangements. However, the unit prices for four service lines are yet to be agreed. The £0.450m represents the CCGs estimate of costs.

Corporate & Support Services
Within the Running Costs budget, there have been a small number of amendments to transfer resource between cost centres but no change to the overall budget presented to the Governing Body in March.

The Programme Costs budget has increased by £0.03m due to an allocation of resource for CCG management posts previously recorded under the Running Costs budget for which the costs meet the definition of Programme Costs.

Non NHS Commissioning
There has been a reduction in the budgets for Continuing Health Care (Adult) and Funded Nursing Care (£0.014m) and an increase to the budget of £0.051m for Continuing Health Care (Children). The budgets have been revised to reflect the year end results, actual costs differ to those anticipated when the budget was calculated.

Medicines Management
The Prescribing Budget has been increased by £0.07m to reflect the revised forecast. The year-end costs for prescribing are higher than those anticipated when the budget was calculated.

2.4 **Reserves**
There has been a reduction in the 2015/16 Reserves budget of £1.800m since the opening budgets were presented. This reflects the increase in operational budgets outlined above.

2.5 **Transformation Fund**
Within the Reserves budget, the CCG has allocated £1.800m resource for the Transformation Fund. Utilisation of this fund will be approved by the QIPP group and Service and Improvement Redesign Committee.

2.6 **QIPP**
The unidentified QIPP target for the CCG is £6.151m. The QIPP budget is set as a negative budget in reserves, and when schemes are identified, their associated resource is transferred to reserves to achieve the requirement.

3 Key Financial Risks and Pressures

3.1 Outstanding contracts – there are a number of uncertainties associated with our contract with Southport and Ormskirk NHS Trust. The move to paying cost per case for a number of items that were previously funded via block arrangements has created a cost pressure. The prices associated with a number of areas are still under negotiation, and the estimated costs could rise, thus necessitating an increase in the cost savings to be identified. In addition to the £0.450m outlined in **Table 3**, the Trust is seeking a further £0.400m. A further increase in 2016/17 is planned as part of a transitional arrangement to pay Southport & Ormskirk in line with other Trusts for activity undertaken.

3.2 The CCG plans have been prepared using 2014/15 financial year out-turn position so any growth in demand will need to be funded using CCG contingency reserves.

3.3 The commissioning of individual packages of care within Mental Health and Continuing Health Care (CHC) was identified as a major risk area for the CCG throughout 2014/15. The 2015/16 budgets have been set on the basis of 2014/15 outturn, plus growth of 5%. There are still some unresolved issues regarding the quality of the underlying data from CSU, which means that there remains some risk around the accuracy of the budget. In addition, the pricing framework expires in-year, and providers may seek an increase to current prices.

3.4 Prescribing - It should be noted that aspects of prescribing remain volatile and this area could present risks to budgets in 2015/16. Continued support from community pharmacist teams and practices will be required to deliver a balanced position.

3.5 Continuing Healthcare (CHC) restitution payments – The CCG has included provision for CHC restitution payments of £0.426m in Reserves. The value of this reserve is based on the most recent guidance from NHS England which indicates that, in 2015/16, CCGs will be required to contribute to a national risk pool.

4. Conclusions & Recommendations

4.1 The Governing Body is asked to:

- Approve the revised financial budgets for the financial year 2015/16;
- Note that unidentified QIPP is valued at £6.151m.

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

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

5. Appendices

Appendix 1 - Analysis by Cost Centre – Revised 2015/16 Budget compared to Opening 2015/16 Budget

Appendix 1

Cost centre Number	Cost Centre Description	Budget Holder	Budget 2015/16 (March 2015)	Revised Budget 2015/16	Increase (Decrease)
			£000	£000	£000
COMMISSIONING - NON NHS					
603501	Mental Health Contracts	Jan Leonard	829	829	0
603506	Child and Adolescent Mental Health	Jan Leonard	163	163	0
603511	Dementia	Jan Leonard	93	93	0
603521	Learning Difficulties	Debbie Fagan	1,397	1,397	0
603541	Mental Health Services - Collaborative Commissioning	Debbie Fagan	0	0	0
603596	Collaborative Commissioning	Jan Leonard	409	409	0
603661	Out of Hours	Jan Leonard	1,065	1,065	0
603682	CHC Adult Fully Funded	Debbie Fagan	7,461	7,478	16
603684	CHC Adult Joint Funded	Debbie Fagan	1,335	1,403	68
603685	CHC Adult Joint Funded Personal health Budgets	Debbie Fagan	176	111	(65)
603687	CHC Children	Debbie Fagan	397	448	51
603691	Funded Nursing Care	Debbie Fagan	3,333	3,300	(33)
603711	Community Services	Jan Leonard	466	466	0
603721	Hospices	Jan Leonard	871	871	0
603726	Intermediate Care	Jan Leonard	435	435	0
603796	Reablement	Jan Leonard	979	979	0
Sub-Total			**19,409**	**19,447**	**38**
CORPORATE & SUPPORT SERVICES					
605251	Administration and Business Support (Running Cost)	Fiona Clark	127	127	0
605271	CEO/Board Office (Running Cost)	Fiona Clark	541	450	(91)
605276	Chairs and Non Execs (Running Cost)	Fiona Clark	157	251	94
605296	Commissioning (Running Cost)	Fiona Clark	1,115	1,085	(30)
605316	Corporate costs	Fiona Clark	248	274	26
605346	Estates & Facilities	Martin McDowell	42	42	0
605351	Finance (Running Cost)	Martin McDowell	265	262	(3)
605391	Medicines Management (Running Cost)	Jan Leonard	18	18	0
605426	Quality assurance	Debbie Fagan	35	35	0
605266	BUSINESS INFORMATICS	Karl McCluskey	59	63	4
	Sub-Total Running Costs		**2,606**	**2,606**	**(0)**
603646	Commissioning Schemes (Programme Cost)	Fiona Clark	746	776	30
603656	Medicines Management (Programme Cost)	Jan Leonard	531	531	0
603776	Non Recurrent Programmes (NPfIT)	Martin McDowell	258	258	0
603676	Primary Care IT	Martin McDowell	174	174	0
603810	Nurse and Quality Programme	Debbie Fagan	127	127	0
	Sub-Total Programme Costs		**1,836**	**1,866**	**30**
Sub-Total			**4,442**	**4,472**	**30**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS					
603571	Acute Commissioning	Jan Leonard	78,346	80,428	2,082
603576	Acute Childrens Services	Jan Leonard	2,204	2,194	(10)
603586	Ambulance Services	Jan Leonard	4,548	4,749	201
603616	NCAs/OATs	Jan Leonard	1,306	1,306	0
603631	Winter Pressures	Jan Leonard	0	0	0
603756	Commissioning - Non Acute	Jan Leonard	27,852	27,545	(307)
603786	Patient Transport	Jan Leonard	8	8	0
Sub-Total			**114,264**	**116,231**	**1,966**
INDEPENDENT SECTOR					
603591	Independent Sector	Jan Leonard	4,061	4,309	248
Sub-Total			**4,061**	**4,309**	**248**
PRIMARY CARE					
603651	Local Enhanced Services and GP Framework	Jan Leonard	2,302	2,302	0
603791	Programme Projects	Jan Leonard	263	263	0
Sub-Total			**2,565**	**2,565**	**0**
PRESCRIBING					
603606	High Cost Drugs	Jan Leonard	1,549	1,549	0
603666	Oxygen	Jan Leonard	158	158	0
603671	Prescribing	Jan Leonard	21,797	21,871	73
Sub-Total			**23,504**	**23,577**	**73**
Sub-Total Operating Budgets pre Reserves			**168,245**	**170,600**	**2,355**
RESERVES					
603761	Commissioning Reserve (Previously General Reserve)		6,017	4,217	(1,800)
Sub-Total			**6,017**	**4,217**	**(1,800)**
Grand Total I & E			**174,262**	**174,817**	**555**

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Wednesday, 18th February 2015	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions
• Estates Review	• Not achieving VFM	• Establish Estates Implementation Working Group

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

- CCG remains on course to deliver it's financial duties for the year, although further management action is required. Key risks to delivery include prescribing costs, CHC and acute care.
- The CCG approved the NICE recommendation in relation to commissioning the drug Nalmefene for reducing alcohol consumption in people with alcohol dependence.
- The Committee noted a number of benchmarking reports, and asked for further clinical engagement to develop a narrative to help identify improved options for value for money/better outcomes.

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Wednesday, 18th March 2015	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions
• Contract issues unresolved with Southport and Ormskirk Trust, carrying risks for 2015/16 plan.	• Potential increased costs depending upon outcome of negotiations.	• On-going negotiations.

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

- CCG remains on course to deliver its financial target.
- QIPP group to be established in April.
- Prescribing report requires adjustments to budgets to reflect changes in population, CATM not included in original budget.
- CVS investment approved.
- 2015/16 Prescribing Quality Scheme approved

Key Issues
Quality Committee

NHS
Southport and Formby
Clinical Commissioning Group

Meeting Date	**February 2015**
Chair	**Helen Nichols**

Key Issues	Risks Identified	Mitigating Actions
• Safeguarding - S&O Safeguarding Performance	• Limited assurance given by the CCG Safeguarding Service	• Contract query signalled at February 2015 meeting
• Complaints – timelines for completion and closure	• Quality of existing process	• Plans in place to performance manage CSU with regard to this function to improve quality of the service • CCG have signalled the intention to bring this service 'in-house' in 2015/16

Notifications for the Governing Body
1. **CCG Safeguarding Strategy 2015-17** – revised version presented to the Quality Committee (further amendments made by the Safeguarding Service to reflect the Care Act). The Quality Committee are recommending approval to the Governing Body.
2. **CQC Intelligent Monitoring** – Bandings of General Practices within the CCG area as of February 2015 received by the Committee.

Key Issues
Service Improvement and Redesign Committee

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Meeting Date	**Wednesday 4th March 2015**
Chair	**Dr Paul Thomas**

Key Issues	Risks Identified	Mitigating Actions
Community navigator model	Lack of alignment and consistency with existing models in place	Tracy to work with Anna Nygaard from Public Health to ensure consistency and alignment going forward
Primary Care Dashboard	Potential lack of clinical application and use at a practice level	Revised primary care dashboard with practice comparators to be available from April 2015 for use through localities

Recommendations to the Governing Body
1. **The Governing Body is asked to receive the contents of this Key Issues log by way of assurance**

Finance and Resource Committee Minutes

Wednesday 18th February 2015, 9.30am to 11.30am

Family Life Centre, Ash Street, Southport

Membership		
Helen Nichols	Lay Member (Chair)	HN
Dr Martin Evans	GP Governing Body Member	ME
Dr Hilal Mulla	GP Governing Body Member	HM
Roger Pontefract	Lay Member	RP
Colette Riley	Practice Manager	CR
Martin McDowell	Chief Finance Officer	MMcD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Ex-officio Member		
Fiona Clark	Chief Officer	FLC
In Attendance		
Malcolm Cunningham	Head of Primary Care & Contracting	MC
David Smith	Deputy Chief Finance Officer	DS
James Bradley	Head of Strategic Finance Planning	JB
Suzie Forde	Senior Healthcare Planner, GB Partnerships	SF
Mike Webb	General Manager, LSHP	MW
Kay Walsh	Senior Practice Pharmacist	KW
Apologies		
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Susanne Lynch	CCG Lead for Medicines Management	SL
Billie Dodd	Head of CCG Development	BD
Becky Williams	Chief Analyst	BW
Minutes		
Ruth Moynihan	PA to Chief Finance Officer	RM

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

Name	Membership	Nov 14	Jan 15	Feb 15	Mar 15	May 15	June 15	July 15	Sept 15	Oct 15	Nov 15	Jan 16
Helen Nichols	Lay Member (Chair)	✓	✓	✓								
Dr Martin Evans	GP Governing Body Member	✓	✓	✓								
Dr Hilal Mulla	GP Governing Body Member	A	A	✓								
Roger Pontefract	Lay Member	✓	A	✓								
Colette Riley	Practice Manager	✓	✓	✓								
Martin McDowell	Chief Finance Officer	✓	✓	✓								
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	✓								
Jan Leonard	Chief Redesign & Commissioning Officer	✓	✓	A								
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A	A	A								
Fiona Clark	Chief Officer	A	A	A								
David Smith	Deputy Chief Finance Officer	✓	✓	✓								
James Bradley	Head of Strategic Finance Planning	✓	✓	✓								
Susanne Lynch	CCG Lead for Medicines Management	✓	✓	A								
Karl McCluskey	Chief Strategy & Outcomes Officer	A	A	A								
Malcolm Cunningham	Head of Primary Care & Contracting	A	✓	✓								

No	Item	Action
FR15/20	**Apologies for absence** Apologies for absence were received from Fiona Clark, Jan Leonard, Billie Dodd, Tracy Jeffes, Karl McCluskey, Susanne Lynch and Becky Williams.	
FR15/21	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflicts of interest. It was noted that there was a potential conflict of interest by Members employed in, or having interests in, general practice with regard to item FR15/24.	
FR15/22	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record, with the exception of additional text to be inserted into item FR15/02 Declarations of interest as follows: *It was noted that Members employed in, or having interests in, general practice had a small financial interest in item FR15/15, and were excluded from decision made.*	
FR15/23	**Action points from the previous meeting** **FR14/129 - *Reducing A&E attendances*** MMcD is to liaise with BW regarding the collation of data in order to move forward on this outstanding item. **FR15/06 - Continuing Healthcare (CHC)** JB produced the requested 2 year graph; it was noted that this was at package level and needed to be looked at from a relativity point of view. HN was concerned at the growth shown in the graph and HM felt it reflected underfunding. **FR15/12 - *Quality Premium Dashboard*** HN said this is now an urgent matter. CR said there are coding issues and is to contact BW today; DS is also to liaise with BW following today's meeting. MMcD confirmed he will ask BW to put advice notes out by the end of this week. **FR15/16 - Work Plan 2015/16** The work plan has been updated following feedback from January's meeting.	MMcD MMcD

No	Item	Action
FR15/24	**Estates Utilisation** A series of utilisation and occupancy studies were undertaken by Suzie Forde, Senior Healthcare Planner, GB Partnerships. The reports detailed reviews of clinical services and administration accommodation provided in the following buildings: • Southport Health and Wellbeing Centre • Ainsdale Health Centre • Curzon Road MMcD stated the purpose of the estates utilisation programme was to identify void spaces, increase better utilisation of spaces and potentially, but not necessarily, bring savings to the CCG. MMcD outlined that this could start the discussion to transform the estate across the CCG. He identified that we should be thinking about how we want the estate to look like in 10 to 15 years' time. SF summarised the reviews and her key observations, stating that the reports will enable the CCG to make informed decisions based upon the findings therein. The results highlighted the possibility of reconfiguring the use of the buildings and, in order to do this, an estates implementation working group needed to be formed to take this to the next stage. RP recommended issues be dealt with as a matter of urgency. In terms of the use of space, RP said that following recent debates eg the King's Fund, there was a list of organisations who the CCG could work with eg local authorities. As such, the idea of co-locating could be looked at to better utilise space in the buildings including renting out space, thus creating income and aid the integration of groups for the CCG to work with HN asked how this is to be taken forward. MMcD said it was necessary to establish both a working group across Sefton, with participation from SSCCG and other local partners, notably the local authority. He outlined that the group should meet on a quarterly basis, with the first meeting to take place in April. Once established, the group will report back into the Committee to keep appraised of potential developments. DF raised an administration issue in relation to the lack of corporate signage at current HQ. MMcD will ask administration team to discuss. Action taken by the Committee The Committee received the report by way of assurance.	MMcD MMcD

No	Item	Action
FR15/25	**Month 10 Finance Report** This paper presented the Finance and Resource Committee with an overview of the financial position for NHS Southport and Formby Clinical Commissioning Group as at month 10, and outlined the key financial risks facing the CCG. JB said the forecast had improved by £100k following the reimbursement of monies from Informatics Merseyside and that, despite the risks identified in the report, month 10 had been a steady and positive month. HN noted a typing error in the QIPP figure in the report which should have read £6.097m and not £0.097m, delivered year to date.	
	Action taken by the Committee	
	The Committee received the report and noted that the CCG remains on target to deliver its financial duties for 2014/15, noting that risks remained in the system, and management action is required to deliver financial balance. The Committee approved the recommendations within the report.	
FR15/26	**Prescribing Performance Update** This paper presented the Committee with an update on prescribing spend for November 2014 (month 8). MMcD said although the update "painted a picture" of overspending, an issue with Category M drugs remained, and this would be looked at with Medicines Management. MMcD also said the risk pool needed to be factored into the dashboard and KW emphasised that the figures were volatile.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/27	**APC Recommendations** The Pan Mersey Area Prescribing Committee has recommended the commissioning of the following medicine at the January 2015 meeting: • Nalmefene for reducing alcohol consumption in people with alcohol dependence KW briefed the Committee on the drug and, as this had been recommended by NICE, the CCG were required to support this. This is a statutory requirement which is to be in place in three months' time. MMcD recognised the cost per population but based on the discussion, expected costs to be lower than predicted in the first instance.	
	Action taken by the Committee	
	The Committee approved the recommendation.	

No	Item	Action
FR15/28	**Capital Plans and Updates** MMcD referred the group to previous discussion on estates and suggested that this item be replaced by Estates Working Group in the work plan. MMcD stated that the estates utilisation programme is to be deferred until the plan for this is put into place.	RM
	Action taken by the Committee	
	The Committee noted the update.	
FR15/29	**External Updates/Benchmarking and VFM reports** This report set out the financial position of the CCG in the key areas of spend against similar CCGs nationally, and also against Cheshire and Merseyside. MMcD said he would like to develop a narrative, with help from GPs, to share with the wider group. MC said it would be useful to look at comparative providers to peers. MMcD said he would like to look at all options over the forthcoming year. HN felt there is real potential to save money resulting in a financial and quality outcome. MMcD said he is having discussions with the Trust on this wants clinical intelligence to support this. HM said it would be beneficial to produce data with reasoning as to why patients are being referred. HN confirmed this piece of work needed to include GP intelligence. MMcD confirmed this was a joint project between Finance and the Business Intelligence Team. DS advised the CCG is now a member of a benchmarking club and will bring an update to each meeting. MMcD said the CCG needed to look at programme budgeting in more detail to identify if spending more or less than peers, and whether the outcomes delivered are providing value for money.	
	Action taken by the Committee	
	The Committee received the report by way of assurance.	
FR15/30	**QIPP Update** MMcD and KMcC are to give a joint presentation to the Governing Body on Wednesday, 25th February.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/31	**Better Care Fund Update and Draft Section 75 Agreement** DS advised that the Section 75 Agreement is due soon, and the template was being tweaked to meet the needs of the CCG. The Agreement will be presented to the Finance and Resource Committee in March 2015 for sign-off.	

No	Item	Action
	Action taken by the Committee	
	The Committee noted the update.	
FR15/32	**Review of Annual Work Plan** The work plan has been updated following feedback from the meeting in January.	
	Action taken by the Committee	
	The Committee noted the updated work plan.	
FR15/33	**Any Other Business** **Primary Care Rebate Schemes** MMcD presented a paper detailing this scheme and the Committee agreed to support this scheme.	
	Action taken by the Committee	
	The Committee approved the recommendation.	
	Mental Health Update HM presented a report on mental health and dementia. HM said the key vision is to provide a good quality service available from a very young age through to adulthood, covering all main conditions including dementia; a service that was ageless, easily accessible and with good quality outcomes. HM said there is a lot of pressure from NHS England to diagnose patients early so that the relevant care can be given. This includes medication which could reduce the rate of deterioration, in turn reducing hospitalisation and/or delaying admission to care homes, thereby incurring potential cost savings. HN said that PbR for mental health is planned to be implemented and this is potentially a risk to the CCG. HM has asked Mersey Care to map out what is in each cluster as these are open to interpretation. MMcD said it would be helpful for the CCG to use its contacts to map across clusters and identify outliers, to understand the percentage of patients within each cluster. The need for a dedicated Programme Support Manager was highlighted to manage this from April, and MMcD confirmed the Governing Body had approved this post subject to receipt of final pricing from CSU. This is to assess whether the CCG remains within its budgeted spend.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/34	**Date of Next Meeting** Wednesday 18th March 2015, 9.30am to 11.30am Family Life Centre, Ash Street, Southport	

Finance and Resource Committee Minutes

Wednesday 18th March 2015, 9.30am to 11.30am
Family Life Centre, Ash Street, Southport

Membership		
Helen Nichols	Lay Member (Chair)	HN
Dr Martin Evans	GP Governing Body Member	ME
Martin McDowell	Chief Finance Officer	MMcD
Ex-officio Member		
Fiona Clark	Chief Officer	FLC
In attendance		
Malcolm Cunningham	Head of Primary Care & Contracting	MC
David Smith	Deputy Chief Finance Officer	DS
Susanne Lynch	CCG Lead for Medicines Management	SL
Apologies		
Roger Pontefract	Lay Member	RP
Dr Hilal Mulla	GP Governing Body Member	HM
Debbie Fagan	Chief Nurse & Quality Officer	DF
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Karl McCluskey	Chief Strategy & Outcomes Office	KMcC
Colette Riley	Practice Manager	CR
Billie Dodd	Head of CCG Development	BD
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Helen Nichols	Lay Member (Chair)	✓	✓	✓	✓							
Dr Martin Evans	GP Governing Body Member	✓	✓	✓	✓							
Dr Hilal Mulla	GP Governing Body Member	A	A	✓	A							
Roger Pontefract	Lay Member	✓	A	✓	A							
Colette Riley	Practice Manager	✓	✓	✓	A							
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓							
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	✓	A							
Jan Leonard	Chief Redesign & Commissioning Officer	✓	✓	A	A							
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A	A	A	A							
Fiona Clark	Chief Officer	A	A	A	A							
David Smith	Deputy Chief Finance Officer	✓	✓	✓	✓							
James Bradley	Head of Strategic Finance Planning	✓	✓	✓	A							
Susanne Lynch	CCG Lead for Medicines Management	✓	✓	A	✓							
Karl McCluskey	Chief Strategy & Outcomes Officer	A	A	A	A							
Malcolm Cunningham	Head of Primary Care & Contracting	A	✓	✓	✓							

No	Item	Action
FR15/35	**Apologies for absence** Apologies for absence were received from Fiona Clark, Hilal Mulla, Roger Pontefract, Debbie Fagan, Jan Leonard, Tracy Jeffes, Karl McCluskey, Colette Riley, Billie Dodd and James Bradley.	
FR15/36	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflicts of interest. Also declared was a potential conflict of interest by Members employed in, or having interests in, general practice with regard to agenda item FR15/48 AOB (2) *"Proposed Prescribing Quality Scheme for the year 2015/16".*	
FR15/37	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record and signed-off by the Chair.	
FR15/38	**Action points from the previous meeting** **FR15/23 (*FR14/129) - Reducing A&E attendances*** DS presented an urgent care practice dashboard showing A&E attendance on a rolling basis over a 12 month period. The importance of capturing the correct data as well as adjustments required to take account of demography was highlighted. It was agreed the dashboard would be a useful tool in aiding future debate. This action is now closed. **FR15/23 *(FR15/12) - Quality Premium Dashboard*** DS confirmed he had liaised with BW and stated that due to incorrect data there had been a discrepancy in the diabetes data. This has now been changed and this action is now closed. **FR15/24 – *Corporate Signage at Curzon Road*** DF has taken ownership of this action. **FR15/28 – Work Plan 2015/16** – this has been updated accordingly.	
FR15/39	**Month 11 Finance Report** This paper presented the Finance and Resource Committee with an overview of the financial position for NHS Southport and Formby Clinical Commissioning Group as at Month 11, and outlined the key financial risks facing the CCG. DS stated that the Month 11 position had improved and the CCG were able to reduce the forecast. It was noted that Aintree Hospital had agreed a final settlement figure, and that the CCG were also in negotiations with Southport and were close to agreeing a settlement figure.	

No	Item	Action
FR15/39	**Month 11 Finance Report *(continued)***	
	MMcD said there was an unallocated reserve of c£200k and assured the Committee that the CCG remained on target to deliver its financial position for 2014/15. The blocking of outpatients was raised and it was agreed that an outpatient strategy needed to be put in place, particularly as there appeared to be a potentially significant flow of outpatients from Southport to providers. MMcD said the risk of non-elective costs increasing as a result of reduced elective activity needed to be considered.	
	Action taken by the Committee	
	The Committee received the report and noted that the CCG remains on target to deliver its financial duties for 2014/15, noting that risks remained in the system which were being managed.	
FR15/40	**Financial Strategy Update**	
	MMcD updated the Committee on the financial strategy and said that following on from the Governing Body discussion, a QIPP target of £5.6m had been identified. The CCG's submission to NHSE showed £3.3m unidentified QIPP. MMcD noted the risks relating to adjustments for non-PbR items, particularly Critical Care, and informed the Committee that sign-off for agreed contracts was expected on 31st March. MMcD said that the Committee and Governing Body needed to consider if a transformation fund or "spend to save" fund should be created, to enable change to take place to secure sustainable financial viability for the local health economy. HN asked if the risks and opportunities could be identified and evaluated for the Governing Body session, including the risks around CHC, and MMcD confirmed this would be done. MMcD noted that the CCG needed to understand who the decision makers in respect of FNC/CHC are, and that they should be aware of the consequences of their actions from a financial perspective.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/41	**Prescribing Performance Update** **Quarter 3 Report** This paper presented the Committee with a report on prescribing performance for the third quarter of 2014/15 for Southport and Formby CCG practices, and compared activity against Q3 2013/14.	

No	Item	Action
FR15/41	**Prescribing Performance Update *(continued)***	
	SL stated that there was a lot of activity and that Southport had increased by c500 patients. ME stated that more nursing homes were being opened. MMcD said that as the CCG is below the English population increase of 0.9%. He noted that the CCG had additional pressures as the CCG's increase was in older population who tend to consume more healthcare resources.	
	Month 9 Report This paper presented the Committee with an update on prescribing spend for December 2014 (month 9). The Southport and Formby CCG position for month 9 is a forecast overspend of £468k on a budget of £20.1m.	
	SL said Category M costs continue to have an impact, as well as increased patient access and team members leaving (ie pharmacists). SL said recruitment is positive and that as a team there is real potential for improvement.	
	MMcD advised that the CCG needed to start looking at age stratified analysis of expenditure.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/42	**External Updates/Benchmarking and VFM reports** This report showed a continuation to build upon the benchmarking information which has previously been presented to the Committee, with a particular focus on urgent care.	
	HN noted the potential opportunities around savings for outpatient attendances. MMcD noted that this was being discussed in terms of contract agreement.	
	MMcD noted the need for GPs to work with programme managers to understand opportunities, and to make sure that this was discussed at locality levels.	
	The opportunity regarding costs associated with NEL spend on cellulitis was noted, and JL/BD will be asked to explore whether a community team would make a difference.	JL/BD
	Action taken by the Committee	
	The Committee received the reports by way of assurance.	
FR15/43	**CCG Assurance** MMcD said he would be attending a Q3 Assurance meeting with NHSE next month, and that obvious issues around performance will be discussed.	
	Action taken by the Committee	
	The Committee noted the update.	

No	Item	Action
FR15/44	**QIPP Update** MMcD said there is a need to establish a separate QIPP sub-group in April and he will send out the relevant Terms of Reference in due course.	MMcD
	Action taken by the Committee	
	The Committee noted the update.	
FR15/45	**Better Care Fund Update** DS said the CCG and Council finance departments are working on Section 75 and hoped to take a draft version to the Health and Wellbeing Board this afternoon; all is in place and only sign-off is required. DS clarified that following talks with NHSE, not having sign-off by 31st March did not present an issue as long as a clear action plan for sign-off was agreed. MMcD said the big issue is Council demography change for social care will have a rise of £3m, and he wanted to see last 3 years' trends before any agreement was entered into with the Council. MMcD is to pick this up with Dwayne Johnson at the Council.	MMcD
	Action taken by the Committee	
	The Committee noted the update.	
FR15/46	**CVS Expenditure** This paper presented the Finance and Resource Committee with details of the proposed investment in continued support for Sefton Council for Voluntary Services (CVS) for 2014/15. It provided information regarding the investment criteria, process and performance management of the investments, as well as a summary of investments provided to date.	
	Action taken by the Committee	
	The Committee noted the update and approved delegation to FLC and MMcD, to agree funding with CVS.	
FR15/47	**Review of Annual Work Plan** The work plan has been updated following feedback from the meeting in February.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/48	**Any Other Business** ***(1) Committee Self Assessment Checklist*** As part of the completion of the Annual Governance Statement of the CCG and the Annual Report, it is necessary that the Governing Body Sub Committees review their effectiveness. As such the Committee was made aware of this checklist and noted that HN and MMcD are to complete this and bring a draft response for discussion to the next Committee meeting in May.	HN/ MMcD

No	Item	Action
FR15/48	**Any Other Business *(continued)***	
	(2) Proposed Prescribing Quality Scheme for the year 2015/16" SL presented a paper on the above Scheme on which the Medicines Management Team (MMT) is briefed and ready to proceed. The aim of the Scheme is to provide an incentive to GP practices to deliver medicines optimisation. SL said that this would be taken out of a budget target and replaced with practices showing engagement with the MMT. HN asked if this was measurable and stated that the terms of the Scheme needed to be clearly explained. SL advised that she had produced a new document for the MMT to use consistently at quarterly meetings, where levels of compliance will be recorded. SL said the Scheme is quality based, with subtle changes aimed at involving the practices more without taking up significant clinician time. HN requested it be noted that ME had an interest in this Scheme as a GP. MMcD proposed that the Committee receive the Scheme on the understanding that it has been fully assessed, and delegate it for approval by MMcD and HN.	
	Action taken by the Committee	
	The Committee received the Scheme and delegated authority for approval to MMcD and HN. The Committee noted that GP Members of the Committee had a potential interest in this Scheme.	
FR15/49	**Date of Next Meeting** Wednesday 20th May 2015, 9.30am to 11.30am Family Life Centre, Ash Street, Southport	

Chair: _____

Date: _____

NHS
Southport and Formby
Clinical Commissioning Group

Quality Committee Minutes

Date: **Wednesday 18th February 2015, 11.30am to 13.30pm**
Venue: **Family Life Centre, Southport.**

Membership		
Dr Rob Caudwell	Clinical Governing Body Member (Chair)	RC
Paul Ashby	Practice Manager Governing Body Member	PA
Dr Doug Callow	Clinical Director Lead for Quality	DC
Malcolm Cunningham	Head of Contracting & Procurement	MC
Billie Dodd	Head of CCG Development	BD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
Helen Nichols (Chair)	Lay Governing Body Member	HN
Ex officio members		
Fiona Clark	Chief Officer	FLC
Also in attendance		
Brendan Prescott	Deputy Chief Nurse / Head of Quality & Safety	BP
Minutes		
Jacqueline Jones	PA to Chief Nurse & Quality Team	JJ

Membership Attendance Tracker

Name	Membership	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 18	Jan 21	Feb 18	Mar 15
Dr Rob Caudwell	GP Governing Body Member (Chair as of Jun 2014)	A	√	√	L	√	A	A	√	√	√	A	
Paul Ashby	Practice Manager, Ainsdale Medical Centre				L	√	A	A	√	A	√	√	
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	√	√	√	√	A	√	L	√	A	√	A	
Malcolm Cunningham	CCG Head of Primary Care & Contracting	√	A	√	L	A	A	A	A	A	A	A	
Billie Dodd	Head of CCG Development	√	A	A	A	A	√	√	√	√	A	A	
Debbie Fagan	Chief Nurse & Quality Officer	√	√	√	√	√	√	√	√	√	√	√	
Martin McDowell	Chief Finance Officer	√	√	√	L	L	A	L	√	√	√	√	
Helen Nichols	Governing Body and Lay Member	√	√	√	√	A	√	L	√	√	√	√	
Dr Kati Scholtz	GP Locality Lead – North	√	√	√	L	L	A						

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/018	**Apologies for Absence** Apologies were noted and documented from :- RC, DC, FC, MC, BD, AD and JH.	
15/019	**Declarations of Interest regarding Agenda Items** None declared for the agenda items with the exception of those attendees who hold posts as part of the CCG joint management team.	
15/020	**Minutes of the previous meeting / Key Issues Log** Minutes and Key Issues log approved as true reflection of the previous meeting.	

No	Item	Action
15/021	**Matters Arising / Action Tracker** **14/136(ii) NWAS 111 Call Report for July 2014 Activity.** DF stated that AD had e-mailed with the necessary assurance regarding safeguarding. This action can be closed. **Outcome: Action closed – remove from the tracker.** **14/156 Primary Care Dashboard** – DF reported that this was now to be presented to the CCG SIR Group not the Quality Committee. This action can be closed. **Outcome: Action closed – remove from the tracker.** **14/183 Safeguarding Peer Review Action Plan** – DF stated that RC would be able to feedback at the next meeting re: PLT **Outcome: Action on-going – deferred until March 2015 meeting.** **14/186(i) Quality Committee Workplan (Revised)** – Agenda item at this meeting. Refer to 15/026. **Outcome: Action closed – remove from the tracker.** **14/186(ii) Joint Internal Quality Committee Proposal** – BP reported that JH has set a date for a Quality Team / Joint CCG Quality Committee away day on 18th June 2015. The notion of holding a joint CCG internal Quality Committee Meeting has been explored for this day and the process for this going forward can be discussed further at this event. HN asked if the clinicians were able to attend this date and DF confirmed that RC had confirmed his ability to attend and JH was awaiting confirmation from DC. This action can be closed. **Outcome: Action closed – remove from the tracker.** **14/187(i) CCG PALS & Complaints Queries** – Agenda item at this meeting. Refer to 15/025. BP reported that JH has confirmed that NHSE attend EPEG and the issue re: dental queries had been taken away as an action for the purposes of mutual assurance. BP reported that the CCG Head of Communications has updated the CCG intranet site with guidance as to the process when individuals have dental queries. This action can be closed **Outcome: Action closed – remove from the tracker.** **15/005(i) Presentation: Nursing Home Catheter Care Project -** DF reported that JH is exploring feasibility of commissioning a Nursing Home Cather Care Service. Support is being given regarding the development of a business case from the CCG Programme Management Office. This action can be closed. **Outcome: Action closed – remove from the tracker.** **15/005(ii) Presentation: Nursing Home Catheter Care Project –** DF reported that JS has included a KPI for negotiation into the contract with relevant providers regarding Catheter Passports. This action can be closed. **Outcome: Action closed – remove from the tracker.** **15/006 Safeguarding Report (S&O Limited Assurance)** DF reported that the Trust had been informed at the last Contract Meeting that the CCG would be issuing a contract query. This process is being managed by the CCG Contracts Team in conjunction with the CCG Safeguarding Service. **Outcome: Action closed – remove from the tracker.** **15/012 GP Audit** – DF reported that JS is reviewing the information collected by DC to look at what could be included in the Quality Schedule. JS will be liaising with DC as part of CCG contract negotiation process. This action can be closed. **Outcome: Action closed – remove from the tracker.**	

15/021	**15/014 Rotavirus Study** - BP has made contact with the LMC in order to have the necessary conversation as requested at last month's meeting. BP has also had a conversation with colleagues from I-Merseyside who may be able to find a way of supporting a remote data collection method. A further update is to be provided at next month's meeting. **Outcome: Action remains on-going – further update to be given at the next meeting.** **15/015 (i/ii) Corporate Risk Register** –(i) DF reported that she has discussed the issue of static risks with TJ and this was discussed at SMT and the necessary action undertaken as part of the review of the Corporate Risk Register; (ii) DF also reported that she had liaised with BD regarding Principle Risk 4.1 and this had been addressed. Both of these actions can be closed. **Outcome: Actions closed – remove from the tracker.** **15/016 (iii) Corporate Objectives** DF reported that the need for consistency with regard to the wording of Corporate Objective 2 in the Governing Body Assurance Framework and the Committee report front covers had been addressed by TJ. This action can be closed. **Outcome: Action closed – remove from the tracker.**	

15/022	**Chief Nurse Report** DF presented the Chief Nurse report to the Committee. The Committee were asked to take particular note of the update given from the CCG/CSU CHC Steering Group that meets on a weekly basis. The Committee were also asked to note that the Chief Nurse had undertaken a shadow shift with the Health Visiting Service in Maghull which is provided by Liverpool Community Health NHS Trust (LCH) and plans were in place to undertake further shadow shifts across other areas in Sefton throughout the year. The CCG Chief Nurse and Deputy Chief Nurse will also be having discussions with both LCH and Southport & Ormskirk Hospitals NHS Trust (S&O) in order to shadow the District Nursing Services. **Action: The Quality Committee received the report.**	
15/023	**CCG Safeguarding Strategy (2015 – 2017)** DF presented the Safeguarding Strategy in the absence of the CCG Safeguarding Service. DF stated that this was a revised strategy that was being re-presented to the Committee as the CCG Safeguarding Service had updated the original version that had been presented to reflect further guidance regarding the Care Act. DF stated that the previous strategy had not been presented to the Governing Body due to this revision. The Committee acknowledged that the Strategy had been developed to go across the Merseyside CCGs but requested that future reiterations be more CCG specific. DF confirmed that this was a discussion that had been had with the CCG Safeguarding Service and had been given reassurance that the action plan to implement the strategy would be more CCG specific and that further re-iterations would also be more localised. HN asked where the local action / implementation plan would be monitored and DF reported that the Safeguarding Service would present this periodically to the Quality Committee. **Action: The Quality Committee received the Safeguarding Strategy and will recommend approval by the Governing Body.**	
15/024	**CQC Intelligent Monitoring for General Practices – NHS Southport & Formby CCG** DF presented the report to the Committee and discussed the key points including the table that indicated the Bandings of the practices within the SFCCG area. HN asked how the bandings were arrived at and PA gave some narrative behind this from his experience as a Practice Manager. HN queried why one of the practices had insufficient data alongside it and it was explained that this may be due to a number of reasons which could include merger of practices. DF explained that the Quality Team were hoping to meet with the CQC to discuss Intelligent Monitoring further. HN asked now that this had been received what the CCG should do with the information. DF explained the process which would include matrix working between the Quality and Primary Care Teams within the CCG in order to use this information as part of a suite of intelligence to aid the CCG in their Primary Care Quality role. . **Action: The Quality Committee received the report.**	

15/025	**PALS and Complaints Feedback to points raised by Quality Committee** BP presented the paper on behalf of JH which gave feedback on the points raised at the December 2014 Quality Committee following discussion relating to the CCG PALS and Complaints Overview Report (1st November 2013 to 31st October 2014). The paper also included an appendix detailing the breakdown of the process of handling complaints. DF explained some of the issues that were being experienced linked to quality assurance of responses and the number of complaints she requests further work to be undertaken on before recommending sign-off by the CCG Chief Officer. In addition, BP stated that CSU report constraints within the system due to delays in providers supplying information to the CSU but then timescales will be agreed with the complainant and updates given. An explanation was also given as to the processes in place which sees the CCG in weekly communication with the CSU for progress reports against each complaint. DF signalled that Complaints Management was a function that the CCG were intending to bring in house from April 2015, therefore improvements should be seen in the management and timelines for closure in Q1. **Action: The Quality Committee received the report.**	
15/026	**Quality Committee Draft Work Plan** BP presented the revised workplan which now also gave clarity on where other CCG meetings undertook work delegated by the Quality Committee eg. EPEG and the Corporate Governance Support Group. HN queried some of the gaps in dates of items to be presented and DF explained that this was due to the fact that these items would be presented on an ad hoc basis eg. MIAA reviews. HN asked when the Francis updated action plan would be presented to the Committee. DF explained that the latest Government update is still being awaited but that the CCG has all the relevant systems and processes in place from a commissioning perspective some of which have been subject to a MIAA review. DF stated that the Quality Team will present an annual report to the Committee in Quarter 1 2015/16 as part of the workplan which will detail the CCG position in relation to Francis. **Action: The Quality Committee received the report.**	
15/027	**Key Issues Log** (Points to be identified from this meeting) The following key issues have been identified for notification to the Governing Body: 1. S&O Safeguarding Performance – Contract Query signalled at February 2015 Contract Meeting 2. Safeguarding Strategy 2015-2017 - Recommendation to approve the Safeguarding Strategy 3. CQC Intelligent Monitoring - Banding of practices in the CCG area have been received by the Committee 4. Complaints – issues regarding timelines for closure remains a concern but plans have been put in place in terms of performance management of CSU and to bring this function back 'in-house' in 2015/16.	

15/028	**Any Other Business** 1. CCG Safeguarding Peer Review Action Plan – DF stated that this item had been deferred in order to provide a more comprehensive update at the next meeting. This was due to the fact that appropriate update information had not been received by the CCG Safeguarding Service in time for submission of the committee papers and that the CCG Network Safeguarding Steering Group was not due to meet until 23rd February 2015. 2. Corporate Governance – Key Issues Log was not yet available from the last meeting but this would be available with the meeting pack for the March 2015 Quality Committee.	
15/029	**Date of Next Meeting** Wednesday 18th March 2015 11.30am – 1.30pm Family Life Centre, Southport	

Chair : _____ _____

PRINT NAME SIGNATURE

Date : _____

NHS
Southport and Formby
Clinical Commissioning Group

Quality Committee Minutes

Date: **Wednesday 18th March 2015, 11.30am to 13.30pm**
Venue: **Family Life Centre, Southport.**

Membership		
Dr Rob Caudwell	Clinical Governing Body Member (Chair)	RC
Paul Ashby	Practice Manager Governing Body Member	PA
Dr Doug Callow	Clinical Director Lead for Quality	DC
Malcolm Cunningham	Head of Contracting & Procurement	MC
Billie Dodd	Head of CCG Development	BD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
Helen Nichols (Chair)	Lay Governing Body Member	HN
Ex officio members		
Fiona Clark	Chief Officer	FLC
Also in attendance		
Brendan Prescott	Deputy Chief Nurse / Head of Quality & Safety	BP
Minutes		
Jacqueline Jones	PA to Chief Nurse & Quality Team	JJ

Membership Attendance Tracker

Name	Membership	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 18	Jan 21	Feb 18	Mar 15
Dr Rob Caudwell	GP Governing Body Member (Chair as of Jun 2014)	A	√	√	L	√	A	A	√	√	√	A	A
Paul Ashby	Practice Manager, Ainsdale Medical Centre				L	√	A	A	√	A	√	√	√
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	√	√	√	√	A	√	L	√	A	√	A	√
Malcolm Cunningham	CCG Head of Primary Care & Contracting	√	A	√	L	A	A	A	A	A	A	A	A
Billie Dodd	Head of CCG Development	√	A	A	A	A	√	√	√	√	A	A	√
Debbie Fagan	Chief Nurse & Quality Officer	√	√	√	√	√	√	√	√	√	√	√	A
Martin McDowell	Chief Finance Officer	√	√	√	L	L	A	L	√	√	√	√	√
Helen Nichols	Governing Body and Lay Member	√	√	√	√	A	√	L	√	√	√	√	√
Dr Kati Scholtz	GP Locality Lead – North	√	√	√	L	L	A						

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/030	**Apologies for Absence** Apologies were noted and documented from :- RC, MC, DF, FC, AD, KMcL.	
15/031	**Declarations of Interest regarding Agenda Items** None declared.	
15/032	**Minutes of the previous meeting / Key Issues Log** Minutes and Key Issues log approved as true reflection of the previous meeting.	
15/033	**Matters Arising / Action Tracker** **14/183 – Safeguarding Peer Review Action Plan - RC to discuss at the next PLT Development Meeting and to report back.** RC was not present at the Quality Committee Meeting to provide an update on this item. QC Committee agreed to defer the item to the April QC Committee Meeting. **15/014 – Rotavirus Study - BP to contact the LMC to discuss the study.** BP confirmed contact has been made and is awaiting a reply. BP will report back to April QC. **New Matter Arising – Mortality Audit** The Mortality Audit was presented to the S&O Board Meeting in December 2014. DC - Queried when an update will be available. BP – The Mortality Audit identified several issues and as a result a Trust Mortality Surveillance Group has been established with sub groups : Pneumonia, Sepsis, Stroke, Serious Illness Recognition Resuscitation Committee (SIRRs). The groups are in the process of establishing ToRs and are looking to develop action plans for respective areas. DC - Raised concern he is not currently included in the communication loop, ie. DC has not been sent any details from the Mortality Audit or invited to attend any Mortality meetings. **Action :** BP agreed to send DC an update on the Mortality Meetings / and provide DC with a list of groups who meet to discuss Mortality. **Summary :** The December 2014 Approved Mortality paper has been presented to the S&O Board and followed up by Dr Rob Caudwell. As a consequence a series of sub-groups have been set up to tackle any issues raised, nothing substantive has come back yet. S&O Board are actively pursuing this, delay caused due to importance of the Mortality paper and the level of importance the S&O Board are ensuring the Mortality Paper receives.	BP

No	Item	Action
15/034	**Provider Quality Reports** SMcG - Provided an update on the Cancer performance and the Cancer Peer Review (External Verification Summary) and raised CNS Specialist Care cover as a current issue. Recruitment is in progress. DC queried whether the issues have an impact on the 62 day waiting period JS – Confirmed that the Trust failed to achieve compliance against the 62 day GP referral to treatment target for January delivering 81.8% (85% threshold). However, the Trust has delivered compliance for quarter 3. This was the result of 8 breaches (13 patients) of a total 44.5 cases. Breaches were spread across a number of tumour sites and following breach themes can be identified: • Delays within diagnostic phases due to complex pathways requiring more than one provider or diagnostic test • Patient choice through holidays and delayed decisions • Two internal diagnostic delays • Patient illness DC queried how other Providers are currently coping ? JS also suggested that the Cancer Network should be invited to the April or May CQPG to discuss the key issues raised in the Cancer Peer review. BP – A format needs to be produced. Issues raised must be included on the CQPG Agenda and a response received from CQPG before the next Quality Committee Meeting in April 2015. <u>Safeguarding</u> TF - S&O have provided their assurances surrounding Safeguarding. BP – Provided a brief update following a Safeguarding Meeting that took place on Tuesday 17th March 2015. A number of issues were discussed. (1) Submission of data to Commissioner which has been late for the previous 2 quarters. (2) A response letter to the contract query from the Trust was requested by the 27th March outlining an action plan to enable the Trust to provide adequate assurance on safeguarding. The action plan will be worked through over the next 12 months. A discussion on reasons why the query had to be generated were discussed, specifically around systems, policy development staffing and HR issues and training of staff on safeguarding. TF had attended a Walk-around, where some issues were identified, but improvements are being made.	

No	Item	Action
15/034	BP stated that over the next 6 weeks S&O have Safeguarding Meetings organised to address any serious concerns. HN asked that training issues and concerns should be discussed again at April's Quality Committee Meeting when further information will be available following the outcome of the S&O Safeguarding Issues & Concerns Meetings. <u>GP Information Sharing</u> BP discussed a ministerial letter highlighting the importance on sharing information between agencies regarding safeguarding children's issues.. DC highlighted GPs require better direction in relation to information sharing. BP proposed a detailed information letter should be sent to GPs regarding information sharing once clarity had been sought from the LSCB chair on statutory authority to request information. **Action :** CCG and LMC will send out a joint communication letter to GPs. <u>Stroke</u> Stroke issues were discussed at length. HN questioned the current service and its capacity to deliver a service to ensure patients receive optimum care and better health outcomes. JS stated Karl McCuskey is currently leading discussions with the Stroke Network on the provision of stroke care across the health economy. HN/DC – Requested an update on actions from the Trust's stroke group going forward. **Action :** Sharon Forrester to investigate and provide feedback. SF to contact GPs and the NWAS to understand, in the interim, where patients should be safely directed.	CCG / LMC SF

No	Item	Action
15/034	A&E Concerns JS gave an overview of current A&E performance with specific reference to Ambulance handover times and FFT A&E feedback. The Trust has provided an initial A&E Action Plan (January 2015) and at the February CQPG the Chief Nurse requested a report outlining an improvement plan and assurance regarding FFT for A&E, Community roll-out and staffing. Results from the Action Plan will be shared with the Quality Committee. JS stated that although FFT will no longer be incentivised by CQUIN it will still be monitored as part of the Quality Schedule in 15/16. Dementia CQUIN performance is also underperforming and will continue to be monitored via CQUIN, the Trust has been asked to develop an Action Plan outlining improvement against the FAIR (find, assess, investigate and refer) tool by the end of Quarter 4. HN raised concern about CCGs missing out on significant information from patients regarding FFT and whether information from Health Watch was discussed / included . JH confirmed no details are currently being received from HealthWatch each month. HN summarised concerns raised by GPs such as mortality figures, staff sickness and clinical areas. MMcD – Staffing levels are an issue on 5 or 6 of the wards at S&O. BP stated a number of S&O Wards are using a high level of Bank Staff. Recruitment is an issue across all trusts in Merseyside and it was recognised locum staffing levels can have an affect on overall performance. MMcD highlighted safer staffing reports are reported on a monthly basis at the CQPG. JH – Confirmed the Trust's Board does supply a summary which contains information relating to risks, incidents and complaints which the Board Director should be able to explain in more detail if questioned. BP stated the CCG was analysing staffing levels within the clinical areas at the Trust. DC raised concerns about the quality of Discharge letters reporting that discharge letters are now being sent out in batches rather than individually. The problem has been raised at a recent Operational Meeting where the problem was acknowledged but a solution to this issue is still being worked through. HN requested the specific issues which have an effect on overall trust performance be fed back to the Trust's Director of Nursing. BP – Agreed to the and stated the staffing report would be presented to SMT and Governing Body. MerseyCare and LCH JS presented the report and asked whether there were any concerns MMcD – Cost of services has been looked into with a review of activity and service delivery. There were ongoing discussions taking place with Merseycare. The issue of length of patient's care episodes was discussed. **Action :** JS & BP to raise at Merseycare CQPG	JS / BP

No	Item	Action
15/035	**Serious Incident Reporting** JH reported on a number of incidents at S&O with two main incidents of an IG breach with the MARAC group and an incident in Theatre regarding incorrect / double usage of a theatre packs discussed further. Trusts have requested a high amount of extensions over the past 3 – 4 months. LHCH and MerseyCare in-particular have experienced an increasing amount. Concern SUI reporting currently falls onto the control of "one" person. JH raised the issue at S&O of the system of SUI reporting being the responsibility of a single member of staff who is proficient in the use of the SUI reporting system. The system needs to be changed so more staff are trained and issued with responsibility of completing reports JH stated RCAs will not be submitted until the end of March when they will be considered late submissions. JH concerned 10 or 11 submissions are too many, a better management and sharing system needs to be created. The issue hasn't yet been formerly raised with the Director of Nursing for their awareness. JH suggested more people need to be familiar and become involved with the SUI reporting structure. HN – Reminded the group we do not want to provide the Director of Nursing with lots of issues, Only main issues should be presented to the Director of Nursing. JH – The SUI issues fall with the DoN at S&O. Each organisation should be responsible for their own SUI issues. Head of Risk has recently organised SUI training for 50 members of staff. **Action :** JH to contact Simon Featherstone to progress <u>Pressure Ulcers</u> HN – Concerned pressure ulcers are not being reported by following the correct process. JH – Confirmed three reporting areas have been simplified to create an easier reporting process. Steering Groups have also been organised to discuss / resolve Pressure Ulcer reporting issues. **Action :** JH to create a more detailed SUI table to clearly identify the areas where SUIs are being raised.	JH

No	Item	Action
15/036	**Draft Quality Strategy** JH – Circulated the DRAFT Quality Strategy document for comments one week prior to the Quality Committee Meetings. The DRAFT Quality Strategy document will be presented to the Governing Body on the 25 March 2015. JH confirmed content and current wording but formatting will be finalised after comments have been received. The final document will be correctly formatted before submission. JH invited comments. HN discussed the strategy with BP outside of the Committee in terms of future versions providing objectives linked to a five year plan. BP commented Quality is ongoing activity and the next version of the Quality Strategy will include any service. JH also stated the advent of co-commissioning would necessitate a revision of the future version of the Quality Strategy document. Potential areas for future inclusion were : GP Practice Information / FFT ; Aspiration – improving the quality in the services that are commissioned; Quality Objectives for the longer term and horizon scanning HN confirmed the committee would approve the current DRAFT Quality Strategy document once the document has been properly formatted. **Action :** BP / JH agreed to review the document again in 6 months / Q2 of the financial year.	BP / JH
15/037	**Safeguarding Service Update Report** Item deferred to April Quality Committee Meeting.	
15/038	**Safeguarding Peer Review Action Plan** BP provided a brief update relating to Chief Nurse updates, HR issues and recruitment issues together with their progress.	
15/039	**Continuing Health Care / Complex Care Services Quality & Safeguarding Report for Southport & Formby** Item deferred to April Quality Committee Meeting.	
15/040	**Dementia Diagnosis Rate Letter** NHS England to create an Action Plan in relation to the Dementia Diagnosis rate. The CCG are also working on this at the moment. (Geraldine O'Carroll leading on this)	
15/041	**GP Quality Lead Update** DC provided a brief overview of the Primary Care Development. • Effective Discharge Summary not yet available but work stream going well. • Understanding of what Primary Care should be responsible for has been discussed. • Challenges regarding Funding within own localities.	

No	Item	Action
15/042	**Locality Update** BD provided a brief Locality update.	
15/043	**Mersey Internal Audit Agency Continuing Healthcare Review Final Report 2014/15.** The review of the Continuing Healthcare (CHC) system has been conducted in accordance with the requirements of the Internal Audit Plan, as approved by the Audit Committee. MIAA has undertaken a review of the approach taken by Southport & Formby Clinical Commissioning Group (SFCCG) in discharging responsibilities in respect of CHC. BP confirmed processes are now in place. HN queried whether the processes are being followed and there was a further discussion on the CHC steering group.	
15/044	**Key Issues Log** HN – The Key Issues Log listing Key Issues raised within today's QC meeting will be completed by HN and sent to JJ.	
15/045	**Any Other Business** JH – Reminded the Committee of the Joint Quality Committee Meeting / Away Day, on Thursday 18th June 2015, Venue : Formby Hall Golf & Spa.	
15/046	**Date of Next Meeting …** **Wednesday 22nd April 2015** **11.30am – 1.30pm** Family Life Centre, Southport (Cypress Room)	

Chair : _____ _____

PRINT NAME SIGNATURE

Date : _____

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Service Improvement and Redesign Committee Minutes

Wednesday 4 March 2015, 9:30 a.m. – 11:30 a.m.
Venue: Classroom 4, Crosby Lakeside Adventure Centre, Crosby Coastal Park, Off Cambridge Road, Waterloo, L22 1RR

Attendees

Dr Niall Leonard	Vice Chair, Southport and Formby CCG	NL
Dr Dan McDowell	Secondary Care Doctor, South Sefton CCG	DMcD
Dr Kati Scholtz	Governing Body Member, Southport and Formby CCG	KS
Dr Jeff Simmonds	Secondary Care Doctor, Southport and Formby CCG	JS
Dr Paul Thomas	Governing Body Member, South Sefton CCG	PT
Steve Astles	Head of CCG Development, South Sefton CCG	SA
Billie Dodd	Head of CCG Development, Southport and Formby CCG	BD
Jan Leonard	Chief Redesign and Commissioning Officer, South Sefton CCG & Southport and Formby CCG	JL
Karl McCluskey	Chief Strategy & Outcomes Officer, South Sefton CCG and Southport and Formby CCG	KMcC
Sarah McGrath	Locality Manager, Southport and Formby CCG	SMcG
Angela Parkinson	Locality Manager, South Sefton CCG	AP
Brendan Prescott	Deputy Chief Nurse, South Sefton CCG & Southport and Formby CCG	BP
Colette Riley	Practice Manager, Governing Body Member, Southport and Formby CCG	CR
David Smith	Deputy Chief Finance Officer, South Sefton CCG & Southport and Formby CCG	DS
Becky Williams	Chief Information Analyst, South Sefton CCG & Southport and Formby CCG	BW

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

Name	Membership	Sept 14	Nov 14	Jan 15	Mar 15	May 15	July 15	Sept 15	Nov 15
Dr Niall Leonard	Vice Chair, Southport and Formby CCG	√	A	√	√				
Dr Dan McDowell	Secondary Care Doctor, South Sefton CCG	√	√	√	√				
Dr Kati Schotz	Governing Body Member, S&F CCG	√	√	√	√				
Dr Jeff Simmonds	Secondary Care Doctor, S&F CCG	A	√	√	√				
Dr Paul Thomas	Governing Body Member, South Sefton CCG	√	√	A	√				
Colette Riley	Governing Body Member, S&F CCG	√	A	√	√				
Karl McCluskey	Chief Strategy & Outcomes Officer, South Sefton CCG and S&F CCG	√	√	A	√				
Jan Leonard	Chief Redesign and Commissioning Officer, South Sefton CCG & Southport and Formby	√	√	√	√				
Steve Astles	Head of CCG Development, South Sefton CCG	√	√	√	√				
David Smith	Deputy Chief Finance Officer, South Sefton CCG & S&F CCG	√	√	√	√				
Billie Dodd	Head of CCG Development, S&F CCG	√	√	√	√				

No	Item	Action
15/010	**Apologies** Apologies were received from Colette Page, Pippa Rose, Dr Debbie Harvey, Dr Pete Chamberlain, Moira McGuinness and Susanne Lynch.	

15/011	**Minutes of Last Meeting** The minutes of the last meeting were agreed.	
15/012	**Matters Arising** Item 14.3 Jan Leonard has spoken to Debbie Fairclough re voting rights as it is not clear where the balance of power lies with it being a committee in common especially if there was an issue with one CCG. Debbie Fairclough will clarify this in the revised terms of reference which will be circulated once amended. Item 14.18 This work is ongoing. Dr Leonard informed the group that Dr Emily Ball from Trinity Practice is interested in undertaking a piece of research work around the frail and elderly in Southport. Dr Leonard also confirmed that once this piece of work has been undertaken he is happy for it to be shared with South Sefton CCG. Item 15.05 Tracy Jeffes and Dr Leonard has met with Anna Nygaard re the Community Navigation Model. Dr Leonard thinks it is more of a public health model and not an operational model which is what the CCGs would want. The committee would be anxious about giving resources to a model which has not been defined as meeting the needs of the clinicians. Tracy Jeffes is meeting with Anna Nygaard on Thursday to discuss further. The model will be brought back to the SIR committee once it is consistent. Dr Bal Duper was invited to the SIR committee but unfortunately couldn't attend. There needs to be a more understanding of the case mix and the model which will be delivered. Jan Leonard informed the committee that there is a QIPP challenge for both CCGs and this needs to be considered with other schemes. Dr Leonard has been having discussions with Dr Mike Briggs, Ophthalmology Consultant at Aintree Hospital who is complementary about the scheme and says it could become effective about reducing the number of people they don't need to see at the Hospital. It is triage and assessments that has put the costs up of the scheme. **Action** The committee is not in a position to consider the business case in its current form but will relook at the model and consider triage and assessment altered in some way with a view to making it more reasonable costs with a lower target in reduction in secondary care. Sarah McGrath will also contact Dr Mike Briggs to discuss further. It was confirmed that the End of Life business case was approved by the Finance and Resource Committees.	TJ SMcG
15/013	**Strategic Programmes – Performance Dashboard Update** A discussion took place regarding the Progamme Milestones Dashboard which Fiona Doherty tabled (copy attached for information). This dashboard included the RAG status so that members of the committee could see how the programmes were progressing. A discussion took place regarding the programmes for 15/16 and Karl McCluskey sought the committee's permission to work up reduced programme areas with a better locality focus. **Action**	

	Karl McCluskey to relook at list of programmes and develop or consolidate high level priorities and how we manage going forward, or whether we take it down to a locality level, this list will be brought back to the committee in May 2015. The clinicians agreed that the data needs to be comparative data and relevant to the GPs and also needs to be in a simplified format.	KMcC
15/014	**Strategic Planning Update and Progress** Karl McCluskey informed the committee that he had attended both recent Governing Body sessions and has shared the planning challenges for 15/16 and beyond. NHSE have altered the dataset that was used for planning purposes in 2014. Last year used monthly activity returns (MAR) which related to general and acute activity only. This year NHSE has asked CCGs to use SUS data, which is more comprehensive and covers all specialties and is based on spells. This has meant considerable inconsistency in relating the plans that were developed in 2014 as part of the two year and five year operational and strategic plans and the 2015/2016 planning submission. The planning team have been working with the respective Governing Body's during January 2015 and February 2015 to develop the submitted plans. Final plans will be signed off by the respective Governing Body's at the end of March 2015.	
15/015	**Primary Care Dashboard** Becky Williams tabled the Primary Care Dashboard (copy attached for information). A discussion took place about the best use of the dashboard and how the content could be improved and made more relevant to clinicians at both a locality and practice level. The purpose of this is to assist practices in understanding their performance against a range of indicators and to assist them in improving their services and commissioned services going forward. It was suggested that the dashboard should be used to share best practice and localities could focus on a different area of the dashboard each month. The committee explored and agreed a range of modifications and improvements to the dashboard which should be reflected in the version going forward from April 2015. This item needs to become a standard item on the agenda which needs to be led by the clinicians. **Action** Becky Williams happy to lead on sessions with locality chairs and locality managers so they're confident about the dashboard. Need to focus on one area each month and not the whole dashboard. Localities have to see the data in advance so it gives them time to digest the information. Agreement that once a topic has been reviewed then the topic is put to bed. Becky Williams to lead on additional items felt useful for the dashboard e.g. walk in centre attendances, GP satisfaction etc.	BW BW BW
15/016	**Any Other Business** There was no other business.	
15/017	**Date of Next Meeting** • 13 May 2015 at 9:30 a.m. venue CLAC	

NHS
Southport and Formby
Clinical Commissioning Group

Ainsdale & Birkdale Locality Meeting

Thursday, 26 February 2015 at 12.30pm at The Family Surgery.
The Family Surgery, 107 Liverpool Road, Southport PR8 4DB

Minutes

Attendees

Dr Kebsi Naidoo	(Chair) GP, Family Surgery	KN
Dr Gladys Gana	GP, Lincoln House Surgery	GG
Dr Sivaranjini Shyamsundar	GP, Lincoln House Surgery	SS
Dr Colette Nugent	GP, Ainsdale Medical Centre	
Dr Lindsay McClelland	GP, Ainsdale Village Surgery	LMcC
Jane Uglow	Locality Development Manager, S&F CCG	JU
Kay Walsh	Medicines Management	KW
Melanie Wright	Locality Development Manager, S&F CCG	MW
Natalie Dodsworth	Practice Manager, The Family Surgery	ND
Janice Lloyd	Practice Manager, Lincoln House Surgery	JL
Nina Price	Practice Manager, The Grange Surgery	NP
Karen Ridehalgh	Practice Manager, Ainsdale Village Surgery	KR

Apologies

Dr Stuart Bennett	GP, Ainsdale Medical Centre	SB
Dr Ian Kilshaw	GP, The Grange Surgery	IK
Paul Ashby	Practice Manager, Ainsdale Medical Centre	PA
Rachael Ogden	Ainsdale Village Surgery	RO

Minutes

Melanie Wright	Locality Development Manager

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr G Gana	Lincoln House Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Dr S Shyamsundar	Lincoln House Surgery	-	-	-	-	-	-	-	-	-	✓	✓	
Dr I Kilshaw	The Grange Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	
Dr K Naidoo	The Family Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Dr R Russell	Ainsdale Medical Centre	✓	✓	✓	✓	✓	A	✓	✓	✓	A	-	
Dr S Bennett	Ainsdale Medical Centre	A	A	A	A	A	✓	A	A	-	✓	A	
Dr C Nugent	Ainsdale Medical Centre	-	-	-	-	-	-	-	-	-	-	✓	
Dr P Smith	Ainsdale Village Surgery	✓	✓	✓	✓	✓	A	A	✓	-	✓	-	
Dr L McClelland	Ainsdale Village Surgery	A	A	A	A	A	✓	✓	A	✓	A	✓	

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/09	**Apologies for Absence** were noted.	
15/10	**Minutes of Previous Meeting and Action Tracker** The Minutes of the previous meeting were agreed as an accurate representation of that meeting. The action tracker was also considered and has been updated under separate cover.	
15/11	**Chair's Update** Dr Naidoo updated the meeting as to the recent quarterly Locality Chairs meeting held jointly with South Sefton CCG. Topics discussed included the draft contract for services in relation to GPs engaged in CCG business, the future direction and development for localities, together with developments in commissioning on a locality basis. The group expressed an interest in Dr Gina Halstead being invited to join a meeting to discuss and compare developments within her own locality. Mel Wright agreed to progress.	MW
15/12	**Quality and Patient Safety** It was agreed that the following issues be escalated to the Governing Body March meeting: • Community Matron have not been seen by GPs within this locality this year. Further, some practices reported that Community Matrons no longer attend MDTs due to staff shortages. Referrals are become challenging as exacting criteria are being adopted resulting in patients being 'bounced' between services. • False positives in relation to Potassium testing continue. • There was a patient safety and quality issue following a lack of cover during the February half term for District Nurses, Community Nurses and Cancer Nurses. • District Nurses attending to patients at home are not treating holistically, rather are just dealing with the one specific attendant problem, as opposed to checking whether there are any other problems.	MW
15/13	**Performances and Finance** There was no performance and finance report available for this month.	
15/14	**Medicines Management** Kay Walsh reported that as at December 2014, all practices are overspent, with the exception of the Family Surgery. The message remains to stick to the agreed workplan. The group also noted that the cost of Category M drugs had increased.	

	An SPU regarding Fentanyl patches has been circulated and prescribers are encouraged to check appropriateness and dosage. Pan Mersey guidelines for infant formula feeds, treatment of dry eyes and COPD are also now available. Further guidance on prescribing NOACs was sought. It was felt that the recent training session provided by the CCG was unhelpful. A flowchart presentation would be better. Mel Wright agreed to feed back.	MW
15/15	**Any Other Business** *Geriatrician Model* – Billie Dodd to be invited to the next meeting to provide an update. Dr McClelland enquired as to whether the £50k locality development money recently surrendered could be reclaimed for use in the locality. Mel Wright agreed to check. Dr McClelland also discussed federation and agreed to share further information with colleagues. She has discussed a low risk model with Dr Rob Caudwell who, in turn, agreed to discuss this with Joe Chattin of the LMC. A response is awaited. Dr Naidoo tabled and discussed *"Quality First: Managing Your Workload to Deliver Safe Patient Care"* from the BMA, which he felt may be helpful to colleagues.	MW MW
15/16	**Date and Venue for Next Meeting** Please note that the date and time of the next meeting has been changed to **Thursday, 19 March 2015** at 12.30pm at The Family Surgery.	

NHS
Southport and Formby
Clinical Commissioning Group

Ainsdale & Birkdale Locality Meeting

Thursday, 19 March 2015 at 12.30pm at The Family Surgery.
The Family Surgery, 107 Liverpool Road, Southport PR8 4DB

Minutes

Attendees

Dr Kebsi Naidoo	(Chair) GP, Family Surgery	KN
Dr Sivaranjini Shyamsundar	GP, Lincoln House Surgery	SS
Dr Colette Nugent	GP, Ainsdale Medical Centre	CN
Dr Paul Smith	GP, Ainsdale Village Surgery	PS
Dr Ian Kilshaw	GP, The Grange Surgery	IK
Paul Ashby	Practice Manager, Ainsdale Medical Centre	PA
Melanie Wright	Locality Development Manager, S&F CCG	MW
Natalie Dodsworth	Practice Manager, The Family Surgery	ND
Janice Lloyd	Practice Manager, Lincoln House Surgery	JL
Karen Ridehalgh	Practice Manager, Ainsdale Village Surgery	KR

Apologies

Dr Gladys Gana	GP, Lincoln House Surgery	GG
Dr Lindsay McClelland	GP, Ainsdale Village Surgery	LMcC
Rachael Ogden	Ainsdale Village Surgery	RO
Nina Price	Practice Manager, The Grange Surgery	NP
Kay Walsh	Medicines Management	KW
Jane Uglow	Locality Development Manager, S&F CCG	JU

Minutes

Melanie Wright	Locality Development Manager

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr G Gana	Lincoln House Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A
Dr S Shyamsundar	Lincoln House Surgery	-	-	-	-	-	-	-	-	-	✓	✓	✓
Dr I Kilshaw	The Grange Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓
Dr K Naidoo	The Family Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr R Russell	Ainsdale Medical Centre	✓	✓	✓	✓	✓	A	✓	✓	✓	A	-	-
Dr S Bennett	Ainsdale Medical Centre	A	A	A	A	A	✓	A	A	-	✓	A	-
Dr C Nugent	Ainsdale Medical Centre	-	-	-	-	-	-	-	-	-	-	✓	✓
Dr P Smith	Ainsdale Village Surgery	✓	✓	✓	✓	✓	A	A	✓	-	✓	-	✓
Dr L McClelland	Ainsdale Village Surgery	A	A	A	A	A	✓	✓	A	✓	A	✓	A

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/17	**Apologies for Absence** were noted.	
15/18	**Community Geriatrician Model** The £50k returned to the central funding pot cannot be retrieved for use in the locality and has now been applied to the CCG's baseline funding. However, funding for the Community Geriatrician (CG) model has been identified in the sum of £200k. It is proposed that a CG can provide diagnostic support to frail elderly patients, which is not currently avaialble, with CG access via telephone 4-days a week or contactable via email. In addition, 3 slots per day will be purchased, 4-days a week. Transport serices will be included within the business plan. The service will commence in June and will be reviewed following a 3-month period.	
15/19	**Locality Development in Seaforth and Litherland** Discussion of this item was postponed until the next meeting, due to the apologies received for Dr Gina Halstead.	
15/20	**Minutes of Previous Meeting and Action Tracker** were agreed.	
15/21	**Chair's Update** In the interests of securing attendance by both a member of the CCG's Leadership Team and a Governing Body GP at future meetings, it was agreed that from May 2014 the meetings would move to the second Thursday of the month.	
15/22	**Quality and Patient Safety** No issues were raised.	
15/23	**Performances and Finance** No issues were raised.	
15/24	Medicines Management An antimicrobial audit had taken place across the practices and the results were shared and discussed.	
15/25	**Any Other Business** Mrs Wright agreed to establish with which provider the contract for ECG referrals was held. There was also a discussion around patients who were fast-tracked for discharge into care homes, upon which GPs were asked to attend without appropriate information and records. Mrs Wright agreed to raise this with the End of Life Lead, Moira McGuinness. It was also agreed that Practice Nurse attendance at locality meetings could be on an *ad hoc* basis.	MW

No	Item	Action
15/26	**Date and Venue for Next Meeting** Thursday, 23 April 2015 at 12.30pm at The Family Surgery.	

Dates for your diary – future meetings *Second Thursday of each calendar month (from May)*
Thursday, 23 April 2015 at 12.30pm
Thursday, 14 May 2015 at 12.30pm
Thursday, 11 June 2015 at 12.30pm
Thursday, 9 July 2015 at 12.30pm
Thursday, 13 August 2015 at 12.30pm
Thursday, 10 September 2015 at 12.30pm
Thursday, 8 October 2015 at 12.30pm
Thursday, 12 November 2015 at 12.30pm
Thursday, 10 December 2015 at 12.30pm

NHS
Southport and Formby
Clinical Commissioning Group

Formby Locality Meeting Minutes

Date: Thursday 5th February 2015

Venue: Formby Village Surgery

Attendees		
Dr Chris Bolton	(Chair) GP, The Village Surgery	CB
Dr Sarah Lindsay	GP, Freshfield Surgery	SL
Dr Deborah Sumner	GP, The Hollies Surgery	DS
Dr Doug Callow	GP, Chapel Lane Surgery	DC
Stewart Eden	Practice Manager, Chapel Lane Surgery	SE
Yvonne Sturdy	Nurse Practitioner, The Village Surgery	YS
Jane Ayres	Medicines Management, S&F CCG	JA
Sharon Forrester	Locality Manager, S&F CCG	SF
Colette Riley	Practice Manager, The Hollies	CR
Lisa Roberts	Practice Manager, Freshfield Surgery	LR
Apologies		
Sue Lowe	Practice Manager, The Village Surgery	SL
Moira McGuinness	Formby Locality Manager S&F CCG	MM
Malcolm Cunningham		MC
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr D Callow	Chapel Lane Surgery	✓	✓	✓	A	A	A	✓	✓	✓	A	✓	
Dr T Quinlan	Chapel Lane Surgery	✓	L	A	✓	A	A	A	A	A	A	A	
Dr C Bolton	The Village Surgery	A	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	
Dr J Reddington	The Village Surgery	A	A	A	A	A	A	A	A	A	A	A	
Dr S Johnson	The Village Surgery	A	A	A	A	A	A	A	A	A	A	A	
Dr L Grant	The Village Surgery	A	A	A	A	A	A	A	A	A	A	A	
Dr D Mortimer	The Village Surgery	✓	A	A	A	A	A	A	A	A	A	A	
Dr J Eldridge	The Hollies Surgery	✓	A	A	A	A	A	A	A	A	A	A	
Dr D Sumner	The Hollies Surgery	A	L	✓	A	A	✓	A	✓	✓	A	✓	
Dr T Brettel	The Village Surgery	A	A	A	A	A	A	A	A	A	A	A	
Dr S Lindsay	Freshfield Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/10	Welcome, apologies and introductions  201502 Formby Attendance sheet.pd	
15/11	**Minutes of the last meeting** The minutes from the last meeting on 15 January 2015 were agreed as an accurate record.  B - 201501 Formby Minutes (FINAL).docx	
15/12	**Matters Arising:** • *CMIP Password* – CB has spoken to admin team and they have passwords and log ins. • *Locality Dashboard* – the data on admissions from last month's meeting is being 'drilled down'. SF advised this information will go direct to practices and clarified that this information is needed to that practices can look at any patterns. • *Community IV* – Liverpool Community Health currently provide Community IV therapy and this is under review at present during which time they are looking at moving the service to the CERT team. Moira McGuinness is leading on this with Dr Rob Caudwell as the Clinical Lead as part of 'Facing the Future Together' programme. SF asked for feedback from the Group about what they would like from Community IV services. Discussion took place over present services and associated problems with referrals; it was agreed that the Group would like this service to be available particularly for patients on long term antibiotics and with cellulitis. Discussion also took place over who would do the prescribing; considering whether a separate team should do this or whether this would be something the CERT team could do with prescribing done by the hospital.	
15/13	**OOH** Malcolm Cunningham was due to attend this meeting to give clarification of the situation with OOH but has sent his apologies. Discussion took place over OOH service. SF discussed piece of work that she is doing with Dr Hilal Mulla relating to obtaining urgent bloods and that patients have to be directed to A&E / EAU. Discussion took place over best practice for obtaining urgent bloods. **Ambulance Delays** CR advised that NWAS are not meeting their targets on the Quality Premium. Discussion took place over problems with the service, particularly during the handover of patients when clinical responsibility shifts.	
15/14	**Antimicrobial Prescribing** The Group discussed the results of the audit.	

No	Item	Action
	JA presented budget data. Discussion took place over problems with prescribing and the new electronic prescribing. JA mentioned the possibility of medication reviews being done.	
15/15	**Quality and patient safety – Dr Doug Callow** *GP Survey* – a reasonable response was received which will be shared in the future; DC discussed some of the feedback given (see attached notes) *Rapid Access Chest Pain Clinic and Cardiology at ICO* SF informed Group of Cardiology Redesign meeting and discussed backlog of new referrals and overdue follow ups across Southport & Ormskirk Hospitals. Dr Fox is due to retire in October 2015; nationally there is a shortage of cardiologists therefore there is a push for a more centralised approach. Liverpool Heart & Chest Hospital are going to provide a consultant to triage all patients in the system. All will be seen at least once, with emphasis on early discharge to primary care with robust management plans. DC advised that the plan is for SDGH to only accept referral to Cardiology via Choose & Book; SF needs to confirm this. There is a long term plan to redesign Cardiology at Southport & Ormskirk Hospitals in the next 18 months. SF advised that there is a need to look at thresholds for referrals and having clear pathways for particular conditions, for example AF. CB noted that an ECG interpretation service would be beneficial. SF also noted that a GPSI service is being looked at for cardiology.	SF
15/16	**Locality Business** *Chair's Update* - Nil to report. *Quality Committee Meeting* Discussion took place regarding the audit that Martin Jones has completed for 2012 across Sefton Nursing homes relating to use of catheters. It was noted that a Urinary Catheter passport will be introduced. *WCG* – nil to report *GP Locality Leads Meeting* - Meeting is due next week. *Governing Body & Finance Meetings* - CR presented feedback to Group – attached.	 F+R and G Feedback Jan 2
15/17	**Any Other Business** Nil	
15/09	**Date of next meeting:** **Thursday 12th March 2015 at 1.15pm** **Formby Village Surgery.**	

NHS
Southport and Formby
Clinical Commissioning Group

Formby Locality Meeting Minutes

Date: Thursday 12th March 2015

Venue: Formby Village Surgery

Attendees		
Dr Doug Callow	GP, Chapel Lane Surgery	DC
Dr Sarah Lindsay	GP, Freshfield Surgery	SL
Dr Deborah Sumner	GP, The Hollies Surgery	DS
Sue Lowe	Practice Manager, The Village Surgery	SL
Stewart Eden	Practice Manager, Chapel Lane Surgery	SE
Yvonne Sturdy	Nurse Practitioner, The Village Surgery	YS
Susanne Lynch	Medicines Management, S&F CCG	JA
Moira McGuinness	Locality Manager, S&F CCG	SF
Colette Riley	Practice Manager, The Hollies	CR
Lisa Roberts	Practice Manager, Freshfield Surgery	LR
In attendance:		
Malcolm Cunningham	S&F / SS CCG	MC
Apologies		
Dr Chris Bolton	(Chair), GP, The Village Surgery	CB
Jenny Kristiansen	SS CCG	
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr D Callow	Chapel Lane Surgery	✓	✓	✓	A	A	A	✓	✓	✓	A	✓	✓
Dr T Quinlan	Chapel Lane Surgery	✓	L	A	✓	A	A	A	A	A	A	A	A
Dr C Bolton	The Village Surgery	A	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	A
Dr J Reddington	The Village Surgery	A	A	A	A	A	A	A	A	A	A	A	A
Dr S Johnson	The Village Surgery	A	A	A	A	A	A	A	A	A	A	A	A
Dr L Grant	The Village Surgery	A	A	A	A	A	A	A	A	A	A	A	A
Dr D Mortimer	The Village Surgery	✓	A	A	A	A	A	A	A	A	A	A	A
Dr J Eldridge	The Hollies Surgery	✓	A	A	A	A	A	A	A	A	A	A	A
Dr D Sumner	The Hollies Surgery	A	L	✓	A	A	✓	A	✓	✓	A	✓	✓
Dr T Brettel	The Village Surgery	A	A	A	A	A	A	A	A	A	A	A	A
Dr S Lindsay	Freshfield Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/18	Welcome, apologies and introductions	Attendance sheet Formby Locality Marcl
15/19	**Minutes of the last meeting** The minutes from the last meeting on 5th February 2015 were agreed as an accurate record. Stewart Eden requested update on portal passwords; discussion took place that some practices still do not have them and some only have one; Colette Riley has password but cannot access any budget information. Susanne Lynch agreed to action this.	FINAL Formby locality Minutes FEB 2 SLy
15/20	**Matters Arising:** • *Community IV* - Moira McGuinness updated the Group with progress; initially it will be available for UTIs and cellulitis with a direct referral from GP and this will be built upon. Spec has been put together that still needs some amendment. Discussions are taking place surrounding who the provider will be; MM is meeting with the CERT team to see what they can offer. Dr Rob Caudwell is clinical lead on this. When this is set up MM will circulate the information to the locality. • *Cardiology & C&B* Dr Callow advised the Group that referrals should not be made to Southport & Ormskirk NHS Trust as they have no availability; a letter will be sent from the Trust to this effect. There are between 500-700 new and follow up appointments outstanding that are Liverpool Heart & Chest Hospital are providing an outreach service for. MM advised that this is already going ahead. It was confirmed that other service providers are aware of these difficulties and the consequent effect of more referrals being made to them.	
15/21	**Ambulance Delays** Moira McGuinness explained that as a result of discussions at a previous meeting regarding how long ambulances were taking to arrive Malcolm Cunningham has attended this meeting today to give feedback on this. Malcolm Cunningham informed the Group that the whole of the system is under huge pressure and therefore there are delays. Unfortunately this impacts mostly on patients and GPs more than anybody else. When a patient is known to be with a GP and therefore being 'supervised' they are automatically triaged so that if a patient at home calls they would be considered more life threatening. Discussion took place over these situations. MC did advise of good news in that Southport & Formby have only seen a 3.9% increase in activity which is low. Merseyside is one of the best performing areas in the North West. At present the service is managed via Blackpool however this should change next year and therefore the targets may well change. Dr Sumner identified that if a GP is calling for an ambulance, saying it is urgent, surely this should count as being triaged. Discussion took place over how to address this. Dr Callow queried approaching NHS England. MC agreed to take it back to the next meeting and he will provide	

No	Item	Action
	feedback on this to the Group. **OOH** Discussion took place over empty sessions at the OOH service and providing cover for patients in Manchester when there are not enough GPs to cover. MC advised that staffing problems are a national issue. Further discussion took place regarding indemnity problems; there is a meeting surrounding this at the end of the month. It was also noted that Go to Doc are looking at putting an event on in the next month in order to attract more GPs.	MC
15/22	**Stoma Services** Susanne Lynch discussed recent work done in the Bootle locality which has won an award. A Stoma Nurse from UHA has reviewed patients; some of which who had not been reviewed for 12 years. This has produced huge clinical outcomes as well as benefits to the prescribing budgets. This is hoped to come to Southport as well and is being progressed; discussion is needed with Jan Leonard and Billie Dodd to check if reviews are in the contract or not; if not this will need negotiating.	
15/23	**Diabetes Dashboard** Dr Callow suggested presenting the dashboard when all the clinicians who dealt with diabetes are present. It was agreed to arrange time for this.	ALL
15/24	**Prescribing update** An SPU has gone out regarding Fentanyl prescribing.There is a lot of variation between practices with regard to their levels of fentanyl prescribing. The SPU has gone out to remind colleagues around potency and that in line with Pan Mersey and our two local acute trusts the Mezolar product should be considered first line. Patients who have been discharged from hospital will receive mezolar. It has been noted that patients often do not perceive the patches as medication and forget to disclose that they are using them and it is important that patients understand that mezolar is fentanyl so more than one patch is not applied. Budgets: Discussion took place over the £467,626 overspend for month 9. Dr Callow asked if the PQS has been set for next year, and if so does it include polypharmacy. SLy advised that there is a slight shift in the PQS for 2015 2016 requesting the practices to complete areas of work and in doing so free up medicines management time to support practices with polypharmacy reviews.	
15/25	**V-Monovette** Discussion took place over the new urine collection system that has been implemented.	
15/26	**Quality and patient safety – Dr Doug Callow** CAMHS – Dr Hilal Mulla has been looking at the problems with access to the CAMHS service. There are 12,000 children in this area who need care; Dr Mulla has been looking at the possibility of one provider and a seamless service. Dr Callow advised the Group to forward any issue to Dr Mulla and copy to him.	Quality Lead n Formby Locality

No	Item	Action
	Lab difficulties – the problems from the lab a few weeks ago have been investigated and it was found that this was caused by a lack of contractual cover over the weekend that caused problems when a piece of hardware broke and could not be replaced. Inclusion Matters – should anybody have received a letter from IM to say please do not refer to them – please ignore this. Easter Opening – is optional for practices and there is a GP available at A&E.	
15/27	**Locality Business** *Connected Communities* MM discussed the Formby project that has been done through volunteers together with support from local businesses; this is coming to an end. MM will be meeting with Geraldine who oversees Connected Communities. MM will circulate information of how to access the 4 hubs in Formby; these include access through the library, church, Formby Pool and a luncheon club. MM considers that the Formby project has been a success and is hoping this model will continue. *Clinician's Group Meetings* – Dr Callow advised that decision needs to be made on what is going into next year's local quality contracts. Any ideas should be forwarded to Dr Niall Leonard, Dr Kati Scholtz and Angie Parkinson. From the Primary Care Development Meeting – Dr Callow discussed a referrals booklet to avoid non elective referrals and specify minimal investigations needed before referrals. Discussion took place over systems adopted by UHA and RLUH where GPs have access to discuss cases with consultants before referral. *Strategic Plan* Dr Callow presented notes on the Strategic Plan for 2015-16.	Strategic Pla 2015-16 (Doug
15/28	**Any Other Business** *Breast Services* – Whiston are doing the follows up and there is a nurse led clinic in Ormskirk. New referrals are being via patient choice to UHA or RLUH. *Community Matrons* – there are only 2 Community Matrons at present across Southport & Formby. It was also noted that District Nurse numbers are reducing. These will be looked at in June. Care Home Innovation Programme (CHIP) MM informed group of pilot being run in South Sefton following a successful pilot in Airedale that saw a 40% reduction in A&E attendances from Care Homes. Part of the programme is providing 'telemedicine' service that is linked to the urgent care team/OOH. *SMS Message* – SE queried withdrawal of funding for reminder service and asked if anybody is looking at alternatives. Discussion took place over DNA rates; SL commented that could still use SMS service but would be charged for this.	

No	Item	Action
	Date of next meeting: **Thursday 2nd April at 1.15pm** **Formby Village Surgery.**	

NHS
Southport and Formby
Clinical Commissioning Group

Central Locality Meeting Minutes

Date: Tuesday 24th February 2015

Venue: Kew Surgery, 85 Town Lane, Southport PR8 5PH

Attendees		
Dr Ian Hughes	GP, Cumberland House	IH
Dr Mark Bond	GP, Curzon Road Surgery	MB
Dr Graeme Allan	(Chair), GP, St Marks Medical Centre	GA
Dr Wendy Coulter	GP, Kew Surgery	WC
Sarah McGrath	Locality Development Manager, S&F CCG	SF
Rachel Cummings	Practice Manager, Cumberland House	RC
Dr Niall Leonard	CCG Board Member	NL
Dawn Bradley-Jones	Practice Manager, Trinity Practice	DBJ
Sejal Patel	Pharmacist, S&F CCG	SP
Kate Wood	Kew Surgery	KW
Apologies		
Dr Halina Obuchowicz	GP, Kew Surgery	HO
Roy Boardman	Business Manager, St Marks Medical Centre	RB
Sharon Forrester	Locality Development Manager, S&F CCG	SF
Kathy Rimmer	District Nurses, Curzon Road	KR
Alix Shore	Community Matron	AS
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr M Bond	Curzon Road Medical Practice	✓	✓	✓	✓		✓	A	✓	A	✓	✓	
Dr A Farrell	Curzon Road Medical Practice	A	✓	A	A		A	A	A	A	A	A	
Dr G Hedley	St Marks Medical Centre	A	A	A	A		A	A	A	A	A	A	
Dr G Allen	St Marks Medical Centre	✓	✓	A	✓		A	✓	A	✓	✓	✓	
Dr G Stubbens	St Marks Medical Centre	A	A	✓	A		A	A	A	A	A	A	
Dr I Hughes	Cumberland House	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Dr H Obuchowicz	Kew Surgery	A	✓	✓	✓		A	✓	✓	✓	A	A	
Dr W Coulter	Kew Surgery	✓	A	A	A		A	A	A	A	✓	✓	
Dr L Campbell	Trinity Practice	✓	✓	A	A		A	A	A	A	A	A	
Dr G Kumble	Trinity Practice	A	A	A	A		✓	A	A	A	A	A	

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/10	**Welcome, Apologies & Introductions** Apologies were noted.	201502 ATTENDANCE S
15/11	**Minutes of previous Meeting/Action Tracker** The minutes of the previous meeting were agreed as an accurate record. 201501 MINUTES Central Locality Jan 2	
15/12	**Matters Arising** Dawn Bradley-Jones advised that Dr Campbell will be returning to work next week and would resume the role of Locality Lead GP for Trinity. Discussion took place regarding replacement of Chair once Dr Allan retires in March – DBJ to discuss with Dr Campbell and inform Dr Allan. Discussion took place surrounding Breast Services. Sarah McGrath advised that the period of engagement with public and patients has finished; the main concerns were around communication. Hoping that Whiston will be doing the follow up clinics – this is to be confirmed. Dr Allan advised that the issue of consultants requesting GPs to organise follow ups has been dealt with and should not happen again. *Chair's Update* Dr Allan discussed recent meeting with Locality Chairs where the effectiveness of the current localities and dissemination of information to the whole practice membership was discussed The locality programme is to be re-invigorated, each will have a link member of the Senior Management Team It was recognised that finance and activity data needs to be made more accessible to localities There was also potential to use the data validation scheme within the Local Quality Contract (formerly SIP LES) to focus and theme evidence around miscoding and charging Dr Bond requested for minutes from the Locality Meeting to be distributed as soon as possible. *Governing Body Update:* *PM Challenge Fund* Dr Leonard advised that more information had been requested in support of the PM Challenge Fund in terms of breaking down of finance; the North will be looked at tomorrow and a decision should be made by Friday 27 February 2015. Should the bid be successful a Programme Board will need	DBJ SMc/CT

No	Item	Action
	to be set up with a view to starting in August 2015. Discussion took place over OOH service and implications if PM Challenge Fund is successful. Dr Hughes had discussed OOH service with patient group who preferred the extended hours. Dr Leonard suggested this may be something to take to the Wider Constituent Group. Dr Leonard advised of possible uplift for Frail patients over 75 from this year's quality scheme with the requirement for innovative interventions to keep patients out of hospital. Dr Leonard has found a GP to look at what evidence for primary care interventions in this group is available Dr Leonard also advised of the possibility of Dementia funding from the Prime Minister but no further details available yet.	
15/13	**Quality & Patient Safety** *Frequent A&E Attendees* Dr Bond discussed the issue of frequent attenders at A&E for dressings – advised to pass to Dr Callow to follow up. *CAMHS* Discussion took place over rejections of referrals to CAMHS team. Dr Bond has requested information from CAMHS about referral criteria and numbers of rejections they make and requested for this to be followed up. Both Dr Allan and Dr Hughes had experienced similar rejections with Dr Hughes being given incorrect telephone advice. Dr Leonard agreed to discuss with with Dr Hilal Mulla.	MB NL
15/14	**Service Improvement/Redesign** *Cardiology* – Dr Hughes discussed Choose & Book appointments advising that there are no appointments available and have to 'defer to provider.' There are patients who have still not heard after 5 weeks. SMc to feedback to Terry Hill. It was also noted that choosing 'defer to provider' means that responsibility stays with GP.	SMc
15/15	**Medicines Management** *Shared Care Agreements* - Discussion took place over need for Shared Cared Agreements when patients are discharged from hospital on Clexane. Sejal Patel updated the Group as follows: Budgets- Month 9 prescribing budgets were presented. Central locality FOT 4.48% above budget, CCG FOT 2.84% above budget. Omega-3 fatty acids (Omacor) for IgA nephropathy- Now classified as BLACK for this indication. Practice pharmacists will identify individual patients within practices receiving Omacor for this indication and discuss with secondary care. No further requests for prescribing to be accepted. Colief drops- CCG Grey list, now classified as black by APC Fentanyl SPU**-** An SPU on fentanyl patches has recently been circulated. SP will bring prescribing data to locality meeting when available	

No	Item	Action
	Pan-Mersey Prescribing guidelines for specialist infant formula feeds in lactose intolerance and cow's milk protein allergy guideline approved at JMOG Pan-Mersey guidelines for the non-specialist management of dry eye symptoms guideline approved at JMOG Pan-Mersey COPD inhaled drug therapy guidelines guideline approved at JMOG The Quarterly antimicrobial review will take place at next month's meeting. Please bring data to next month's meeting.	**ALL**
15/16	**Any Other Business** • Dr Allan informed the Group that Macmillan have funded a person to look at the physical activity / lifestyle in cancer patients once their treatment has finished. Referrals can be made by Clinical Specialist Nurses as well as GPs. • The Trust have started to do an electronic holistic needs assessment (eHNA) for cancer patients in some specialities which will help with Cancer Care Review • Excel for Health referral forms now have box that can be ticked for patients with cancer. • Dr Daniel Seddon, NHS England will be contacting Practices across Merseyside regarding improving breast/colorectal screening. • Connected Communities – Dr Allan queried whether this ends in March – tbc and discussed at next meeting.	SMc/SF
15/17	**Date and Venue for next meeting:** Tuesday 31st March 2015 at 1:00pm to 3:00pm Kew Surgery	

NHS
Southport and Formby
Clinical Commissioning Group

Central Locality Meeting Minutes

Date: Tuesday 31st March 2015

Venue: Kew Surgery, 85 Town Lane, Southport PR8 5PH

Attendees		
Dr Ian Hughes	GP, Cumberland House	IH
Dr Adele Farrell	GP, Curzon Road Surgery	AF
Dr Graeme Allan	(Chair), GP, St Marks Medical Centre	GA
Dr Halina Obuchowicz	GP, Kew Surgery	HO
Dr Louise Campbell	GP, Trinity Practice	LC
Dr Kati Scholtz	CCG Board Member	KS
Sharon Forrester	Locality Development Manager, S&F CCG	SF
Roy Boardman	Business Manager, St Marks Medical Centre	RB
Sejal Patel	Pharmacist, S&F CCG	SP
Kate Wood	Kew Surgery	KW
Apologies		
Dr Wendy Coulter	GP, Kew Surgery	
Dr Mark Bond	GP, Curzon Road Surgery	HO
Dawn Bradley-Jones	Practice Manager, Trinity Practice	DBJ
Rachel Cummings	Practice Manager, Cumberland House	RC
Kathy Rimmer	District Nurses, Curzon Road	KR
Alix Shore	Community Matron	AS
Aisling O'Kane	Cheshire & Wirral Partnership	AO
Jo Ball	Public Health	JB
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr M Bond	Curzon Road Medical Practice	✓	✓	✓	✓		✓	A	✓	A	✓	✓	A
Dr A Farrell	Curzon Road Medical Practice	A	✓	A	A		A	A	A	A	A	A	✓
Dr G Hedley	St Marks Medical Centre	A	A	A	A		A	A	A	A	A	A	A
Dr G Allen	St Marks Medical Centre	✓	✓	A	✓		A	✓	A	✓	✓	✓	✓
Dr G Stubbens	St Marks Medical Centre	A	A	✓	A		A	A	A	A	A	A	A
Dr I Hughes	Cumberland House	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Dr H Obuchowicz	Kew Surgery	A	✓	✓	✓		A	✓	✓	✓	A	A	✓
Dr W Coulter	Kew Surgery	✓	A	A	A		A	A	A	A	✓	✓	A

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr L Campbell	Trinity Practice	✓	✓	A	A		A	A	A	A	A	A	✓
Dr G Kumble	Trinity Practice	A	A	A	A		✓	A	A	A	A	A	A

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/18	**Welcome, Apologies & Introductions** Apologies were noted.	
15/19	**New IAPT Provider** Apologies have been received from both Aisling O'Kane and Amanda Hampton from the Cheshire & Wirral Partnership. Hopefully this will be rescheduled.	
15/20	**Minutes of previous Meeting/Action Tracker** The minutes of the previous meeting were agreed as an accurate record and the Action Tracker was updated. FINAL 201502 MINUTES Central Loc	
15/21	**Matters Arising** *Welcome back to Dr Campbell* Dr Campbell agreed to replace Dr Allan as Chair at forthcoming locality meetings. *Chair's Update* Dr Allan updated the meeting with discussions that took place at the last locality leads meetings; these surrounded the PM Challenge Fund and co-commissioning. Dr Allan advised the Group of discussions that took place regarding the way the locality system works and how this can be improved to include having measured outcomes and reporting these to the Board. Following this Dr Scholtz discussed the work the Redesign Committee are doing to complete a dashboard each month to go to each locality meeting which would include emergency admissions, A&E Attendances, prescribing, detailed information on referrals, etc. Specific areas of the dashboard would be discussed at each locality meeting. The idea is for each locality to then create ideas from this data of how improvements can be made. Sharon Forrester advised that an Action Plan for 2015/16 needs to be produced for each locality. Group discussed possible areas in Primary Care for which improvement could be made or could be managed more effectively – for example cellulitis – and this could go into the locality's action plan, it was noted that this would need clinical engagement to achieve this. Dr Scholtz noted that these could also feed into other groups – for example the Clinician's Group which Dr Scholtz chairs; all aimed at influencing change. Dr Allan discussed the need for properly protected time to enable this	ALL

No	Item	Action
	work to be done and suggested a change to the way the locality meets with a half-day session, 8 afternoons a year and creation of a working group. Discussion took place of how practices could manage this arrangement. Discussion also took place regarding PLT venued events and whether this time could be used more productively. Dr Scholtz discussed the next Wider Constituent Meeting that takes place on 15 April 2015 which will cover locality redesign and improvement. Dr Scholtz will feedback to the locality. Dr Scholtz also discussed the working group that is looking at the referral process and working through each speciality of what should be done before a referral is made. *Governing Body Update* Dr Scholtz advised that co-commissioning is going ahead. Unfortunately we did not get the PM Challenge Fund. *Champix*- at present the initial prescription has to be done by a GP however this will eventually be done by Smoking Cessation Services. If a patient is on any other meds they cannot have Champix. *Respiratory* – the new respiratory packs will be sent out this week. *Oxygen ordering* – Dr Scholtz highlighted oxygen ordering: the HOOF form is for emergencies only; if the patient needs long term oxygen a referral should be made through Ainsdale Community team for an oxygen assessment. This will be emailed through to all Practice Managers and GPs. *Geriatrician Services* – is going ahead. Start date likely to be 1st June and there are two purposes; instant advice for patient via telephone/email to geriatrician and secondly, if a patient would benefit from a quick diagnostic test can speak to the geriatrician and there will be three slots available each day.	KS
15/22	**Quality & Patient Safety** New IAPT service starts tomorrow and the existing referral forms can still be used until the new referrals forms are sent through.	
15/23	**Service Improvement/Redesign** • **Cardiology** – New clinics provided by Liverpool Heart & Chest Hospital have now started for new patients and follow ups. All patients have been reviewed via case notes; all those needing urgent appointments have been seen and it is envisaged that all will be seen by the end of May/beginning of June. Discussion took place over Hospital's request to use Choose & Book for referrals and 'defer to provider.' SF advised that a letter is due to be sent out from the Trust regarding the situation. Discussion took place over long term solutions to the problems with Cardiology to commission new services from LHCH. Any new patients should be referred to another provider at present. • **AF and Stroke Prevention-** the first 72 hours of Stroke care is currently under review at for Southport & Ormskirk NHS Trust. They are also looking to commission an early supported discharge service.	

No	Item	Action
	SF presented an AF audit to the Group to complete to try to understand current non elective activity in patients who attended the A&E with a primary diagnosis of AF. Dr Allan questioned whether this could be a coding issue. SF discussed that this can be ascertained by completing the audit. SF to send out data from the CCG Analyst – there are 66 patients for currently to review for Central locality. • **Connected Communities** – is going really well and will be running until June at which time it will reviewed in terms of cost effectiveness. This is only happening in two localities and is thought that it might be of benefit across a wider area. It is hoped that funding will be granted for a further twelve months. Jane Uglow locality manager for Ainsdale and Birkdale is preparing a report.	ALL
15/24	**Medicines Management** Sejal Patel presented the month 10 budget figures for the Locality. Fentanyl- SP handed out practice prescribing data for fentanyl patches. Practices advised to review to ensure prescribing is appropriate. Quarterly review of antimicrobial prescribing for care home patients – SP has not seen the results for all practices so unable to do a summary for the locality. Common themes highlighted e.g. cephalexin and co-amoxiclav for UTI, duration of course. Denosumab- query raised by Dr IH re denosumab for a male patient. SP to contact interface pharmacist for clarification.	SP
15/25	**Any Other Business** Dr Campbell informed Group that Dan Seddon has advised that there will be no help with flu vaccinations for nursing home patients by district nurses unless the patient is already on their list. Discussion took place over how this could be managed and whether the nursing homes are able to administer. This is to be discussed with DS. SF to feed this back to Billie Dodd	SF
15/26	**Date and Venue for next meeting:** Tuesday 28th April 2015 at 1:00pm to 3:00pm Kew Surgery	

NHS
Southport and Formby
Clinical Commissioning Group

North Locality Meeting Minutes

Date: Thursday 26th February 2015 at 13.00

Venue: Marshside/Corner Surgery

Attendees		
Dr Kati Scholtz	GP, Norwood Surgery	KS
Dr Miles Moriarty	GP, The Corner Surgery	MM
Rob Caudwell	GP, Marshside Surgery	RC
Carol Mackenzie	Practice Manager, The Corner Surgery	CM
Nicole Marshall	Practice Manager, Marshside Surgery	NM
Sarah McGrath	Locality Development Manager, S&F CCG	SMc
Jane Ayres	Medicines Management	JA
Rachel McKnight	MerseyCare	RMc
Dr Niall Leonard	GP, Roe Lane Surgery	NL
Lydia Hale	Practice Manager, Roe Lane Surgery	LH
Sam Muir	Practice Manager, Norwood Surgery	SM
In Attendance		
Graham Perry	Sefton Council	GP
Alex Spencer	Sefton Council	AS
Apologies		
Dr Ian Scott	(Chair) GP, Churchtown Medical Centre	
Dr Hilal Mulla	GP, Corner Surgery	HM
Dr Rory Kidd	GP, Churchtown Medical Centre	RK
Lyn Roberts	Practice Manager, Churchtown Medical Centre	LR
Val Sheard	Public Health	VS
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr K Scholtz	Norwood Surgery	✓	✓	✓	✓	✓	A	A	A	✓	✓	✓	
Dr A Al-Dahiri	Norwood Surgery	✓	A	A	A	A	✓	A	A	A	A	A	
Dr S Tobin	Norwood Surgery	A	A	A	A	A	A	A	A	A	A	A	
Dr D Unwin	Norwood Surgery	A	A	A	A	A	A	A	A	A	A	A	
Dr A Zubairu	Norwood Surgery	A	A	A	A	A	A	✓	✓	A	A	A	
Dr N Leonard	Roe Lane Surgery	A	✓	A	✓	A	✓	✓	A	L	✓	✓	

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr A Trevor	Roe Lane Surgery	✓	A	✓	A	A	A	A	A	A	A	A	
Dr J Fox	Roe Lane Surgery	A	A	A	A	✓	A	A	A	A	A	A	
Dr J Canavan	Roe Lane Surgery								✓	A	A	A	
Dr H Mulla	The Corner Surgery	✓	A	✓	A	✓	A	✓	A	✓	✓	A	
Dr S Woodcock	The Corner Surgery	A	A	A	A	A	✓	A	A	A	A	A	
Dr M Moriarty	The Corner Surgery	A	✓	A	✓	A	A	A	✓	A	A	✓	
Dr R Caudwell	Marshside Practice	✓	✓	✓	A	✓	A	✓	✓	A	✓	✓	
Dr M McCormack	Churchtown Medical Centre	A	A	A	A	A	A	A	A	A	A	A	
Dr R Kidd	Churchtown Medical Centre	A	A	A	A	A	✓	✓	A	✓	✓	A	
Dr I Scott	Churchtown Medical Centre	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	
Dr P Giannelli	Churchtown Medical Centre	A	A	A	A	✓	A	A	A	A	A	A	

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/14	**Welcome and apologies** Apologies were noted. See attendance sheet below:	201502 Nor Locality Attend
15/15	**Cambridge Social Isolation Project** Graham Parry and Alex Spencer from Sefton Council presented the above project to the Group and asked for thoughts from practices around identification of people who may benefit from such a project.	Cambridge Sc Isolation Projec
15/16	**Minutes of the last meeting** The minutes of the last meeting were agreed as an accurate record. Dr Scholtz also noted that the *Community Geriatrician Scheme* is going ahead as reported at last meeting however there is no further news. *PM Challenge Fund*. Dr Leonard advised that there was no news as yet; hoping for decision by next Monday or Tuesday 2/3 March 2015. Dr Leonard advised that, should we be successful in the bid the start date would likely be August 2015	201501 Nor Locality Minutes
15/17	**Quality and Patient Safety** *Breast Clinic* The patient engagement period has finished; it is hoped that Whiston will be doing the follow up clinics – this is to be confirmed. *Cardiology & Rapid Access Chest Pain Clinic* There has been some progress in relation to the backlog at Southport & Ormskirk NHS Trust; working with Liverpool Heart & Chest Hospital.	

No	Item	Action
	Discussion took place over Choose & Book referrals; if 'Defer to Provider' is chosen then this will remain the responsibility of the GP referring. Other providers with slots available can be selected. At present paper referrals to Southport & Ormskirk NHS Trust will be returned. Please be aware that some patients may be discharged following review by Liverpool Heart and Chest Hospital. *Potassium Reporting* Discussion took place over potassium reporting; it was thought that this has been dealt with for this locality. If individual cases arise, please contact Paul Mansour directly on paul.mansour@nhs.net	
15/18	**Practice Peer discussion – Long Term Condition Prevalence** The Group discussed the data presented which also shows the average data as requested. Discussion took place relating to asthma data; it was noted by Jane Ayres that mild asthma does not get counted. Dr Scholtz asked for opinions regarding diagnosis of children with asthma without spirometry being used. Dr Caudwell advised the group that there is a project being done by a Respiratory Consultant at Ormskirk District General Hospital who is looking at a standardised asthma management plan. Dr Scholtz noted that a Respiratory Nurse from Liverpool came to Practice for a pilot project to look at patients on COPD register; the results of which were that 6 out of 14 patients did not actually have COPD. Discussion took place over the issue of incorrect coding. Dr Caudwell also noted that double coding can take place for patients with both COPD and asthma. Discussion took place over Roe Lane Surgery's figures for Atrial Fibrillation. Lydia Hale advised group that they have been taking a 'one-stop' approach for patients with a number of chronic diseases, they are doing pulses routinely. Appointment times may vary according to how many chronic diseases the patient has; being able to telephone the patients due to their list size allows a good uptake of appointments. Further discussion took place over the increase in figures for Cancers which could indicate better survival rates Rachel McKnight informed the Group of a pilot project that Merseycare have funding for, to identify patients in residential care homes with suspected dementia and to go out and assess these patients. The funding is running until the end of March. It was noted that Churchtown Medical Centre's depression rates were high but overall mental health prevalence was average. SMc to raise with IS since the practice were not present. With regard to the Diabetes data; it was noted by some practices that their pathology form has been amended to include HbA1c – data facilitators should be able to do this for any practices.	SMc

No	Item	Action
15/19	**Medicines Management Update** Jane Ayres will circulate information from the Area Prescribing.	JA
15/20	**Locality Development** Sarah McGrath discussed the Localities in this area; noting that although this locality has the benefit of several Governing Body Members other localities do not. Therefore each locality will be assigned a Governing Body Member and Senior Management Team member to attend their meetings. It has been suggested to have a Joint Away Day/time out for 2 or more localities to look at what we want to achieve over the next few years. Discussion also took place regarding having 2 or 3 meetings a year to have all the GPs from the locality attend and having sessions to come together as clinicians, with some education and development opportunities.. SMc asked for thoughts on this to be sent to her. RMc discussed possibility of adding Mental Health to locality meetings. At present the Community of Practice meetings do not get well attended.	All
15/21	**Locality Business**	
15/22	**Any other business** DoLS Sarah McGrath raised this matter on Dr Scott's behalf; if a patient who is subject to a DoLS passes away then the Coroner needs to be informed. Discussion followed over difficulties in completion of DoLS and RMc suggested possibility of having education events that would cover this type of thing.	
15/23	**Date of Next Meeting:** **PLEASE NOTE CHANGE OF DATE:** **Thursday 19 March 2015, 13.00- 14.30, Marshside/Corner Surgery**	

NHS
Southport and Formby
Clinical Commissioning Group

North Locality Meeting Minutes

Date: Thursday 19th March 2015 at 13.00

Venue: Marshside/Corner Surgery

Attendees		
Dr Ian Scott	(Chair) GP, Churchtown Medical Centre	IS
Dr Kati Scholtz	GP, Norwood Surgery	KS
Dr Hilal Mulla	GP, Corner Surgery	HM
Dr Rory Kidd	GP, Churchtown Medical Centre	RK
Dr Niall Leonard	GP, Roe Lane Surgery	NL
Carol Mackenzie	Practice Manager, The Corner Surgery	CM
Nicole Marshall	Practice Manager, Marshside Surgery	NM
Sarah McGrath	Locality Development Manager, S&F CCG	SMc
Lydia Hale	Practice Manager, Roe Lane Surgery	LH
Sam Muir	Practice Manager, Norwood Surgery	SM
Lyn Roberts	Practice Manager, Churchtown Medical Centre	LR
In Attendance		
Sharon Forrester	S&F Locality Manager/CVD Lead	
Aisling O'Kane	Cheshire & Wirral Partnership	AO
Amanda Hampton	Insight Healthcare	AH
Apologies		
Dr Miles Moriarty	GP, The Corner Surgery	MM
Dr Rob Caudwell	GP, Marshside Surgery	RC
Jane Ayres	Medicines Management	JA
Rachel McKnight	MerseyCare	RMc
Sharon Johnson	iMersey	SJ
Val Sheard	Public Health	VS
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr K Scholtz	Norwood Surgery	✓	✓	✓	✓	✓	A	A	A	✓	✓	✓	✓
Dr A Al-Dahiri	Norwood Surgery	✓	A	A	A	A	✓	A	A	A	A	A	A
Dr S Tobin	Norwood Surgery	A	A	A	A	A	A	A	A	A	A	A	A
Dr D Unwin	Norwood Surgery	A	A	A	A	A	A	A	A	A	A	A	A

Name	Practice / Organisation	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr A Zubairu	Norwood Surgery	A	A	A	A	A	A	✓	✓	A	A	A	A
Dr N Leonard	Roe Lane Surgery	A	✓	A	✓	A	✓	✓	A	L	✓	✓	✓
Dr A Trevor	Roe Lane Surgery	✓	A	✓	A	A	A	A	A	A	A	A	A
Dr J Fox	Roe Lane Surgery	A	A	A	A	✓	A	A	A	A	A	A	A
Dr J Canavan	Roe Lane Surgery								✓	A	A	A	A
Dr H Mulla	The Corner Surgery	✓	A	✓	A	✓	A	✓	A	✓	✓	A	✓
Dr S Woodcock	The Corner Surgery	A	A	A	A	A	✓	A	A	A	A	A	A
Dr M Moriarty	The Corner Surgery	A	✓	A	✓	A	A	A	✓	A	A	✓	A
Dr R Caudwell	Marshside Practice	✓	✓	✓	A	✓	A	✓	✓	A	✓	✓	A
Dr M McCormack	Churchtown Medical Centre	A	A	A	A	A	A	A	A	A	A	A	A
Dr R Kidd	Churchtown Medical Centre	A	A	A	A	A	✓	✓	A	✓	✓	A	✓
Dr I Scott	Churchtown Medical Centre	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	A	✓
Dr P Giannelli	Churchtown Medical Centre	A	A	A	A	✓	A	A	A	A	A	A	A

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/24	**Welcome and apologies** Apologies were noted. See attendance sheet.	 Attendance sh North locality M
15/25	**AF Update** Dr Leonard discussed the Hyperacute Stroke Services available and this led into Sharon Forrester's update on AF. SF presented the SNAP data from the National Stroke Services Unit alongside the dashboard. To be able to deliver the Hyperacute Stroke Services have to be within 45 minutes travel of 72 hour Stroke Unit. At present UHA/RLUH are scoring really well and there have been discussions that they could work collaboratively and share services. SF presented 'Aliveco' system for smart phones that can be used to identify AF. This gives a rhythm strip that can be emailed and uploaded to EMIS. There is a pilot running at the moment that requires practices to demonstrate that they are using the system and complete an audit. If any other practices are interested please email SF. The PLT venued event in February raised awareness of prescribing NOACs although nobody from this locality attended. SF will run an audit for this locality's practices around data for prescribing NOACs Discussion took place around how AF is managed in primary care; and the extended role of the pharmacists in this. Dr Mulla and Dr Leonard to discuss with Susanne Lynch to see if this could be taken forward.	All (pilot) HM/NL

No	Item	Action
	Discussion also took place around West Lancs anti-coagulation services SF to to share model and outcomes SF to send out questions to the locality for feedback on discussions today. SF to clarify NOAC prescribing rates vs other CCGs and local QOF exception coding rates for AF compared with national rates.	SF
15/26	**New IAPT Service** Aisling O'Kane and Amanda Hampton attended the meeting today to introduce the new IAPT service from the Cheshire & Wirral Partnership. and Insight Healthcare. Over the next few months they hope to come back to see what they can do to increase referrals to them. They would like to understand what the practices want and the locations required; at present they work from hubs in Southport and Bootle. Feedback has shown that problems arise with the 'opt in' aspect of the referral process and they are proposing to duplicate a system used elsewhere that allows for self-referrals to be made or for a GP to refer as well. They would like to have leaflets available in community settings as well. Amanda Hampton talked about plans for patients to manage their own referrals; there would be an initial assessment between 3-5 days and an initial conversation with the PWP (Psychology Wellbeing Practitioner) who would assess if issues were more complicated and then would be looked at by a more senior practitioner. At present they are not sure what the waiting times will be as have not yet taken over the service. Aisling O'Kane discussed work with Age UK to identify issues with the older generation and also around patients with long term illnesses/conditions. There is the hope that they can provide help for patients with anxiety/depression causes by long term health problems. Dr Mulla commented that it will be useful to have a service that will help patients with unexplained symptoms, for veterans and cancer patients. A leaflet explaining whatvadditional services are on offer would be useful. Dr Mulla further discussed the possibility of using surgeries for clinics as some GPs are already keen for these services. At present the system for referral stays the same; they will continue to accept old referral forms and new referral pro formas will be sent out next week.	AOK/AH
15/27	**Minutes of the previous meeting and Action Tracker** The minutes of the last meeting were agreed as an accurate record. It was also noted that from the *Peer Discussion* section that Sharon Johnson is going to share condition specific blood forms.	FINAL - Nor Locality Minutes
15/28	**Quality and Patient Safety** Dr Mulla discussed High Potassiums are still happening and he has	

No	Item	Action
	looked at 6 in one day. Discussion took place over whether this could be related to an earlier collections on protected learning time days. SMc to take up with Dr Paul Mansour	SMc
15/29	**Medicines Management Update** Apologies received from Jane Ayres.	
15/30	**Locality Business** ***Locality Development*** Sarah McGrath advised that the locality meeting held on 21 May will be used for locality development and will follow a slightly different format with a facilitator. The timescale will remain the same.	
15/31	**Any other business** *PLT:* Dr Leonard advised that the next PLT will have an Innovation slot and Q&A all about sharing good practice. If anybody has any contributions please advise Dr Leonard. *SMS Text messages:* Sam Muir asked about the SMS text messaging service for which funding is being withdrawn from October. SMc to follow up for next meeting. *PM Challenge Fund:* Dr Leonard advised that date for announcement of the decision has been postponed until 27 March 2015.	All SMc
15/32	**Date for Next Meetings:** Thursday 16 April 13:00 - 14:30 Thursday 21 May 13:00 - 14:30 Thursday 18 June 13:00 - 14:30 Thursday 16 July 13:00 - 14:30 Thursday 20 August 13:00 - 14:30 Thursday 17 September 13:00 - 14:30 Thursday 15 October 13:00 - 14:30 Thursday 19 November 13:00 - 14:30 Thursday 10 December 13:00 - 14:30	