- The development in Southport of the Dementia Independent Living facility for couples should provide an opportunity for Churchtown to become Dementia Friendly based around the Health Centre and the local shops.

- People with dementia could give talks to local businesses to give their perspective on what it's like to live with the condition – break down barriers.

- Pubs should become Dementia Friendly so that people with dementia can have some sense of doing what they would normally do. Could be a special hour when the pub would normally be quiet.

- Need to help people to keep working as long as they can after diagnosis if they are able to.

- Later retirement age (people having to work longer) –v- increase in number of people with dementia?

- Helping people to make changes to live well with dementia and as normal as possible for as long as possible.

- Diagnosis – then what?

- Not shutting people with dementia away but encouraging them to be part of the community.

- Care homes should become community hubs – have more interaction with the local community.

- Common interests/memories – people with dementia sharing with peers at places such as day centres, etc.

- Are the services we provide dementia friendly?

- Identify places where people know that they can go to get help if they need it ("safe havens").

- Incorporate existing services into Dementia Friendly ones.

- Services/things need to join up and connected.

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- Specific training needed for transport providers and taxi drivers.
- Lifestory network – developing services in Liverpool.
- Need better information – lots on physical disabilities but little for mental health issues.
- What is happening in Sefton? Need grass roots level approach.
- Need neighbourhood return scheme – volunteers helping to find people who wander.
- Lack of marketing – nobody knows what's out there.
- Need to support carers so that they don't lose their own identity.

Questionnaire for People with Dementia

A Questionnaire was developed to be completed by people with dementia, to get their thoughts and opinions on their experiences and what would help them to live well with dementia.

The Alzheimer's Society were available to act as advocates to help people complete the questionnaires if required.

7 people completed the questionnaire

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Question 1 – Please tell us how you are completing this form	No of responses	%
On my own	5	70
With a family member who is not my carer	1	15
With my carer	1	15
With a health and social care professional	0	0
Other	0	0

Question 2 – How long ago were you diagnosed with dementia?	No of responses	%
Less than one year	2	29
1-3 years	2	29
3-5 years	1	13
6-10 years	2	29
10+ years	0	0

Question 3 – Who first realised that you were having problems with your memory?	No of responses	%
My GP	4	57
Other health professional – as part of another health problem	0	0
I noticed myself that I was having problems	1	15
Somebody else (family/friends) noticed something was wrong	2	28
Other (please give details)	0	0

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Question 4 – How easy was it for you to get a confirmed diagnosis of your dementia?.	No of responses	%
It was very easy – professionals listened	5	83
It wasn't as easy as it should have been – I had to convince professionals that there was a problem	1	17
It was very difficult – professionals dismissed my early concerns, and did not listen	0	0

Have you received enough information about your condition	No of responses	%
Yes	7	100
No	0	0

What other information would you like? Please describe:-

Felt time between being diagnosed and appointment at memory clinic should have been substantially shorter. Constant phone calls made to chase up.

Please give details of any problems you faced or things that went well:-

- Dolypazk tablets are very successful for me
- After working until I was 72 and being a production control manager and sales manager I found it difficult to fill my time in and not a great deal to motivate me
- Joining the Alzheimers society - thankyou

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Question 4 - **Here are some things that people with dementia have said are important to them. Are they important to you**	**Yes**	**No**
In terms of my healthcare I will be able to be seen by the same person and not have to repeat my story over and over again to different people.	4	0
I will always be asked what I want, even when I find it difficult to answer.	5	0
My carer and I will have access to information and support throughout our journey, including services that will help me to stay well, safe and independent in my own home.	4	0
I will be able to communicate my likes and dislikes where ever I am	4	0
I will have a say in my end of life plan and will be supported to die peacefully in a place of my choosing.	3	0

Question 5 – Now we would like to ask you about the services that you receive to help you with coping with your dementia

Did you have a choice of provider?	**No of responses**	**%**
Yes	3	75
No	1	25

What do you think of the services they provide?

- Being cared for at home by my husband
- Excellent - my carer is my husband
- Good
- Alzheimers Society - Very good

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Question 6 – have you spent time in hospital?	No of responses	%
Yes	2	29
No	5	71

If you answered yes please tell us about your time in hospital:-

- Not with dementia, other illnesses. Staff very busy. Needed more time for one to one

- Some was bad and some was good. I found the untrained staff didn't listen - they would put my drinks and food out of reach, the ones on nights couldn't answer bells - were rude and in one case when I asked for the commode the nurse said "you've a toilet in your room use it". I told her the specialist said I wasn't to use it. She said "what does he know" and she grabbed my arm and pushed me - I had a dizzy spell and I grabbed to stop me falling and she said "you bitch".

Question 7 – Do you have opportunities to meet and talk to other people with dementia?	No of responses	%
Yes	6	100
No	0	0

Question 8 – Is there anything else that you would like to do such as attending events and classes at local centres?

- Yes if possible
- Have some in Southport
- Social events organised by Alzheimers
- We already do
- No

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Question 9 – is there anything missing from these questions that is important to you (please tick all that apply)?

No responses given

Question 10 - Would you like the following people to have a better understanding of dementia?	No of responses
Family	2
Friends	2
Employers	1
Hospital Staff	2
Social Workers	1
GPs	0
Care Providers	0
People who work in shops, banks, offices and post offices	2
Police	1

Question 11 – details of any discussions you feel are imporatnt

No responses given

About You

What is the first part of your Post Code		L23 1 23% L30 1 23% L37 1 23% PR9 2 31%
Are you:		Male 5 71% Female 2 29%

What is your age?		0 0% 0 0% 0 0% 2 29% 5 71%
Disability – Do you have?		Physical Impairment 3 Visual Impairment 1 Learning Disability 0 Hearing Impairment/ deaf 2 Mental health/ Mental Distress 2 Long Term Illness 2 Other: Depression Diabetes Arthritis Autovalve replacement
Do you class yourself as disabled?		Yes 2 29% No 5 71%
Ethnicity		White British 5 84% White English 1 26%
Do you have a religion or belief		Yes 5 71% No 2 29% 5 people identified as Christian

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Questionnaire for people who are for somebody with Dementia

A Questionnaire was developed to be completed by people who care for a person with dementia, to get their thoughts and opinions on their experiences about their caring role. The questions mirrored those that were put to people suffering from dementia to see if the things that were important to people with dementia were also important to those who care for them.

20 people completed the questionnaire

Question 1 – How long ago was the person you care for diagnosed with dementia?	No of responses	%
Less than one year	1	5
1-3 years	9	45
3-5 years	1	5
6-10 years	8	40
10+ years	1	5

Question 2 – Who first realised that person you care for, was having problems?	No of responses	%
My GP	3	15%
Other health professional – as part of another health problem	1	5%
I noticed myself that I was having problems	14	70%
Somebody else (family/friends) noticed something was wrong	2	10%
Other (please give details)	0	0

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Question 3 – How easy was it for the person you care for to get a confirmed diagnosis of dementia?	No of responses	%
It was very easy – professionals listened	15	75
It wasn't as easy as it should have been – I had to convince professionals that there was a problem	4	20
It was very difficult – professionals dismissed my early concerns, and did not listen	1	5

Have you received enough information about dementia?	No of Responses	%
Yes	17	85
No	3	15

What other information would you like? Please describe:-

- What are the long-term symptoms. How to go about choosing residential care. What costs will be incurred in residential care.
- Need more aftercare after diagnosis
- General information
- I find the website 'Talking Point' very good
- I have received information by researching it myself. I would like to have been signposted to support organisations
- Sometimes it seems too much

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Please give details of any problems you faced as a carer or things that went well:-

- I found it difficult at times when I have been ill myself
- Getting reliable carers. So many just do it as a job and do not seem to remember that the patient is also a person. It was extremely hard coping with the patient's frustration.
- Main problem was distance. I was too far away so had to rely on Social Services
- Having considerable patience
- It is a very long road having to do everything that was done by two, especially making all decisions. Lack of help with transport
- No major problems as yet
- Acting as a memory bank
- Main problem is working my way through the minefield of financial support
- The initial memory test is not conclusive and the carer has a more accurate insight in the early stages. The initial diagnosis lacked empathy, understanding and any avenue of support. We were left reeling
- Meeting at Keystones (St. Lukes Church, Crosy) excellent help
- Getting a diagnosis for a 54 year old, then getting good care and getting appropriate support
- Being part of the Alzheimers society is a godsend
- Original diagnosis was vascular dementia - no medication. 6 months later, different doctor reviewed CT scan, etc., and re-assessed as mixed dementia and dorepezil prescribed. 6 months with no treatment was wasted time/Opportunity??

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Question 4 - **Here are some things that people with dementia have said are important to them. Are they important to you as a carer?**	**Yes**	**No**
In terms of healthcare I will be able to be seen by the same person and not have to repeat my story over and over again to different people.	17	0
The person I care for will always be asked what they want, even when they find it difficult to answer.	15	2
The person I care for will be able to communicate their likes and dislikes where ever they are living	14	3
The person I care for will have a say in their end of life plan and will be supported to die peacefully in a place of their choosing.	12	0

The following comments were made in response to the above questions:-

Being able to see the same person every time

- It is very helpful if the person with the dementia can be seen by the same person. They can't always speak for themselves because of their problems.
- Carer has to repeat general day to day. Particularly medical appointments and happenings.
- Yes - going to Alzheimers Groups very important
- Very important - doctors at memory clinic different every time you go. No continuity of care.

The Person I care for will be asked what they want

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- Very important. You should try not to lose sight that the patient is a person
- Yes, sometimes they do understand just don't remember the decisions made
- Yes, but they need to be included.
- You always try to give them choice but most times they cannot decide for themselves
- Yes and ask me what I want.
- They must be treated as individuals for as long as possible with the carer's advice sought as back up
- Important. As disease progresses this is increasingly difficult to achieve. A lot of patience needed.

<u>The person I care for will be able to communicate their likes and dislikes</u>

- Should be able to. The system should be constant
- No one knows what the future will bring. I hope the person can stay at home for as long as possible.
- No - change upsetting
- Not always
- Less important. This is likely to be known by spouse, family

<u>The Person I care for will have a say in their End of Life Plan</u>

- Important but obviously should be discussed whilst the patient is still able to make decisions.

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- Done early enough, yes.
- I hope they are able to choose, and that hospitals and care homes have the right training for staff.
- Have not considered this
- Not considered yet
- This needs to be addressed early on before it is too late due to advancement of disease

Question 5 – Now we would like to ask you about the services that you receive to help you and the person you care for cope with dementia

Did you have a choice of provider?	No of responses	%
Yes	4	22
No	14	78

What do you think of the services they provide?

- He has attended the Willows in Maghull when I had operations. They were very good with him.
- Poor standards
- We set up a care package but effectively it could never work because they were not able to be there 24/7
- Able to manage at home at this present time
- Excellent service from Sefton for Care and help in improving home environment
- Excellent

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- At present none received or wanted but I know where to look for help if required
- I went to Alzheimer's society for information and support and their support staff and services are excellent

- I thought it was very poor and after research I realised I could request an out of area referral and did so. I also wrote to lots of people to highlight the inadequacies and received a social worker visit which was good

- Good

- Cared for by family at home only support by GP, memory clinic and community nurse. Needs to be better co-ordination and links between services. All very hit and miss. No one takes the lead. Responsibility not clear

Question 6 – has the person you care for spent time in hospital?	**No of responses**	**%**
Yes	4	22
No	14	78

If you answered yes please tell us about your experience of hospital

- They were ok but I noticed they just put the food down and left him to eat it. Luckily I took him homemade chicken soup every day so I knew he was eating a little.

- But not for dementia

- But not for dementia - an operation on her hand became infected and she spent 3 weeks in Whiston. Care was very good but the individual rooms were like prison cells with no view from the windows due to renovations on the exterior

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Question 7 – Do you have opportunities to meet and talk to other people with dementia and/or other carers for people with dementia?	No of responses	%
Yes	13	68
No	6	32

If you answered No what opportunities would you like?

- At the moment I would like him to go to a Day Centre for one day a week for him to mix with different people.
- To be able to talk to carers in similar situations would be very useful. As ideas, methods used, etc., could be swapped
- Did have very good chats with the psychiatric nurse. Gave us some good advice which stood me in good stead.
- Have help from various groups
- One-to-one counselling. Not group social activities

Question 9 – is there anything missing from these questions that is important to you (please tick all that apply)?

- That all people can get the help they need without being financially assessed. It is very difficult on public transport to get to a care centre
- The circumstances of the initial diagnosis are very important and should be treated with understanding and compassion by professionals

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Question 10 - Would you like the following people to have a better understanding of dementia?	No of responses
Family	13
Friends	10
Employers	4
Hospital Staff	10
Social Workers	4
GPs	8
Care Providers	4
People who work in shops, banks, offices and post offices	10
Police	7
Other:- • Everyone • All people with whom we have had contact with have been very supportive • Transport	

Question 11 – details of any discussions you feel are important

- Being able to come to the memory clinic to discuss any problems we may have

- Although there are a lot of people waiting to help and a lot of information that is available, it can be a bit of hit and miss on whether you get all the support you need. For example it took some time before I realised I could be registered as a carer and I didn't know until I asked, that you can purchase items for use by the person suffering from dementia VAT free. Perhaps when a person is first diagnosed with dementia somebody should identify

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who the carer is going to be and make sure they have a copy of something like the excellent "Dementia Guide" published by the Alzheimer's society.

About You

What is the first part of your Post Code		L22 1 7% L23 1 7% L30 2 14% L31 2 14% L37 2 14% PR8 1 7% PR9 5 37%
Are you:		Male 7 41% Female 10 59%
What is your age?		16-24 0 0% 25-39 0 0% 40-59 1 6% 60-75 11 61% 75+ 6 33%
Disability – Do you have?		Physical Impairment 0 Visual Impairment 4 Learning Disability 0 Hearing Impairment/ deaf 3 Mental health/ Mental Distress Long Term Illness 1 Other: Diabetes Osteoporosis
Do you class yourself as disabled?		Yes 1 7% No 13 93%

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Ethnicity		White British White English White Welsh Black English	14 3 1 1	74% 16% 5% 5%
Do you have a religion or belief		Yes No 11 people identified as Christian	11 6	65% 35%

Questionnaire for Carers who had recently lost a person with Dementia

A questionnaire was developed to help us to understand the experiences of people who had recently lost a person with dementia. This was also to determine whether end of life plans were in place and if so if they were followed.

The Sefton Carers Centre facilitated this small sample of returns – 3 people completed the questionnaires.

Question 1 – How long did the person you are for have dementia?

- 3-4 years – Deceased 2013
- Official diagnosis 5/12 - Deceased 7/13 - Probable length of illness 2-3 years
- Approx 10 years

Question 2 – where did the person you cared for pass away?	No of responses	%
At home	0	0

In hospital	1	33
In a care home	2	67

Question 3 – did the person you cared for have an end of life plan in place?	**No of responses**	**%**
Yes	2	67
No	1	33

Question 4 – were the wishes of the person you cared for as stated in the plan carried out?	**No of responses**	**%**
Yes	2	100
No	0	0

Question 5 – What support did the person you cared for receive in their final days and who from?

- Care Home staff made mum comfortable an clean at all times
- NHS/Alzheimer's Society support
- Support from family, care home staff, GP, mental health team, district nurses, priest

Question 6 - What support did you receive and who from?

No responses given

Question 7 - Were you and the person you cared for treated with respect and compassion and kept informed as to what was happening?

- Yes, once in the care home

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Question 8 - What did you feel was helpful to you and the person you cared for during the process?

- The compassion shown by the care home

Question 9 - What did you feel was not done well and made the process difficult for both you and the person you cared for?

No responses given

Question 10 - Is there anything you would like to add?

Getting a diagnosis was very hard as letters from the GP were sent to mum. Also found out about Alzheimer's Society far too late. But that is now starting to change. Mum was not diagnosed with dementia until she was in hospital for another reason

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The Public Questionnaire

The questionnaire was available on-line (via e-Consult) and also as a hard copy. Distribution of hard copies was supported by the Sefton Pensioners Advocacy Service (SPAC), the Alzheimer's Society and the Sefton Carers Centre. It was available for people to complete from 28th May 2014 – 10th August 2014. A copy of the questionnaire is attached to the report.

The purpose of the questionnaire was to ascertain people's knowledge and perceptions of dementia in general, and to test out whether the aims and objectives in the Strategy were the right ones.

A total of 78 people completed the questionnaire. 70 people have fully completed the questionnaire and 8 people have partially completed the questionnaire (i.e. they have not answered one or more questions in the consultation; this may include monitoring questions).

It is important to note that these results are not representative of the Sefton population. The results of the questionnaire will support the feedback from the other engagement methods used.

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Question 1 – We would like to know about your level of understanding about dementia. Please answer true or false to each of the following statements	No of responses True	No of responses False
Dementia is a disease of the brain (**True)**	73	2
Dementia can be cured **(False)**	70	4
There are drug treatments that help with dementia **(True)**	66	5
There are many different kinds of dementia **(True)**	68	4
Dementia is part of the normal process of ageing **(False)**	9	64
People who eat healthily and exercise are less likely to get dementia **(True)**	28	43
Most people with dementia live in care **(False**)	8	66

Question 2 – If somebody has been diagnosed with dementia do you think that they should:-	Agree	Disagree	Not sure
Continue to live alone	21 (31%)	27 (38%)	27 (38%)
Be supported so that they can continue to work as long as they can	70 (93%)	3 (4%)	2 (3%)
Continue to drive as long as they are able	51 (69%)	13 (18%)	10 (13%)
Use technology to enable people to stay safe in their home	65 (88%)	1 (1%)	8 (11%)
Have a single point of contact for their dementia care	65 (89%)	0 (0%)	8 (11%)

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Question 3 – These are some statements that have been made about people with dementia. Please indicate whether you agree, disagree or are not sure about each:-	Agree	Disagree	Not sure
People with dementia should be involved in activities in the community	72 (98%)	1 (1%)	1 (1%)
It is better for people with dementia and their families if they are cared for in a residential unit or a nursing home.	4 (5%)	53 (72%)	17 (23%)
There is little or no benefit to be gained from telling someone they have dementia	15 (21%)	36 (49%)	22 (30%)
People who have just been diagnosed with dementia are unable to make decisions about their own care	6 (8%)	63 (86%)	4 (6%)
There is no point in trying to talk to people with dementia as they won't be able to understand	1 (1%)	66 (92%)	5 (7%)

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Do you have any comments about any of these statements?

- This will be dependent on severity and how far the dementia has progressed and how long they had dementia before they were diagnosed.

- I think that people with dementia should be involved - included in as many activities as their illness allows. I also think that you should continue talking as they can be reached by part or parts of the conversation.

- See question above about being cared for in residential unit or care home - depends on the stage of their dementia. Later stage advanced dementia is better cared for in a residential unit where specialist care is available.

- My opinion currently through the experience of looking after my mum who had Alzheimer's Dementia is that there is no point in getting a dementia diagnosis. There is very little support, you are on your own. GP's, Memory Clinics and NHS are all poor for understanding and support. They just do what they have got to do to tick the box, get the QUOF points and stuff like that.

- Though there can be confusion it is my experience that there is much understanding and less fear if they can do as many of the normal things as possible.

- I think a lot of the statements above are considerations that need to be thought about depending on each individual circumstance. The dementia consultant told my dad that there wasn't much point trying to explain to mum that she has dementia as she wouldn't remember BUT my mum does remember some things and I think it is important to try and help her understand.

- All cases are as individual as the person is. It also depends on family and support of family. No one knows what its like to live with this debilitating illness. Carers need more help in every aspect and different levels of dementia need different support. Activities, exercise and respite is very important to both carer and the person with the condition. This is not always possible because of all the obstacles and no one understanding. Training of staff of establishments to which we could attend. Carers' allowance should be looked at too - and the limitations to obtaining this should be lifted.

- It is not practicable to give a simple answer to the statements as more information about the individual involved and more clarity about the actual situation is needed (What does '... just been diagnosed ...' mean? The person could be at the early stages or the later stages when they have just been diagnosed) essentially, each individual is different and needs to be treated differently although some aspects may be common to many cases.

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- Most of these answers would depend on the stage of dementia. People with early onset dementia would understand diagnosis and carry on making their own decisions.
- These statements imply that dementia is a fixed condition with "one solution fits all". It is a complex and multi-faceted disease with most patients experiencing differing levels of capacity and understanding at different points in the disease.
- I don't know anybody with dementia
- I really don't know enough about dementia to offer an opinion
- People with dementia are human beings and should be treated as such
- Need more intervention as disease progresses
- You can't give up on people with dementia. They need mental stimulation and everyone is an individual.
- People who are diagnosed with dementia and live at home should, with help from family if possible. They should be given the choice until such time as their dementia is in need of extra care.
- Apart from the first statement, all the others are very negative.
- Questions 1+2+4+5 answers would depend on the progress of the dementia in the individual. I have presumed that the person is in the early stages rather than the later stages.
- Yes - the person with dementia is me and it is at this point loss of memory As a registered person with some loss of memory I still live on my own, do absolutely everything on my own in the home and outside (even though I probably do things twice over!, lose things, forget things). Up until now I have not missed any doctor's appointments, missed a bus or train, but I do have to write everything down in several places around the house. It is pleasant when I can spend a few days here and there with members of the family - shelve some of my responsibilities. My writing has

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deteriorated badly but I still write quite a lot of letters. I attend 6 or 12 months assessment of abilities, and have done so for three years.

- Depends on the severity and advancement of the dementia
- Not sure about some answers. Depends how far into dementia they are. Some I know are in early stages and understand. Short term memory that's all, remember everything years ago.
- The last four statements epitomise many people's (who do not know exactly what dementia is and how it can develop) opinions
- A lot depends on the severity of the dementia
- Very thorough and thought provoking
- I really do not know enough about dementia to give an opinion
- It all depends on the level of dementia. At first it is quite manageable but it is important to be able to identify the stage when they can no longer carry on their normal activities
- If people who have dementia are fortunate enough to have someone to love and care for them as long as it is possible, they are the lucky ones. the ones with no-one then must be placed in safe care.
- Must listen to people with dementia and their families, need to be involved in decision making they are the experts in what is happening individually to them.
- People with dementia should continue to live well in their community. Advice & support should be accessible. Early diagnosis so they can plan for the future and receive medication if suitable.
- There is a need for education and increased awareness around the condition to ensure everyone has a greater understanding of the conditions and how people can be supported.

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- I think many of the above questions above don't give a true value as to how progressive Dementia is and at what stage intervention is required.

Question 4 – The Government launched the Prime Minister's Dementia Challenge in 2012. This includes creating dementia friendly communities. What do you think dementia friendly communities look like	**Agree**	**Disagree**	**Not sure**
People with dementia are supported to remain active and included members of their communities	72 (95%)	0 (0)	4 (5%)
People will have increased understanding and awareness about dementia and how to support individuals with dementia.	71 (93%)	1 (1%)	4 (5%)
To support individuals living with dementia and their carers to maintain their independence for as long as possible	73 (100%)	0	0
People with dementia being treated as valued members of society	67 (88%)	0	9 (12%)
People with dementia and their carers feel comfortable in their local environment (shops, leisure facilities, etc.)	68 (91%)	0 (0%)	7 (9%)

	Agree	**Disagree**	**Not sure**
People who work in the local community are trained to respond to the needs of people with dementia and do very simple and	70 (93%)	0 (0%)	5 (7%)

practical things that can make an enormous difference			
Implementing simple steps to help people with dementia such as slow lanes in supermarkets and banks	47 (64%)	11 (15%)	15 (21%)
Support from befriending groups to help people with dementia do the things that they want to	71 (99%)	1 (1%)	0 (0%)

Any other comments?

- Not so sure about the "SLOW" Lane in supermarkets/banks. This is secluding people with dementia. I recently became a dementia friend and found it very rewarding. Society needs to become more sympathetic and tolerant towards people with dementia.
- We just want understanding, trust, patience but to be treated normally with respect and to feel comfortable.
- Awareness of dementia is improving which is very good.
- I agree with all the above points but to achieve the above would be amazing.
- I have never attended any such groups - never been offered - but I don't think I could. Nice to sit down in the evening to watch a programme or two on TV. For me its a strain to have to answer questions when I am assessed.
- The last but one statement only applies to more advanced stages of dementia. Where possible they would not be made to feel to be a burden on society
- Slow lanes might make other users irritated and the sufferer feel loss of dignity.
- Again, some things will only be a real handicap when dementia is advanced. It seems a bit presumptuous to provide slow lanes. Perhaps these would be useful if dementia is advanced. It seems a bit patronising (is that the word I am searching for?)

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- When is all this going to happen?
- Families should not have to fight constantly for support from social services
- Peer support for both carer and person with dementia. Access to advice, one on one support.
- I think day-centres may be best suited to accommodate Dementia suffers as they will be able to stimulate individual minds and monitor progress. Also provide less stress for working family members, knowing their loved one is safe.

Question 5 - The following questions relate to your thoughts about the Dementia Strategy and the Strategic Objectives for 2014 - 2019

Aims for People with Dementia

These are the aims included in the draft strategy which will help people with dementia and their carers live their lives in a positive way. Please rank them in order of importance where 1 is the most important and 9 is the least important.

These are the results of the surveys with the aim getting the most number of 1 ranked first, etc.

Rank

1. People with dementia should be diagnosed in a timely way
2. People with dementia are treated with dignity and respect
3. People with dementia get the treatment and support which is best for their dementia and their life
4. People with dementia will have help in planning for their future health and care needs through a co-ordinated health and social care service.
5. People with dementia's wishes with regard to end of life will be respected

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6. People with dementia know what to do to help themselves and who else they can go to for help

7. Those looking after people with dementia are well supported.

8. People with dementia should feel included as part of society

9. People with dementia can make decisions for themselves

Strategic objectives for people with dementia in Sefton

These are the Strategic Objectives in the draft Strategy that will provide people with dementia and their carers with the support to live their lives in the way they would want to? Please rank them in order of importance where 1 is the most important and 5 is the least important :-

These are the results of the surveys with the aim getting the most number of 1s ranked first, etc.

Rank

1. Timely diagnosis, appropriate treatment and involvement in care plans

2. Support to live independently for as long as possible, and to make decisions for myself

3. Inclusive and dementia friendly communities

4. Information, advice and support for people with dementia and their carers

5. End of Life Services, ensuring a peaceful and pain free death in the place of choice.

Question 8 – Do you have any other comments about the Strategy or have we missed something?

The following responses were given:-

- I think all the above are very important and should be included in a comprehensive holistic approach.

- The strategic vision sounds good on paper but how are these objectives going to be implemented and met in practice. I feel the support for my mum who was diagnosed before Christmas has been really poor. I don't feel like we know where to go for support. The memory clinic we attend with mum says there are things like day centres my mum could go to but then we hear no more information and don't know where to go. The Social Care is supposed to be coming round to assess mum in her home - we are still waiting. It is all these things that on paper the strategic plan sounds good but not sure where the support is or how we access it.

- All these questions are for early onset. Every GP should have the ability to give all the patients on their books a well check alert after they are 60 and then every 5 years after that. This would make sure that a lot of people with early signs of dementia do not slip through the net and get the help and support they need. Financial help without means testing i.e. carers' allowance should be available to all even those on pensions as they are still carers no matter what age you are. Recognise dementia as a terminal illness.

- End of life services should not distinguish people with dementia from other people in similar situations. The implication of the above appears to be different from what is now legally available for all people.

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- I would have liked the option to put many of these options as joint priorities especially for younger dementia patients which is what I am familiar with. Younger dementia patients need access to early diagnosis screening as it is so often misdiagnosed as anxiety or depression and specialist advice and support as risk management is harder for more mobile patients whose carer may still be employed and supporting children.

- I found ranking the aims difficult. I feel that the vast majority are ranked 1 because they are all interconnected. Early diagnosis is KEY. Support for independent living is vitally important. Information, advice and support are crucial keys. I am anxious when I see "End of Life" approaches. I would love 'Hospice Care' for all but am uncertain about offering medical professionals power to influence or provide 'end of life' services. 'The Liverpool Way' was a terrible thing though it meant well.

- Troubled by end of life services. How do people with severe dementia make end of life choices? The Liverpool Pathway was flawed. I asked was this used in care homes. Still waiting for reply. Finances - a trusted organisation to look after dementia sufferers' finances. Is social isolation the right way? I think not. The strategy should also include carers. How many people are caring for loved ones who are not registered because of the stigma? A strategy for dementia should have been well in place.

- End of Life should be extended to give support to carers at this difficult time.

- Too many questions are repeated?? was this intentional?

- I can't answer these because we are all different, our needs are different. I do not have a carer but on occasions my daughter may give me a hand when I get particularly anxious. Hearing As an individual I am usually ignored in conversations, chiefly because I am slow to answer and have to ask for things to be repeated, having great difficulty in understanding a lot of words. I use two hearing aids which still lack clarity. Loop system is used very little and those that have it don't understand how it works. I once asked a Post Office assistant to switch on the loop system After searching underneath the counter for ages she came up with a

very dirty looking piece of equipment but didn't manage to get it working - so we struggled on!

- They are all important. End of life services!!!?? I have sat with a friend where the family had agreed to the Pathway, where food and water is withdrawn, only they didn't sit with her and I never want to again, she was begging for a drink of water, tea, anything she said. I feel it's open to abuse. It made me ill. I couldn't get her out of my mind day or night. I'm sure the hospital didn't manage it properly. I did phone up and complain without the family knowing and said I think they had a few Dr. Shipmans working there, one nurse was horrible.

- Very difficult to rate any of these questions as they are all very important in their own way

- What does diagnosed in a timely way mean? Does it mean early? If people have dementia how do they know what to do? People with dementia should be part of society as long as they are aware yes

- I am so pleased that the strategy takes on board the knowledge that many people reaching the end of life want some control over their death. We all will die some day but why should we suffer the pain, the indignities and the fear of a horrible death. It is barbaric and in this day and age should be totally avoided. We put animals down for less than some people have to suffer. We should be given a form from our doctors as a matter of fact so that we can make a decision whilst we are of sound mind so that the doctor is aware, well ahead of end of life, that that is our dearest wish if that be so.

- I don't think ranking is helpful as it implies that items ranked lowest are not important which is not the case - all these aims are important

- Quicker response for support and care from staff specially trained and skilled at listening and communicating

- Advocacy

- It was difficult to rank the Q1 and Q2 statements as there were no least important ones
- Care staff should receive full training, experience and be to be able to cope and assist with changes to the individual as their prognosis develops. Also it is important nutritional care is given to maintain a healthy body and mind.

Equalities Monitoring

Post Code 	Completed by 53 people	**CH45** 1 **L20** 2 **L21** 4 **L22** 1 **L23** 3 **L30** 2 **L31** 12 **L37** 2 **L38** 2 **L39** 1 **L40** 1 **PR8** 13 **PR9** 9
Gender 	Completed by 64 people	Male 11 (17%) Female 53 (83%)
Age 	Completed by 66 people	25 – 39 1 1% 40-59 18 27% 60-75 17 26% 75+ 30 46%
Disability 	People indicated that they have a disability as follows:- 37 people consider themselves disabled	8 Have a physical impairment 5 Have a visual impairment 0 Have a learning difficulty 10 Have hearing impairment 3 Have mental health / mental distress 13 Have a long term illness

Ethnicity 	Completed by 65 people	White British 38 57% White English 26 40%

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		White Welsh 1 1% Black British 1 1% Indian 1 1%
Religion 	Have a religion completed by 59 people	Have a Religion 45 76% 42 (71%) are Christian
Sexual Orientation 	Completed by 65 people	Heterosexual 54 83% Gay 2 7%
Gender  	Completed by 60 people	60 (100%) Live in the gender assigned at birth

What will happen with what you have told us?

We will take on board what people have told us and make sure that it is reflected in the draft Strategy for Sefton. The Strategy will be approved by the Cabinet Member for Older People and Health and will form part of the Sefton Health and Wellbeing Strategy.

An Action Plan will be developed for the Strategy and progress against actions will be monitored.

The Strategy is a living document and will be refreshed and updated as legislation and guidance is updated. The Strategy and action plan will be published on the Council's website.

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Contributors

List of Contributors to Living Well with Dementia: A Strategy for Sefton 2014-2019

(No particular order)

This list contains the people and organisations that offered sustained and invaluable support to the process. We would like to thank everyone who was part of the process and it would be impossible to list and thank everyone as it was a huge piece of work. In particular we would like to thank:

- Councillor Paul Cummins, Cabinet Member for Older People and Health
- NHS South Sefton CCG
- NHS Southport and Formby CCG
- Sefton CVS, Mersey Care NHS Trust
- Alzheimer's Society
- Sefton Pensioners Advocacy Centre
- Age Concern
- Sefton Partnership for Older Citizens
- One Vision Housing, Care Homes Association
- Liverpool Community Health NHS Trust
- Southport & Ormskirk Hospital NHS Trust.
- Sefton Council Business Intelligence and Performance Team

Finally we would like to acknowledge and thank all the people of Sefton who contributed to this report.

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List of Organisations who took part in the Open Space Innovation Events

Sefton Carers Centre
Southport District General Hospital
Community Emergency Response Team (Southport Hospital)
Parkhaven Trust
Living Well Centre, Southport
Sefton CVS
Care Connect
Sefton Council Public Health
The Alzheimer's Society
Sefton Council Adult Services
Community Integrated Care (Green Heys)
Lifestory Network
Merseycare
One Vision Housing
Councillor Pat Keith
Councillor Sue McGuire
Birch Abbey
ICCM
The Footcare Service
The Regenda Group
Sefton Pensioners Advocacy Service
Ainsdale Community Centre
Vitalise - Sandpipers
Brookdale Resource Centre
Brighter Living Partnership
Councillor David Barton
Sefton Community Learning Disability Team
Memory Clinic, Merseycare NHS Trust

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Sefton Council

Dementia Strategy 2014 - 2019

Equality Analysis Report

DRAFT

June 2015

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Section One: Introduction

The Equality Act 2010

In order to meet equality legislation public bodies have to consider Section 149 of the Equality Act 2010:

A public authority must, in the exercise of its functions, have due regard to the need to –

(a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Protected Characteristics

Equality Law (Equality Act 2010) is clear that there are particular characteristic intrinsic to an individual against which it would be easy to discriminate. Section 149 (the Public Sector Equality Duty) lists the goals of the act and the characteristics, known as 'protected characteristics' against which we have to test for discrimination. These characteristics are gender, race/ ethnicity, religion and belief, sexual orientation, age, gender reassignment, pregnancy and maternity and disability.

Tackling Inequalities

The Marmot review; 'Fair Society, Healthy Lives', published in 2010, confirmed that health inequalities result from social inequalities and that action is required across all the wider determinants. The review identified the need for action to focus on reducing the gradient in health by focusing on those most in need.

In Sefton we have a strong commitment to promoting equality, tackling disadvantage and improving the life chances of our residents. We are aware that many factors combine to affect the health and wellbeing of individuals and communities. While health care services have an impact, other factors such as where people live, income, education, life experiences, behaviours and choices, along with relationships with friends and family, all have a considerable impact.

Sefton's Dementia Strategy 2014 - 2019

The Dementia Strategy must show due regard to the Equality Act 2010 and demonstrate through the process of producing, publishing and updating using both the National and Local Context how it meets the Public Sector Equality Duty. This equality analysis report is part of that process.

How we developed the Dementia Strategy for Sefton

The draft strategic objectives in the Dementia Strategy were co-produced following engagement and consultation events with service users, service providers, practitioners, VCF support organisations and carers, as well as local communities, partners, voluntary, community and faith sector and other stakeholders.

This engagement and consultation informed the setting of the overall strategic priorities outlined in the Draft Sefton Dementia Strategy.

A full report on the outcomes of the consultation and engagement will be made available at www.sefton.gov.uk

Strategic Objectives

Five Strategic Objectives for Carers in Sefton have been identified, these have been developed through both understanding the needs of the population and what carers and the people they care for including young carers, the public, community organisations and groups, commissioners and providers of services told us during the consultation and engagement process.

The strategic objectives for Dementia in Sefton are:

Timely diagnosis, appropriate treatment and involvement in care plans – people receive a timely diagnosis of their dementia, have their concerns listened to by healthcare professionals, and, together with their cares, are involved in developing care plans.

Support to live independently for as long as possible, and to make decisions for myself – people with dementia and their carers can live in their own homes for as long as they choose to do so, and can make decisions about choices that affect their lives.

Inclusive and dementia friendly communities – people with dementia and their carers will have support from local communities, will not suffer any stigma as a result of their condition and will be able to live as normal a life as possible for as long as they can.

Information, advice and support for people with dementia and their carers – people with dementia and their carers will have easy access to the information and advice they need to manage their condition, to stay as well and active as possible, and know where to go to find out what they need to know.

End of Life Services, ensuring a peaceful and pain free death in the place of choice – people with dementia and their carers will be helped to plan for their end of life, enabling them to die free from pain, fear and with dignity, cared for by people who are trained and supported in high quality palliative care, in the place of their choosing.

Section Two: Identifying Impacts across Protected Characteristics

In considering the impact of the Dementia Strategy, the following analysis has been undertaken across the Strategic objectives:

The analysis has been carried out using both Office of National Statistic (ONS) Census 2011 data and responses to the Sefton Dementia Strategy; both of these data sets are created through self identification and therefore show an approximate representation.

Protected characteristic	What the Consultation and the National and Local Context told us	Linked Strategic Objective(s)	Next Steps and Action
Gender	Nationally, two thirds of people with dementia are women. Locally there is limited data regarding the demographics of people with dementia in Sefton, further data collection and analysis will improve our knowledge of need.	***Timely diagnosis, appropriate treatment and involvement in care plans*** ***Support to live independently for as long as possible, and to make decisions for myself*** ***Inclusive and dementia friendly communities*** ***Information, advice and support for people with dementia and their carers*** ***End of Life Services, ensuring a peaceful and pain free death in the place of choice***	Feedback from the consultation and engagement process to the Dementia Subgroup, Health and Wellbeing Board, Adult Forum to be considered when developing Strategies and planning for the future. Data collection and analysis to identify local trends regarding gender and dementia

Protected characteristic	What the Consultation and the National and Local Context told us	Linked Strategic Objective(s)	Next Steps and Actions
Age	Dementia is most common in older people but younger can get it too. Younger people with dementia will face different issues, especially if they are still working when they receive a diagnosis. They may face discrimination at work and have to give up work earlier than they would like. As the population ages and the retirement age increases, it is more likely that more people will be diagnosed with dementia while they are still in work. Nationally one in three people over 65 will develop dementia and one in twenty people with dementia are under the age of 65 There is currently very little information available about the numbers of younger people (under 65) in Sefton with dementia. Further data collection and analysis will improve our knowledge of need.	***Timely diagnosis, appropriate treatment and involvement in care plans*** ***Support to live independently for as long as possible, and to make decisions for myself*** ***Inclusive and dementia friendly communities*** ***Information, advice and support for people with dementia and their carers*** ***End of Life Services, ensuring a peaceful and pain free death in the place of choice***	Feedback from the consultation and engagement process to the Dementia Subgroup, Health and Wellbeing Board, Adult Forum to be considered when developing Strategies and planning for the future. Further data collection and analysis to identify local trends regarding Age and dementia
Protected characteristic	**What the Consultation and the National and Local Context told us**	**Linked Strategic Objective(s)**	**Next Steps and Actions**
Disability	Dementia generally affects people with learning disabilities in similar ways to people without a learning disability, but there are	***Timely diagnosis, appropriate treatment and involvement in care***	Feedback from the consultation and engagement process

	some important differences. People with a learning disability are at greater risk of developing dementia at a younger age – particularly those with Down's syndrome where one in three develop dementia in their 50s. Nationally Studies have shown that the numbers of people with Down's syndrome who have Alzheimer's disease are approximately: • 1 in 50 of those aged 30 to 39 years • 1 in 10 of those aged 40 to 49 years • 1 in 3 of those aged 50 to 59 years • more than half of those who live to 60 or over. With regard to those people with learning disabilities other than Down's syndrome studies suggest that approximately:- • 1 in 10 of those aged 50 to 65 • 1 in 7 of those aged 65 to 75 • 1 in 4 of those aged 75 to 85 • nearly three-quarters of those aged 85 or over. There is currently very little information available about the numbers of people with a learning disability in Sefton with dementia.	***plans*** ***Support to live independently for as long as possible, and to make decisions for myself*** ***Inclusive and dementia friendly communities*** ***Information, advice and support for people with dementia and their carers*** ***End of Life Services, ensuring a peaceful and pain free death in the place of choice***	to the Dementia Subgroup, Health and Wellbeing Board, Adult Forum to be considered when developing Strategies and planning for the future. Further data collection and analysis to identify local trends regarding Disability and dementia

	Further data collection and analysis will improve our knowledge of need.		
Protected characteristic	**What the Consultation and the National and Local Context told us**	**Linked Strategic Objective(s)**	**Next Steps and Actions**
Race/ Ethnicity	There is currently very little information available about the numbers of people from a Black and minority ethnic background in Sefton with dementia. Further data collection and analysis will improve our knowledge of need.	***Timely diagnosis, appropriate treatment and involvement in care plans*** ***Support to live independently for as long as possible, and to make decisions for myself*** ***Inclusive and dementia friendly communities*** ***Information, advice and support for people with dementia and their carers***	Further data collection and analysis to identify local trends regarding race and dementia Action will be taken to gather further information to enhance our understanding of the needs of people from BME backgrounds with regard to dementia.
Protected characteristic	**What the Consultation and the National and Local Context told us**	**Linked Strategic Objective(s)**	**Next Steps and Actions**
Religion or Belief	There is currently very little information available about people from different religious backgrounds in Sefton with dementia. Further data collection and analysis will improve our knowledge of need.	***Support to live independently for as long as possible, and to make decisions for myself***	Action will be taken to gather further information to enhance our understanding of the contribution faith

		Inclusive and dementia friendly communities ***Information, advice and support for people with dementia and their carers***	communities can make supporting people with dementia in Sefton.
Sexual Orientation	No data available	***Support to live independently for as long as possible, and to make decisions for myself*** ***Inclusive and dementia friendly communities*** ***Information, advice and support for people with dementia and their carers***	Action will be taken to gather further information to enhance our understanding of the needs of gay, lesbian and bi-sexual people and additional support will be sought through the VCF sector to help with this understanding
Protected characteristic	**What the Consultation and the National and Local Context told us**	**Linked Strategic Objective(s)**	**Next Steps and Actions**
Gender Re-assignment	No data available	***Support to live independently for as long as possible, and to make decisions for myself*** ***Inclusive and dementia friendly communities***	Action will be taken to gather further information to enhance our understanding of the needs of transgendered people and additional support will be sought

		Information, advice and support for people with dementia and their carers	through the VCF sector to help with this understanding.
Protected characteristic	**What the Consultation and the National and Local Context told us**	**Linked Strategic Objective(s)**	**Next Steps and Actions**
Pregnancy and Maternity	No data available	***Support to live independently for as long as possible, and to make decisions for myself*** ***Inclusive and dementia friendly communities*** ***Information, advice and support for people with dementia and their carers***	Further feedback will be sought to enhance our understanding of the impact dementia may have of those using pregnancy and maternity services particularly with regard to caring responsibilities and the links to the dementia strategy.

Section Three: Advancing equality of opportunity and fostering good relations between people and communities

The National and Local context document identifies key messages relating to the prevalence of need by gender, disability, age and other identified characteristics including disability. This information, combined with the feedback from the consultation and engagement process, has informed the setting of the strategic objectives within the Sefton Dementia Strategy. This information will help partners to tailor services to address the needs of carers and those cared for in communities by providing information and signposting that advance equality of opportunity and foster good relations between people and communities.

Section Four: Conclusion

The Sefton Dementia Strategy - National and Local Context Document and the consultation and engagement feedback reports contain evidence and insight relating to different groups of people within the community. They have informed the development of the Sefton Dementia Strategy and Action Plan. Partners will seek to gather further evidence relating to specific characteristics where there are current gaps in our understanding.

Section Five: Action Plan

What	When	Who
Communications Plan for Dementia Strategy	Sept2015	All Partners
Publish Final Equality Analysis Report	Sept 2015	Sefton Council
Gather further feedback or evidence on the gaps of our understanding as identified in the Equality Analysis Report and identify how relevant evidence has been used to understand the potential equality impacts and update the Equality Analysis Report.	Sept 2016	All Partners
Annual review of the Strategy and Equality Analysis Report.	Sept 2016	All Partners

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
July 2015

Agenda Item: 15/133	**Author of the Paper:** Tracey Forshaw Designated Nurse Safeguarding Adults Email tracey.forshaw2@haltonccg.nhs.uk 0151 495 5469
Report date: July 2015	

Title: Hosted Safeguarding Service Governing Body Update: HM Coroner (Merseyside) and Deprivation of Liberty Safeguards authorisations, and Counter Terrorism & Security Act (2015).

Summary/Key Issues:

This paper presents the Governing Body with an update in relation to HM Coroner Merseyside for adult deaths within a care home, where a Deprivation of Liberty Safeguards authorisation remains in place.

An update in relation to Prevent and the Counter-Terrorism and Security Bill which received Royal Assent in February 2015, making Prevent Duty a legal requirement for public bodies.

Recommendation

The Governing Body is asked to receive and note the content of this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
	To achieve financial duties and commission high quality care.

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			Quality Committee – May 2015

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
July 2015

1. Executive Summary

1.1 A briefing has been circulated by NHS England (Cheshire & Merseyside) on behalf of Southport & Formby's CCG hosted Safeguarding Service to all General Practitioners (GPs) and GP out of hours services across Southport and Formby CCG. The circular informs GPs of the requirements to inform the Coroner of all deaths within a care home where the person has a Deprivation of Liberty Safeguards authorisation (DoLS) in place as determined in the Coroners and Justice Act 2009 (section 1(2)(c)).

1.2 The Counter-Terrorism and Security Bill received Royal Assent in February 2015 making the Prevent Strategy and Duty, as part of the overall counter terrorism strategy called CONTEST a legal requirement for public bodies. The Department of Health Prevent Duty came into force on 1st July 2015; this currently applies to NHS Trusts and Foundation Trusts only.

A national review of the current guidance is taking place, it is anticipated that the Prevent Duty will be extended to include Primary Care and CCG, when the revised document is published in October 2015. The CCG has responded and submitted information to NHS England's request on the CCG's state of readiness in-line with the Prevent Duty guidance.

2. Introduction and Background

This paper provides the Governing Body with a briefing in relation to the bulletin circulated to GPs across Southport and Formby CCG, outlining HM Coroner for Merseyside's requirements, when an adult dies within a care home, with a DoLS in place, and an update in relation to the Counter-Terrorism and Security Bill received Royal Assent in February 2015, of which the of which the Channel programme, Prevent Strategy and Duty sits.

3. Key Issues

3.1 Mental Capacity Act / Deprivation of Liberty Safeguards Coroners Process

When a person dies with a DoLS authorisation in place, the deaths are now considered to be deaths in custody. As such all deaths of a person subject to a DoLS authorisation must be reported to the Coroner and each death will require an Inquest. It is essential that all GPs are aware of a DoLS authorisation being in place in care homes as this will affect the issuing of the death certificate. Consequently deaths under these circumstances are reported to the Coroner.

A briefing specifically for GPs has been prepared in relation to this guidance and circulated to all GPs employed within Southport & Formby CCG, including out of hours GP Providers commissioned by Southport & Formby CCG. The circular outlines the expectations and role of GPs where a person within a care home dies, which is subject to a DoLS authorisation (Appendix 1). This process has been described by Mr. Sumner (HM Coroner) for Merseyside, in line with section 1(2)(c) of the Coroners Act and Section 16 of the Chief Coroner's Guidance.

https://www.judiciary.gov.uk/wp-content/uploads/2013/10/guidance-no16-dols.pdf

3.2 Counter-Terrorism and Security Act 2015

The Counter-Terrorism and Security Bill received Royal Assent in February 2015 making the Channel programme, Prevent Strategy and Duty, as part of the overall counter terrorism strategy called CONTEST a legal requirement for public bodies. The over-arching principle for Prevent and Channel is to protect vulnerable people from being drawn into terrorism. Under section 36 of the Counter-Terrorism and Security Act, Local Authorities are required to ensure that Channel panels are in place for their area. Partners of the panel have a duty to co-operate, the NHS have been cited as being required to participate as panel members.

The Department of Health Prevent Duty came into force on 1st July 2015. Whilst this currently applies to NHS Trusts and Foundation Trusts only, the guidance is subject to review following national consultation. An update is expected to be published in October 2015. There is an expectation that the Prevent Duty will be extended to Primary Care and CCGs. NHS England, in anticipation of the expected extension to the Prevent Duty Guidance has undertaken a benchmarking exercise across CCGs nationally, to determine the state of readiness. A formal response in relation to key criteria has been collated and submitted by the Safeguarding Service on behalf of Southport and Formby CCG

The Prevent Duty has been cited within the NHS Contract 2015/16, and local Key Performance Indicators have been set across the Merseyside NHS providers by the CCG Safeguarding Service. These have also been agreed with the NHS England North West Prevent Co-ordinator. The indicators are included within the safeguarding quality schedule and will be monitored by the safeguarding service.

4. Conclusions

4.1 General Practitioners have been notified of their legal requirements in line with section 1(2)(c) of the Coroners Act and Section 16 of the Chief Coroner's Guidance, when a person within a care home dies with a Deprivation of Liberty Authorisation in place.

4.2 The Counter-Terrorism and Security Bill received Royal Assent in February 2015, making Prevent a legal requirement for public bodies. Currently Prevent Duty applies to NHS Trusts and Foundation Trusts only, however a national review which is expected to be published in October 2015, is expected to be extended to Primary Care and CCGs. The CCG has responded to NHS England's request on the CCG's state of readiness in-line with the Prevent Duty guidance.

5. Recommendations

The Committee are asked to receive the content of the report.

Appendices

Appendix 1: GP Bulletin MCA / DoLS Coroners Process

Tracey Forshaw
July 2015

Appendix 1: GP Bulletin MCA / DoLS Coroners Process

Information Bulletin for General Practitioner Practices

Mental Capacity Act & Deprivation of Liberty Safeguards

Introduction

The Mental Capacity Act (MCA) 2005 was fully implemented in October 2007. The Deprivations of Liberty Safeguards (DoLS), which form part of the Act, were introduced in April 2009 as part of the amendments to the Mental Health Act 1983. The intention was to provide a legal framework around the deprivation for those people who are assessed as lacking the capacity to make decisions about their care and treatment or support. The intention was to avoid breaches of the European Convention on Human Rights, which occurred in HL v United Kingdom (ECtHR; (20040 40 EHRR 761), and often referred to as the 'Bournewood Gap'.

Application of the Legislation

- If a person is assessed as lacking capacity to agree to their care or treatment, and are living in a registered care home or hospital (managing authority), and the managing authority believe the persons care amounts to a deprivation of their liberty, to, protect the person from harm, is proportionate and the care is in their best interest then the managing authority will make a request for a deprivation of liberty assessment.
- The application is made to the Local Authority where the person is ordinarily resident. If the application is for a person who is self- funding then the request will be made to the Local Authority where the managing authority is based, which would also be the case for a person of no fixed abode.
- An assessment will be carried out by 2 assessors (Best Interest Assessor and a Mental Health Assessor). The assessment will determine if the persons care is in the person's best interest, is proportionate and cannot be provided in a least restrictive way, and is necessary to prevent harm coming to the person, amounting to a deprivation of their liberty.
- A DoLS authorisation can last up to a maximum of12 months once in place.

Informing the Coroner

- If the deprivation is authorised, the person is classed as being in *safe detention*. where the person dies whilst subject to an authorisation the coroner **must be informed in line with the Part 1 Coroners Act (2009)**.
- Registered General Practitioner and care home have a duty to notify the Coroner of any death occurring whilst the deceased was subject to detention under the Deprivation of Liberty Safeguards. If a GP is requested to confirm death they **cannot** issue the medical certificate of cause of death as they are required to inform the Coroner, as any death in state detention will require an inquest.

Recent Case Law

- Originally there did not exist in law a specific definition about what amounted to a Deprivation of Liberty, there were a number of factors which were required to be considered (Page 17 DoLS Code of Practice).

- However, since the Supreme Court ruling in March 2014, Cheshire west and Chester local authority were challenged in the High Court on a DoLS authorisation that was granted on *P.* In March 2014, a Supreme Court Judgement was passed, ruling that the deprivation was unlawful. The judgment of *P & Q* v Surrey County Council also determined unlawful deprivation. These land mark cases have led to significant changes to whom and when a Deprivation of Liberty authorisation must be made. There is a clear definition of the factors to consider when deciding is a person is being deprived of their liberty;

- They introduced the **"acid test"** term which need to be considered when deciding whether a person is being deprived of their liberty:
    - 1 - The person lacks capacity **AND**
    - 2 - The person is not free to leave **AND**
    - 3 - The person is subject to continuous supervision

  The number of DoLS referrals has significantly increased as a result of the judgement. This is a national concern and the implications are far reaching in; resources, workload and financial costs. Several test cases continue to be taken through the Court of Protection.

Procedure to Follow

- It is the responsibility of the care homes to apply for the authorisation for the DoLS.
- It is the responsibility of the GP to clarify with the care home when a notification has been received of a death, whether the person was subject to a DoLS authorisation.
- **GP Practices need to ensure that Health Professionals are aware when a person has a DoLS in place** (Out of Hours GP services, registered nurses whom are competent in verifying death).
- **If the DoLS is authorised and the person dies, the GP must inform** the coroner and will not be able to issue the medical certificate of cause of death, as these deaths require an inquest. *(If a person is subject to a DoLS then a registered nurse cannot verify death).*
- The care home **must contact the police who will inform the coroner.** *(Applies to deaths which occur within the jurisdiction for Knowsley, Liverpool, Sefton, St. Helens)*
- In natural cause deaths where there are no issues surrounding care or treatment**. The coroner's office will request a statement from the registered GP relating to the persons health and well-being before their death and if their death was expected.**
- The Coroner will inform the Registrar of Births and Deaths of the conclusion of the inquest, the cause of death given and will provide details for the registration of the death. The family or representative can obtain a copy of the medical certificate of cause of death from the registrar within 5 working days**.**
- The DoLS does not impact on any decisions that are made in the persons best interests relating to resuscitation. However if the person has no friends or family an IMCA (Independent Mental Capacity Advocate) should be involved for people who lack capacity and represent their views if there is no one else to fulfil this role.
- **You will need to check** - your policy and procedures relating to your DNAR process.
- **You will need to check** - your policy if you have registered nurses who verify death as the person is classed as being in detention.
- **Health professionals have a responsibility to** keep updated on constant changes relating to MCA & DoLS.

The information in this bulletin has been undertaken in consultation with:

Organisation	Name	Title
Coroner's Office		
Merseyside (Knowsley, Sefton, St Helens) HM Mr. Sumner	Lynda Roberts	Coroners Officer
Liverpool HM Mr. Rebello	Albert Howard-Murphy	Coroners Officer
Cheshire (Halton) HM Mr. Rheinberg	Christine Hurst Joanne Corteen	Senior Coroner's Officer Coroners Officer
NHS England		
NHS England (Cheshire & Merseyside)	Michelle Cox Lisa Copper Dr. Kieran Murphy	Quality and Patient Experience Manager Deputy Director of Quality & Safeguarding Medical Director
Clinical Commissioning Groups (CCG)		
NHS Halton CCG	Jan Snoddon Jenny Owen	Chief Nurse Deputy Chief Nurse
NHS Knowsley CCG	Helen Meredith Dr. Sunandini Sethuraman	Lead Nurse Named GP
NHS Liverpool CCG	Jane Lunt Kerry Lloyd Dr. Margaret Goddard	Chief Nurse Deputy Chief Nurse Named GP
NHS Southport and Formby CCG	Debbie Fagan Brendan Prescott Geraldine O'Carroll	Chief Nurse Deputy Chief Nurse Senior Integration Commissioning Manager
NHS South Sefton CCG	Debbie Fagan Brendan Prescott Geraldine O'Carroll	Chief Nurse Deputy Chief Nurse Senior Integration Commissioning Manager
NHS St. Helen's	Sarah O'Brien Dr Michael Ejuoneatse	Chief Nurse General Practitioner
Local Authority MCA / DoLS Lead		
Halton	Lindsay Smith	
Knowsley	Vince Williams	Mental Capacity Act Co ordinator
Liverpool	Duncan Robinson Jan Summerville Helweun Davies Michelle Barry Nadia Cattell	Solicitor Liverpool City Council Safeguarding Adults Board and Partnership Co-ordinator Manager Quality Assurance and Adult Safeguarding Team DoLS Team Leader Mental Capacity Act Implementation Officer
Sefton	Nick Roberts	Service Manager MCA/DoLS
St Helens	Linda Wojcik	Mental Capacity Act Co ordinator

For further information: suggested links

Coroners and Justice Act 2009
Chief Coroners Guidance No. 16 https://www.judiciary.gov.uk/wp-content/uploads/2013/10/guidance-no16-dols.pdf
Local Authority MCA – DoLS information
http://liverpool.gov.uk/council/strategies-plans-and-policies/adult-services-and-health/deprivation-of-liberty-safeguards/
http://www.ascsthelens.co.uk/resources/the-deprivation-of-liberty-safeguards-(dols)/
Cheshire West & Cheshire Council V P (2014) UKSC 19, (2014) MHLO
http://www.mentalhealthlaw.co.uk/Cheshire_West_and_Chester_Council_v_P_(2014)_UKSC_19,_(2014)_MHLO_16
P&Q v Surrey Council 2014
https://www.supremecourt.uk/decided-cases/docs/UKSC_2012_0068_Judgment.pdf
Mental Capacity Act 2005: Code of Practice
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Capacity_Act_code_of_practice.pdf
Deprivation of liberty safeguards: Code of Practice
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

NHS
Southport and Formby
Clinical Commissioning Group

Flowchart- Death of Person Subject to DoLS Authorisation

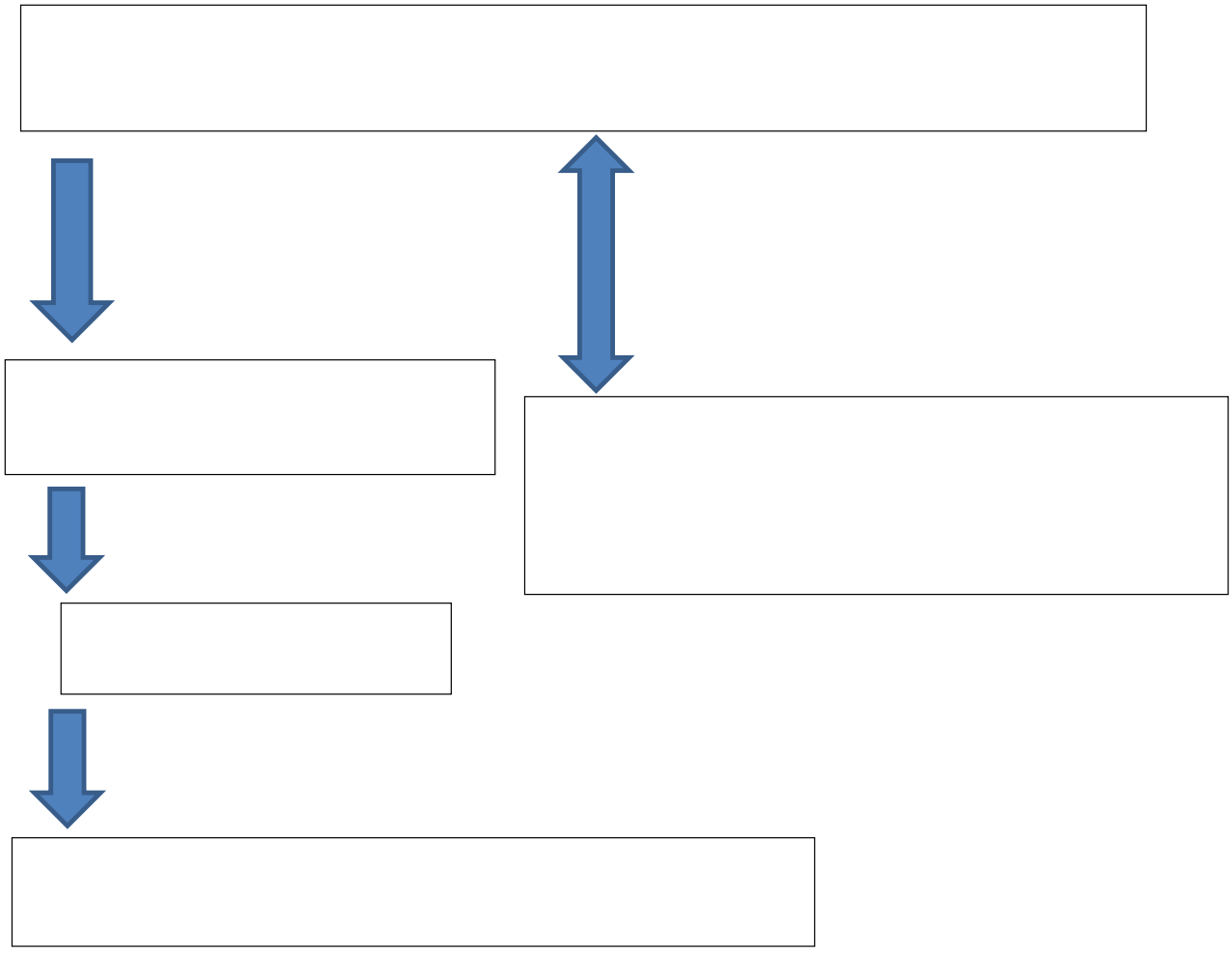
For a DOLS to exist the 'Acid Test' must be met – Person **LACKS CAPACITY**

NOT FREE TO LEAVE

REQUIRES CONTINUOUS SUPERVISION

[Assessment conducted by Best Interests Assessor and Section 12 DoLS Doctor]

[DoLS can be in place for a maximum of 12 months - Safe detention]



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 May 2015 (note: time periods of data are different for each source).

CCG Key Performance Indicators

NHS Constitution Indicators	Footprint	
A&E 4 Hour Waits	CCG	
Ambulance Category A Calls (Red 1)	CCG	
Cancer 2 Week GP Referral	CCG	
RTT 18 Week Incomplete Pathway	CCG	
Other Key Targets		
A&E 4 Hour Waits	S&ORM	
Ambulance Category A Calls (Red 2)	CCG	
Ambulance Category 19 Transportation	CCG	
Ambulance Category 19 Transportation	NWAS	
Cancer 2 Week GP Referral	CCG	
Cancer 2 Week GP Referral	S&ORM	
Cancer 2 Week Urgent GP Referral - Breast Symptoms	CCG	
Cancer 62 Day Standard	CCG	
Cancer 62 Day Standard	S&ORM	
HCAI - C.Diff	CCG	
HCAI - C.Diff	S&ORM	
HCAI - MRSA	S&ORM	
Local Measure: Diabetes	CCG	
Stroke	S&ORM	
TIA	CCG	
TIA	S&ORM	

Key Information from this report

The financial position for Southport and Formby CCG as at 30 June 2015 (Month 3) is £0.133m underspent on operational budget areas before the application of reserves or contingency. The forecast outturn is £0.227m overspent. The CCG experienced significant financial pressures in the last financial year and a number of risks continue into the new financial year. Although budgets have been increased for growth, there are cost pressures emerging which will need close management if the CCG is to achieve the planned surplus. In addition, plans to achieve the CCG's QIPP requirement of £6.151m have not yet been fully identified.

A&E waits – Year to date the CCG achieved 93.78% against a 95% target (in-month May achieving 94.4%). The CCG have failed the target since October in 2014. Southport & Ormskirk achieved 93.26% year to date (in-month May 93.96%) again failing the target. The Trust have also failed the target each month since October 2014. At the July CQPG the Trust presented their A&E improvement plan, this will be monitored via the SRG and the CQPGs.

Ambulance Activity - Category A Red 1, 8 minute response time – The CCG recorded 72.20% year to date failing to achieve the 75% target (but performance has improved in-month at 81.6%). The CCG are also failed Category A Red, 2 recording 73.40% year to date against a 75% target (but performance has improved in-month 77.6%). Category 19 Transportation recording 90.90% year to date also failing the 95% target (in-month 95%). NWAS have achieved both Cat A targets and are flagged as green. Although NWAS are failing the Category 19 target recording 94.80% in year to date and are flagged as amber.

Cancer Indicators – For April the CCG are failing 3 cancer indicators. The 3 indicators are, 2 week wait which is reporting 90.07% against a target of 93%, 2 week breast symptom which is reporting 88.24% also against a target of 93% and the 62 day standard which is report 80.56% against a target of 85%. Southport & Ormskirk are also failing their 2 week wait target and are reporting 92.52% and 62 day standard which is 83.52% year to date. Some actions are being addressed across the entire cancer network footprint.

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

Measure – April 2015	Southport & Ormskirk	England Average
Inpatient – response	14.8%	26.8%
Recommended	93.1%	95.7%
Not Recommended	2.9%	1.4%
A&E – response	5.1%	14.1%
Recommended	87.6%	88.3%
Not Recommended	7.7%	6.0%

HCAI – C difficile – The CCG is failing the monthly target for C difficile year to date, (actual 10 / plan 6) Year-end plan 38. Southport & Ormskirk are also failing the monthly target for C difficile year to date (actual 8 / plan 6), Year-end plan is 36 cases.

HCAI – MRSA – In May the CCG had no new cases of MRSA. Southport & Ormskirk had no new cases in May, however, there was 1 new case reported for Southport & Ormskirk in April, the case is related to a West Lancashire CCG patient. The trust are over the zero tolerance so will remain red for the rest of 2015-16.

Patient Safety Incidents Reported – Southport & Ormskirk reported 12 Serious Untoward Incidents in May, bringing the year to date total to 37. Of the 12, 10 were pressure ulcers grade 3 and 4 and 2 were for sub-optimal care of the deteriorating patient.

Stroke 90% time on stroke unit – Southport & Ormskirk failed to achieve the 80% target in May, only 24 patients out of 34 spending at least 90% of their time on a strok unit, 10 breaches (70.59%).
TIA assessed and treated within 24 hours – The CCG failed the 60% target in May (0%). There were a total of 3 high risk patients all of which were not assessed and treated within 24 hours. Southport & Ormskirk also failed the target with 2 out of 6 high risk patients getting assess and treated within 24 hours (33.3%).

2. Financial Position

2.1 Summary

This report focuses on the financial performance for Southport and Formby CCG as at 30 June 2015 (Month 3). The financial position is £0.133m underspent at Month 3 on operational budget areas before the application of reserves or contingency. The forecast outturn is £0.227m overspent.

The CCG experienced significant financial pressures in the last financial year and a number of risks continue into the new financial year. Although budgets have been increased for growth, there are cost pressures emerging which will need close management if the CCG is to achieve the planned surplus.

In addition, plans to achieve the CCG's QIPP requirement of £6.151m have not yet been fully identified.

Figure 1 Financial Dashboard

Key Performance Indicator	This Month	Prior Month
1% Surplus	✓	✓
0.5% Contingency Reserve	✓	✓
2.5% Non-Recurrent Headroom	✓	✓
Financial Surplus / (Deficit) before the application of reserves - £'000	(£0.227m)	£0.00m
Unmet QIPP to be identified > 0	£5.789m	£6.151m
CCG running costs < National 2015/16 target of £22.07 per head	✓	✓
NHS - Value YTD > 95%	98.4%	99.0%
NHS - Volume YTD > 95%	82.6%	90.2%
Non NHS - Value YTD > 95%	90.3%	90.3%
Non NHS - Volume YTD > 95%	92.2%	91.8%

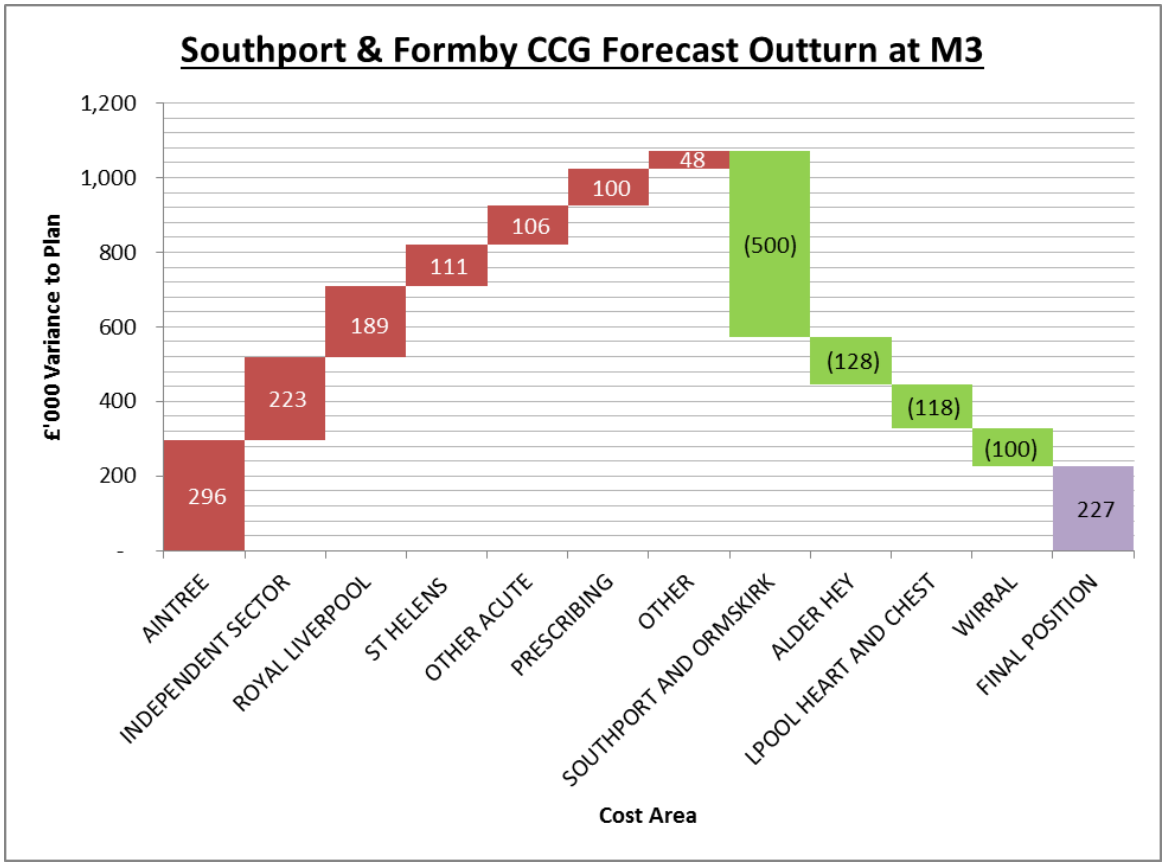
2.2 Resource Allocation

The Resource Allocation has increased by £0.371m in Month 3 in respect of the Primary Care IT budget allocations.

2.3 Financial Position and Forecast

The forecast financial position is based on data received for the year to date. For Acute Commissioning budgets, this is data up to the end of May 2015. It should be noted that at this stage in the financial year, forecasting can be difficult and subject to variation.

Figure 2 Forecast Outturn at Month 2



Southport and Ormskirk NHS Trust

Acute commissioning

Whilst the financial reporting period relates to the end of June, the CCG has based its reported position on activity information received from acute trusts to the end of May 2015.

Southport and Ormskirk NHS Trust

The contract for 2015/16 is still yet to be agreed with the Trust. The element of the contract that covers activity reported under national rules (Payment by Results) has been agreed and the Trust has presented data in relation to this activity. The latest contract offer has been reflected in the budget, but contract negotiations are ongoing regarding the locally negotiated prices for a number of services. The Trust is requesting a further £0.400m from the CCG. This dispute remains unresolved.

The CCG has received month two data from the Trust which shows an underspend of £0.367m against the phased contract for PbR services. The underspend is in the following areas:

- Non-elective (including short stay admissions) - £0.231m. This is 6.6% lower than budget. One of the reasons for the underspend is the non-charging of GPAU activity. GPAU attendances that do not end in admission are currently not being charged by the Trust. They have sought a local price, and the CCG is awaiting further analysis from the Trust before

agreeing. GPAU activity under the Trust proposed price is valued at £0.084m at month 2. It is therefore only one of the reasons for the current underspend against emergency activity.

- New outpatient attendances - £0.098m. 20% lower than plan.
- Follow-up outpatient attendances - £0.042m. 5.7% lower than plan.

The Trust are unable to explain the extent of the underspends in both outpatient and emergency care. They continue to analyse the data, and are expected to report further findings in late July to the Information sub-group.

Aintree NHS Foundation Trust

The forecast out-turn overspend at Aintree is £0.296m. The Month 2 data shows an overspend for both Aged Related Macular Degeneration (ARMD) outpatient appointments and drugs. There are also overspends within excluded drugs at the Trust. ARMD continues to be an area of significant growth for the CCG.

Independent Sector Providers

The forecast out-turn overspend for Independent Sector providers is £0.223m. This is projected using on month one data received from the providers. The majority of this overspend (£0.200m) is with Ramsay Healthcare. There are also forecast overspends within Spire Healthcare.

Continuing Health Care (Adult) / Funded Nursing Care

This area continues to be a high risk for the CCG, and annual budgets have been increased in 2015/16 by 5% from the activity levels seen in the latter part of last year.

The current forecast for this budget is an underspend of £0.050m. The month 2 data from the CSU showed a drop in estimated costs. The reported forecast reflects the current number of patients and average package costs, and builds in an estimate of growth between now and the end of the year. If growth in patient numbers or prices is not realised, then the forecast position will be reduced.

2.4 QIPP

The QIPP savings target for Southport and Formby CCG is £6.151m for 2015/16. This has reduced slightly to £5.789m following reductions in contract value with a number of providers and reflecting move to cost per case for Cheshire and Merseyside rehab services.

The CCG has a QIPP Committee that identifies, evaluates and monitors QIPP schemes. There is also a 1% Transformation Fund in reserves which was established to fund transformational initiatives that would result in more efficient delivery of healthcare and improvements to quality. In addition, the CCG has invested in system resilience schemes that are aimed at reducing emergency care.

A number of schemes have recently been approved and are being implemented:

- Telehealth in nursing homes – initial scheme will cover 15 homes, with anticipated reductions in expenditure of £0.400m.
- Respiratory primary care training – Anticipated savings of £0.785m

Both schemes will take time to deliver the savings, and progress will be monitored via the QIPP Committee. When schemes are deemed to be embedded and delivering, the CCG will reduce operational budgets and offset the QIPP reserve with the savings made.

2.5 CCG Running Costs

The CCG is currently operating within its running cost target of £2.606m. The target has been reduced in 2015/16 to £22.07 per head (from £24.81 per head in 2014/15). Plans agreed by the Governing Body to meet this target have been implemented and the relevant budgets reduced.

The current year forecast for these budgets is an underspend of £0.023m due to vacant posts.

2.6 Evaluation of Risks and Opportunities

The CCG's primary risk is non-achievement of the QIPP requirement. A further £5.789m of savings must be realised in 2015/16 in order to achieve financial targets on a recurrent basis. In addition, there are a number of other risks that require monitoring and managing:

- Acute cost per case contracts – The CCG has experienced significant growth in acute care in previous years. Although historic growth has been factored into plans, there is a risk that activity will continue to grow beyond budgeted levels.
- Southport & Ormskirk NHS Trust – There remains a number of contract issues with S&O relating to the prices for some services that aren't governed by national prices. The difference across the four services where the parties have not reached agreement is £0.400m. The CCG is seeking a solution with the Trust without recourse to an independent party for decision.
- Continuing Healthcare Costs – The CCG experienced significant growth in costs for continuing healthcare in 2014/15. The CCG has increased its budgets by 5%, and is focussing on reviewing high cost packages. The risk of overspending is augmented not only by increases in patient numbers, but also increases in the price. The framework is being renewed in year, and may result in increased prices. A number of providers are already pursuing higher prices.
- Continuing Healthcare restitution claims – The CCG has contributed to a national risk pool in line with the values previously notified by NHS England. Reserves were set aside for this purpose. There is a risk that claims made nationally will exceed the value of the risk pool and further contributions from CCGs will be sought.
- Estates – The methodology for charging estates costs is expected to change in 2015/16. Previously, the costs had been based on historic charges. In 2015/16, the organisation that administers the LIFT buildings will be charging based on actual usage. The implementation of this change has been delayed to quarter 3. The CCG has set aside reserves to cover estates costs, but up to date cost estimates have not yet been received by the CCG.

- Prescribing / Drugs costs – This is a volatile area of spend, and is also subject to potential pricing changes halfway through the year. To date, only 1 months' worth of data has been received showing a small overspend against budget.

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

Figure 3 Summary of Financial position

	Recurrent £000	Non-Recurrent £000	Total £000
Target surplus	1.800		1.800
Unidentified QIPP	(6.151)		(6.151)
Revised surplus / (deficit)	(4.351)		(4.351)
Forecast (against operational budgets)	(0.227)		(0.227)
Contingency reserves	1.581		1.581
Transformation Fund slippage		0.500	0.500
Unutilised reserves	0.263	1.642	1.905
Quality Premium:			
Confirmed element		0.138	0.138
Awaiting further development		0.092	0.092
QIPP:			
CM Rehab	0.300		0.300
Contract Adjustments	0.062		0.062
Forecast surplus / (deficit)	(2.372)	2.372	0.000
Risks	(1.050)		(1.050)
Risk adjusted forecast surplus / (deficit)	(3.422)	2.372	(1.050)

The CCG is on course to deliver its breakeven target and must find further savings totalling £1.8m to deliver its target surplus. There are further risks that will need to be closely monitored to prevent the CCG reporting a deficit position in this year. The risks are difficult to quantify with certainty because it is still early in the year.

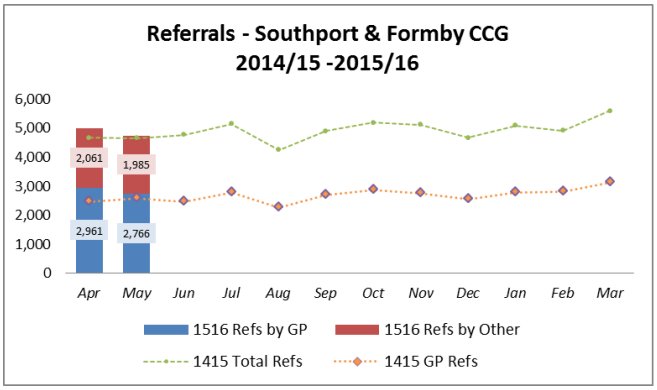
Failure to deliver all of the QIPP on a recurrent basis in 2015/16 will increase the financial pressure in future years. The financial challenges will continue into 2016/17 and it is imperative that the CCG instigates actions to recover the financial position to ensure recurrent balance by the end of this financial year.

The risk of not achieving the CCGs financial surplus target has been escalated within the CCGs risk reporting framework and must be considered as the CCGs top priority alongside commissioning safe services.

3. Referrals

3.1 Referrals by source

Figure 4 Number of GP and 'other' referrals for the CCG across all providers for 2015/16



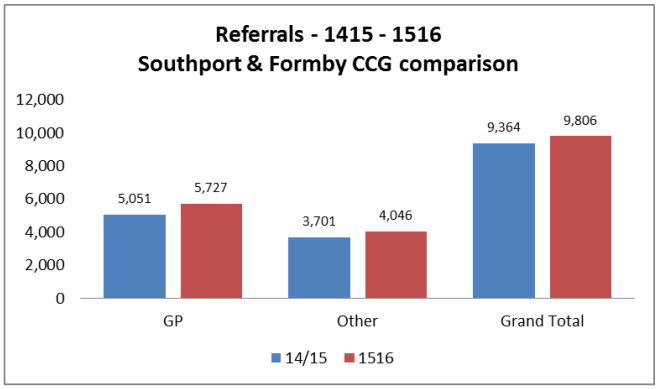


Figure 5 GP Referrals by Specialty 1516 YTD v Average of 1314-1415 YTD.

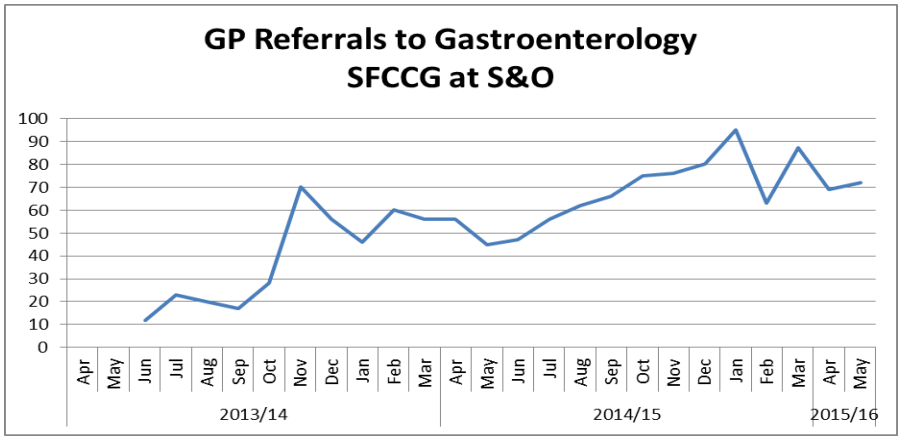
GP REFERRALS	YTD Apr - May			
	Average YTD Total (1314-1415)	1516 YTD Total	1516 Difference to average	% Variance
RESPIRATORY MEDICINE	103.5	247	144	139%
ENT	404	547	143	35%
BREAST SURGERY	120	223	104	87%
DERMATOLOGY	291	392	102	35%
GASTROENTEROLOGY	61	156	95	156%
CARDIOLOGY	147	234	88	60%
TRAUMA & ORTHOPAEDICS	184	256	73	40%
OBSTETRICS	5	75	71	1567%
RHEUMATOLOGY	90	158	68	76%
UROLOGY	185	235	51	27%
CLINICAL PHYSIOLOGY	86	132	46	53%
CLINICAL HAEMATOLOGY	97	141	45	46%
PHYSIOTHERAPY	862	903	42	5%
ENDOCRINOLOGY	35	57	23	65%
PAEDIATRICS	125	145	20	16%
ALL OTHER	2278	1826	-452	-20%
Grand Total	**5069**	**5727**	**658**	**13%**

The rise in obstetrics may be mirrored in a reduction in another maternity associated specialty e.g. Midwifery. Enquiries with Southport & Ormskirk Hospital are ongoing to understand if this is a simple shift in coding to a different specialty or a genuine increase. Since the IT system upgrade at the Trust,

the Trust are using less of the General Medicine/General Surgery specialty codes and more specific cods such as Respiratory Medicine. This may explain why “All other” specialties have reduced by 20%.

The increase in Gastroenterology referrals is widespread across practices in both Southport and Formby and indeed South Sefton. A number of cancer awareness campaigns have been carried out recently and may explain the increase in referrals.

Figure 6 Total Gastroenterology GP Referrals, per month, to S&O.

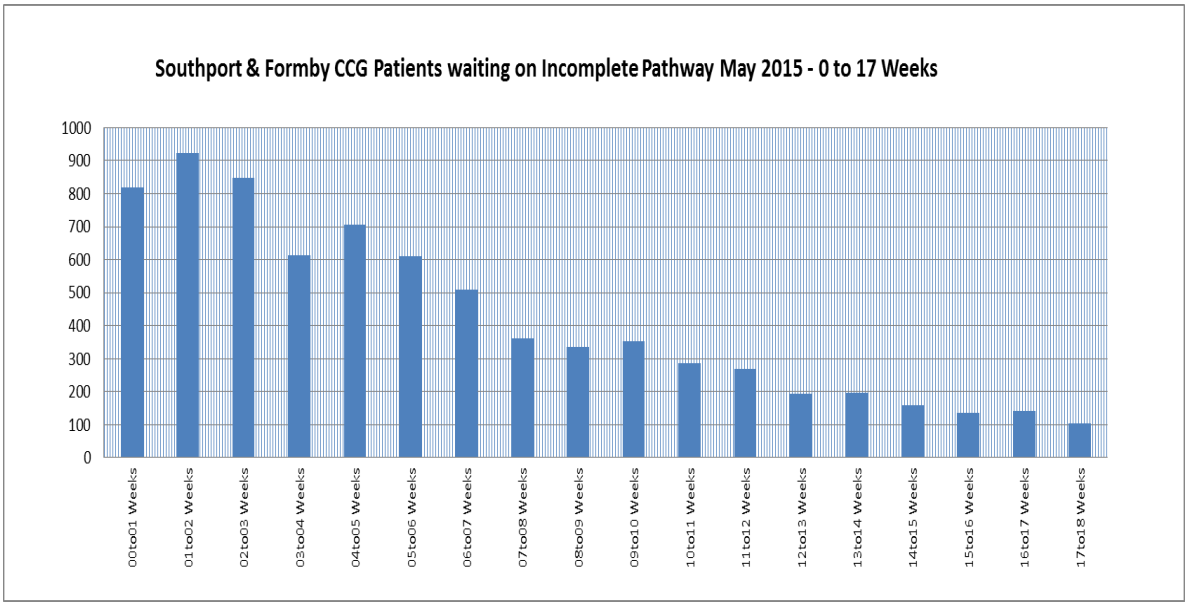


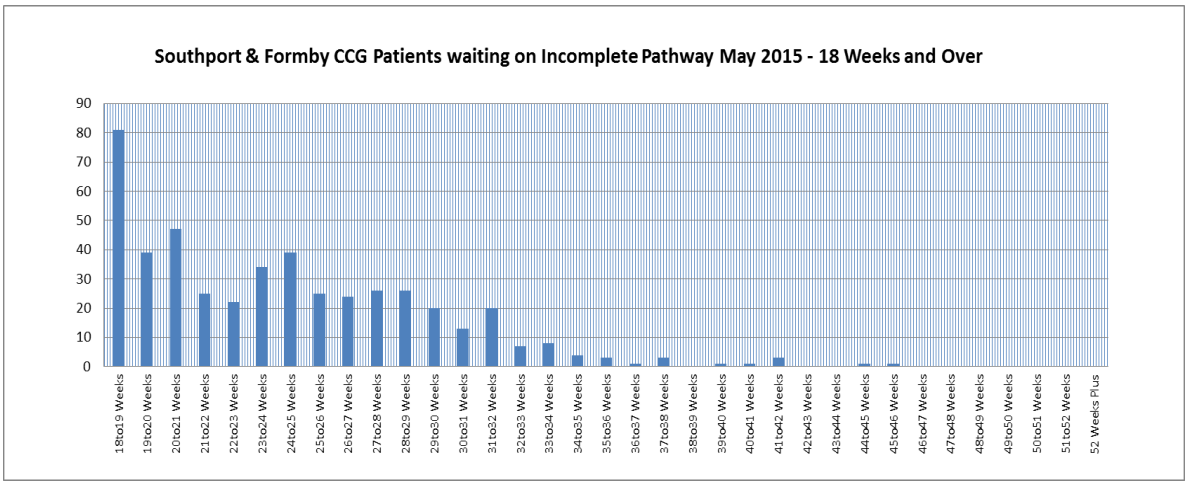
4. Waiting Times

4.1 NHS Southport and Formby CCG patients waiting

Please note the 24th June 2015 announcement from NHS England, Monitor and the Trust Development Agency that the he admitted and non-admitted operational standards are being abolished, and the incomplete standard will become our sole measure of patients’ constitutional right to start treatment within 18 weeks.

Figure 7 Patients waiting on an incomplete pathway by weeks waiting





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	4492	1027	5519	218	144	49	411	5930
RENACRES HOSPITAL	447	121	568	0	0	0	0	568
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	383	87	470	8	0	0	8	478
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	311	72	383	8	8	7	23	406
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	62	41	103	0	2	2	4	107
Other Providers	383	138	521	14	6	8	28	549
Total All Providers	6078	1486	7564	248	160	66	474	8038

4.3 Provider assurance for long waiters

Figure 9 Southport RTT caseload

Admitted Pathway	Wait experience						
Specialty	30	31	32	36	38	39	Grand Total
Dermatology		1					1
ENT	1						1
General Medicine				1		1	2
Ophthalmology			1				1
Pain Management					1		1
Trauma & Orthopaedics	1						1
Grand Total	2	1	1	1	1	1	7

Admitted Pathway	TCI							
Specialty	27/07/2015	03/08/2015	06/08/2015	10/08/2015	16/08/2015	25/08/2015	not dated	Grand Total
Dermatology						1		1
ENT				1				1
General Medicine		1			1			2
Ophthalmology			1					1
Pain Management		1						1
Trauma & Orthopaedics	1							1
Grand Total	1	1	1	1		1	2	7

Ongoing (incomplete pathways)	Wait experience												
Specialty	30	31	32	33	34	35	36	37	38	39	40	41	Grand Total
Cardiology				1	1								2
Clinical Oncology	2	2	1										5
Dermatology		2											2
Endocrinology		1		1				1	1				4
ENT	1												1
Gastroenterology	13	13	11	10	10	18	14	8	7	9	4	2	119
General Medicine							1			1			2
Neurology	1												1
Ophthalmology			1	1									2
Pain Management									1				1
Plastic Surgery												1	1
Respiratory Medicine	1												1
Rheumatology						1							1
Trauma & Orthopaedics	1												1
Urology		1											1
Grand Total	19	19	13	13	11	19	15	9	9	10	4	3	144

5. Planned Care

5.1 All Providers

Agreed 2015/16 plans have been used, where applicable. Where 1516 plans have not yet been agreed or loaded, the 2014/15 Month 2 position has been used. The providers using 1415 position are:

- Southport & Ormskirk Trust
- Isight
- Wirral
- Renacres

Performance at Month 2 of financial year 2015/16, against planned care elements of the contracts held by NHS Southport & Formby CCG shows an over-performance of circa £318k.This over-performance is driven by increases at Renacres Hospital (£37k), Royal Liverpool (£25k) and St Helens & Knowsley Hospitals (£34k).

Figure 10 All Providers (Excl. S&O)

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	13,962	2,244	2,506	262	11.70%	£2,814	£453	£466	£13	2.84%
Alder Hey Childrens NHS F/T	5,048	755	740	-15	-1.94%	£627	£94	£101	£7	7.56%
Countess of Chester Hospital NHS Foundation Tr	0	0	14	14	0.00%	£0	£0	£1	£1	0.00%
Liverpool Heart and Chest NHS F/T	1,622	251	245	-6	-2.40%	£913	£141	£133	-£9	-6.04%
Liverpool Womens Hospital NHS F/T	2,398	398	355	-43	-10.74%	£727	£120	£123	£3	2.17%
Royal Liverpool & Broadgreen Hospitals	14,718	2,324	2,260	-64	-2.74%	£3,093	£488	£514	£25	5.19%
ST Helens & Knowsley Hospitals	4,280	683	725	42	6.12%	£946	£150	£184	£34	22.67%
Wirral University Hospital NHS F/T	315	50	33	-17	-33.94%	£103	£16	£9	-£7	-44.54%
Central Manchester University Hospitals Nhs Fou	236	39	32	-7	-18.64%	£44	£7	£5	-£2	-25.52%
Fairfield Hospital	103	14	10	-4	-29.43%	£27	£4	£2	-£2	-51.91%
ISIGHT (SOUTHPORT)	2,518	420	525	105	25.10%	£582	£97	£132	£35	36.21%
Renacres Hospital	8,079	1,347	2,128	781	58.03%	£3,130	£522	£559	£37	7.18%
SPIRE LIVERPOOL HOSPITAL	866	134	136	2	1.52%	£229	£35	£42	£6	18.23%
University Hospital Of South Manchester NHS FT	199	33	47	14	41.86%	£36	£6	£11	£5	76.23%
Wrightington, Wigan And Leigh Nhs FT	2,163	360	437	77	21.22%	£1,031	£166	£173	£7	4.17%
	56,507	**9,051**	**10,193**	**1,142**	**12.62%**	**£14,303**	**£2,302**	**£2,455,648**	**£154**	**14.88%**

5.2 Southport and Ormskirk Hospital NHS Trust

Figure 11 Month 2 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	11,747	1,985	2,087	102	5.14%	£6,367	£1,076	£1,175	£99	9.18%
Elective	1,554	265	267	2	0.75%	£4,142	£706	£675	-£30	-4.31%
Elective Excess BedDays	315	54	19	-35	-64.81%	£70	£12	£5	-£7	-58.89%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	800	134	96	-38	-28.36%	£129	£21	£16	-£5	-24.42%
OPFASPCL - *Outpatient first attendance single professional consultant led*	18,095	3,023	2,449	-574	-18.99%	£2,767	£462	£369	-£93	-20.09%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	1,885	315	285	-30	-9.52%	£198	£33	£31	-£2	-5.09%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	45,503	7,602	7,093	-509	-6.70%	£4,188	£700	£659	-£41	-5.85%
Outpatient Procedure	20,351	3,400	3,481	81	2.38%	£3,599	£601	£620	£19	3.19%
Unbundled Diagnostics	10,220	1,707	1,632	-75	-4.39%	£820	£137	£139	£2	1.14%
Grand Total	**110,470**	**18,485**	**17,409**	**-1,076**	**-5.82%**	**£22,280**	**£3,749**	**£3,690**	**-£59**	**-1.56%**

5.2.1 Southport & Ormskirk Hospital Key Issues

Although Daycases are showing a £99k over performance against plan, under performance in Outpatients First & Follow Ups amounts to a -£59k under performance in Planned Care against 2015/16 Month 2 plan. Trauma & Orthopaedics and General Surgery are the 2 main contributors. Analysis shows a possible shift in T&O from Electives to Daycases. This is also coupled with a shift from some daycase activity to Outpatient Procedure. This will be raised with the provider through the contract review meeting mechanism.

5.3 Renacres Hospital

Figure 12 Month 2 Planned Care- Renacres Hospital by POD

Renacres Hospital 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	934	156	225	69	44.46%	£1,380	£230	£241	£11	4.88%
Elective	224	37	28	-9	-25.17%	£738	£123	£141	£18	14.63%
OPFASPCL - *Outpatient first attendance single professional consultant led*	2,625	438	567	129	29.58%	£468	£78	£77	-£1	-1.27%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	1,792	299	1,024	725	242.86%	£273	£46	£63	£17	37.11%
Outpatient Procedure	1,732	289	120	-169	-58.43%	£204	£34	£21	-£13	-37.74%
Unbundled Diagnostics	771	128	164	36	27.63%	£66	£11	£16	£5	46.21%
Grand Total	**8,079**	**1,347**	**2,128**	**781**	**58.03%**	**£3,130**	**£522**	**£559**	**£37**	**7.18%**

5.3.1 Renacres Hospital Key Issues

Daycases make up the majority of Renacres planned care over performance. The cost continues to be driven by activity in T&O under the HRG “HB51Z - Major Hand Procedures for non Trauma Category 2” and “HB61C - Major Shoulder and Upper Arm Procedures for Non-Trauma without CC”.

NB: 1516 plans have now been received and will be ready and loaded for Month 3 reporting.

6. Unplanned Care

Performance at Month 2 of financial year 2015/16, against unplanned care elements of the contracts held by NHS Southport & Formby CCG shows an over-performance of circa £7k.Royal Liverpool is showing a £51k over performance, which is offset by under performance in the majority of other Providers.

6.1 All Providers

Figure 13 Month 2 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	1,865	315	212	-103	-32.65%	£915	£154	£134	-£20	-13.13%
Alder Hey Childrens NHS F/T	773	133	124	-9	-6.74%	£379	£63	£44	-£19	-30.33%
Countess of Chester Hospital	0	0	5	5	0.00%	£0	£0	£1	£1	0.00%
Liverpool Heart and Chest NHS F/T	133	22	18	-4	-18.65%	£421	£70	£63	-£7	-9.86%
Liverpool Womens Hospital NHS F/T	247	41	42	1	2.69%	£202	£33	£47	£14	40.90%
Royal Liverpool & Broadgreen Hospitals	1,083	181	281	100	55.66%	£644	£107	£159	£51	47.80%
ST Helens & Knowsley Hospitals	398	67	68	1	1.95%	£214	£35	£28	-£7	-19.70%
Wirral University Hospital NHS F/T	112	19	15	-4	-20.72%	£45	£8	£6	-£2	-20.79%
Central Manchester University Hospitals	88	15	9	-6	-38.64%	£30	£5	£1	-£4	-83.73%
University Hospital Of South Manchester	47	8	5	-3	-36.90%	£8	£1	£6	£5	360.20%
Wrightington, Wigan And Leigh	62	10	14	4	35.48%	£53	£9	£5	-£4	-44.96%
Grand Total	**4,808**	**810**	**793**	**-17**	**-2.08%**	**£2,910**	**£486**	**£493**	**£7**	**1.48%**

6.2 Southport and Ormskirk Hospital NHS Trust

Figure 14 Month 2 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	35,509	5,973	5,869	-104	-1.74%	£3,951	£665	£659	-£5	-0.80%
NEL/NELSD - *Non Elective/Non Elective IP Same Day*	11,175	1,907	1,788	-119	-6.24%	£19,185	£3,274	£3,090	-£183	-5.60%
NELNE - *Non Elective Non-Emergency*	1,254	214	298	84	39.25%	£2,115	£361	£319	-£42	-11.54%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	217	37	30	-7	-18.92%	£68	£12	£10	-£2	-14.64%
NELST - *Non Elective Short Stay*	1,776	303	240	-63	-20.79%	£1,242	£212	£165	-£47	-22.34%
NELXBD - *Non Elective Excess Bed Day*	5,298	904	819	-85	-9.40%	£1,113	£190	£170	-£20	-10.60%
Grand Total	**55,229**	**9,338**	**9,044**	**464**	**4.97%**	**£27,674**	**£4,713**	**£4,413**	**-£299**	**-6.35%**

6.3 Southport and Ormskirk Hospital NHS Trust Key Issues

Southport & Ormskirk Trust is reporting a -£299k underspend for PBR activity and finance within Unplanned Care. This is attributable to a large under spend within NEL which is reporting a -£231k under spend.

(NB: Further plan-actual analysis can take place when we receive the agreed 1516 plan file. PBR plan received but cant be loaded into reporting portal until NonPBR is also signed off)

7. Mental Health

7.1 Mersey Care NHS Trust Contract

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

	NHS Southport and Formby CCG			
PBR Cluster	Plan	Caseload (Apr-2015)	Variance from Plan	% Variance
0 Variance	32	40	8	25%
1 Common Mental Health Problems (Low Severity)	35	20	(15)	-43%
2 Common Mental Health Problems (Low Severity with greater need)	45	28	(17)	-38%
3 Non-Psychotic (Moderate Severity)	162	193	31	19%
4 Non-Psychotic (Severe)	128	135	7	5%
5 Non-psychotic Disorders (Very Severe)	29	24	(5)	-17%
6 Non-Psychotic Disorder of Over-Valued Ideas	25	27	2	8%
7 Enduring Non-Psychotic Disorders (High Disability)	96	119	23	24%
8 Non-Psychotic Chaotic and Challenging Disorders	62	60	(2)	-3%
10 First Episode Psychosis	52	65	13	25%
11 On-going Recurrent Psychosis (Low Symptoms)	282	283	1	0%
12 On-going or Recurrent Psychosis (High Disability)	151	158	7	5%
13 On-going or Recurrent Psychosis (High Symptom & Disability)	105	107	2	2%
14 Psychotic Crisis	18	19	1	6%
15 Severe Psychotic Depression	7	6	(1)	-14%
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	6	7	1	17%
17 Psychosis and Affective Disorder – Difficult to Engage	35	28	(7)	-20%
18 Cognitive Impairment (Low Need)	365	258	(107)	-29%
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	465	741	276	59%
20 Cognitive Impairment or Dementia Complicated (High Need)	159	196	37	23%
21 Cognitive Impairment or Dementia (High Physical or Engagement)	50	50	-	0%
Reviewed Not Clustered	30	34	4	13%
No Cluster or Review	46	90	44	96%
Total	2,385	2,688	303	13%

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

	Follow up from Inpatient Discharge		Apr-15	May-15
E.B.S.3	The % of people under adult mental illness specialities who were followed up within 7 days of discharge from psychiatric inpatient care	95%	100.0%	100.0%

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

	Follow up from Inpatient Discharge		Apr-15	May-15
KPI_32	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%

7.2 Improving Access to Psychological Therapies Contract

Figure 18 Prevalence and Recovery

CCG name	Month	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	15/16 total
Southport and Formby CCG	First treatment numbers required each month to deliver equivalent to the CCG 2015/16 plan (should equate to 3.75% each quarter)	195.2	195.2	195.2	195.2	195.2	195.2	195.2	195.2	195.2	195.2	195.2	195.2	2342.4
	Actual First Treatment Numbers delivered	151	153	153										457
	Current First treatment number shortfall this month *(automatically generated)*	-44.2	-42.2	-42.2	-195.2	-195.2	-195.2	-195.2	-195.2	-195.2	-195.2	-195.2	-195.2	-1885.4
	The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).							19079						
	Monthly Access rate *(automatically generated)*	0.79%	0.80%	0.80%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
	Quarterly Access rate *(automatically generated)*		2.40%			0.00%			0.00%			0.00%		2.40%
	Actual Recovery Rate delivered (%)	48%	36%	45%										
	Planned % of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period													
	Actual % waiting 6 weeks or less	72%	92%	91%										
	Planned % of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.													
	Actual % waiting 18 weeks or less	98%	100%	100%										

8. Community Health

8.1 Southport and Ormskirk Community Health

Wheelchair Service: Activity in this service remains above plan but is lower than the same time last year. A business case has been put together and is currently under discussion within the trust as it requires substantial investment in IT hardware. An update is awaited.

Podiatry Non AQP-There has been a shift in activity between clinic based and community contacts.
Integrated Care- The trust has opened the debate around whether this service should be classified as an acute or community service. Historically staffing funding has been via the community route. At the moment the activity is not recorded on any electronic systems or manually, however what is clear is that the activity needs to be reported on in any case. A resolution to this issue is awaited.

CERT-The trust have not reported on this services performance and have explained that this is due to technical reasons related to EMIS and its functionality and the difficulties that have been experienced extracting data. The trust has logged a number of jobs with EMIS to resolve this and to date it still remains unresolved. To date an update on progress is awaited.
Community Matrons have also moved to EMIS and technical issues has affected the reporting at month 2 with elements of activity not included within the reporting. Awaiting an update from the trust on progress to resolve this issue.

Community Gynaecology-The trust have provided data however it does not includes the capture of onward referrals. The service is due to migrate to EMIS in 2016 when this issue will be rectified. This is all part of the on-going discussions around this service with the commissioner

Waiting Times
Work is on-going to set appropriate wait targets by service as the national RTT targets are inappropriate for community services. The trust has been reminded again at the finance and information group that it was agreed that thematic reasons would be provided on a monthly basis around breaches.

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 Finance and Information Group.
There is likely to be general implications during the year as the trust move from the IPM community system to EMIS and Medway.

Any Qualified Provider
The locally agreed assessment tariff of £25 is being used from 1st April in the podiatry AQP dataset; however a query has been raised with them in relation to patients discharged at first visit and charged at the tariff price. A response is awaited.

Bridgewater
Paediatric Audiology

100 % of patients (Initial Appointments) are waiting less than 11 weeks (threshold is 60%)
First DNA is above the 10% threshold and follow up DNA is 7% threshold. The position for initials has worsened from 23.1% in April to 27.3% in May. Follow up DNAs have improved to 5.4% in May from 19.4% in April. The longest wait was remains at 5 weeks. All patients are waiting under 11 weeks. Bridgewater has transferred a member of staff from the previous provider, and is in the process of recruiting another two members of staff. The trust has been asked to update on the recruitment process.

Liverpool Community Health Trust
The trust has not provided an exception report around service performance at month 1 or 2 despite this being promised at month 2. This was discussed at the recent Finance and information group and the commissioner has agreed that it is now to be included at month 3. A query log has been sent to LCH and a response is awaited.
Overall adult services demand and activity is above planned levels at month 2, with children's demand and activity below plan.

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.
IV therapy: demand and activity below plan even though both have increased compared to last month.

A review and cleanse of waiting list will be done in June 2015 as the trust report that most of the maximum waits are due to data quality issues.
Waiting times are not being recorded for several services: Community Cardiac/Heart Failure, IV Therapy. The development of waiting time thresholds is part of the work plan for the FIG as currently the default of 18 weeks is being used**.**

Patient Identifiable data

The Trusts Caldicott guardian has requested that no patient identifiable data sets are to be released from the trust. This includes all national submissions such as those made to the secondary user's service e.g. Inpatient, outpatient and WIC CDS. This was escalated last year and the commissioner and trust are in discussions about this and an update is awaited.

9. Third Sector Contracts

The NHS Standard Contract 2015/16 has been populated and issued to Providers for signature.

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)**	15/16 - May	6	10	↓	There were 3 new cases reported in May 2015, against a monthly plan of 3, which was an improvement on the April figure of 7 cases reported. The 3 new cases were reported by Southport and Ormskirk Hospital (1 apportioned to acute and 2 apportioned to community). Year-end plan is 38.	The majority of Southport & Formby CCG C.difficile cases belong to Southport & Ormskirk Hospitals .Please see below for Southport & Ormskirk's narrative.
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Southport & Ormskirk)**	15/16 - May	6	8 (4 following appeal)	↓	There were 3 new cases reported in May 2015, against a monthly plan of 3 cases. The 3 cases were aligned to Southport and Formby CCG. Year to date plan is 36.	The 2015/16 target is 36 attributable cases i.e an average of no more that 3 cases per month. In May the Trust had 3 new cases - 8 YTD, however following the root cause analysis , it was decided 3 of these would go to appeal. The first 2015/16 Appeals Panel met on 26th June and 4 out of the the 5 cases submitted were upheld . Antimicrobial prescribing remains good. The focus remains on early isolation of patients with diarrohia and close liason with infection prevention control team particularly when side rooms are not available. P*lease 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)**	15/16 - May	0	0	↔	No new cases reported in May 2015.	
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Southport & Ormskirk)**	15/16 - May	0	1	↔	No new cases have been reported in May 2015. The trust are above the zero tolerance so will remain red for the rest of 2015-16.	In April 2015 The Trust had an MRSA bacteraemia and are therefore over the annual trajectory of zero. A Patient's Infection Review (PIR) has been completed in collaboration with the CCG and reported to Public Health England. Primary Care and Secondary Care issues have been identified and will be reported back to SEMT in a formal de-brief to ensure lessons have been learnt and embedded. The standard of care provided by the Critical Care Unit should be highlighted and commended for a 12 month zero rate of central venous catheter related infections. This has been accomplished through continued excellent use of aseptic technique, clinical decision making of where lines are sited combined with the relative recent innovation of chlorhexidine impregnated discs at line insertion sites. *Please Note - Data has been taken from the National HCAI Database - this is updated centrally therefore not all local appeals will be reflected in the table.*
Enhancing quality of life for people with long term conditions						
Patient experience of primary care i) GP Services	Jul-Sept 14 and Jan-Mar 15		4.44%	New Measure		
Patient experience of primary care ii) GP Out of Hours services	Jul-Sept 14 and Jan-Mar 15		10.98%	New Measure		
Patient experience of primary care i) GP Services ii) GP Out of Hours services (Combined)	Jul-Sept 14 and Jan-Mar 15	6%	5.18%	New Measure		

Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s(Cumulative)	15/16 - May	93.97	64.07	New Plans	The agreed plans are based on activity for the same period last year. The decrease in actual admissions is 7 below the same period last year.	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	15/16 - May	201.4	155.55	New Plans	The agreed plans are based on activity for the same period last year. The decrease in actual admissions is 56 lower the same period last year.	
Emergency Admissions Composite Indicator(Cumulative)	15/16 - May	404.29	364.32	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. The CCG is under the monthly plan and had 146 less admissions than the same period last year.	
IAPT Access - Roll Out	Q1 15/16	3.25%			No data at present for month 1 and 2, new services mobilised in April 2015	
IAPT - Recovery Rate	Q1 15/16	50.00%				
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	Q1 15/16	75.00%				
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period	Q1 15/16	95%				
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.	This has been chosen as the CCG Quality Premium measure for 2015/16. Clinical engagement between primary and secondary care is taking place to understand how each can support. Proposal to use Shared Decision Aids with patients being discussed at QIPP, Quality Committees and Locality Lead GP meetings.
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)	15/16 - May		15.02	↔		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	15/16 - May	21.36	21.36	New Plans	The agreed plans are based on activity for the same period last year. (Numbers are generally very low for this indicator).	
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	15/16 - May	279.17	204.67	New Plans	The agreed plans are based on activity for the same period last year. This indicator is below plan, the decrease in actual admissions is 91 lower the same period last year.	

% who had a stroke & spend at least 90% of their time on a stroke unit **(CCG)**	15/16 - May	80%	81.82%	↑		
% who had a stroke & spend at least 90% of their time on a stroke unit **(Southport & Ormskirk)**	15/16 - May	80%	70.59%	↓	Southport & Ormskirk have failed to achieve the target in May, only 24 patients out of 34 spending at least 90% of their time on a stroke unit.	The main reason for the beaches relate to pressures across the Trust. Actions - There will be a relocation of beds within urgent care that will facilitate a dedicated stroke ward. This will assist in ensuring that patients are allocated to the correct area, particularly in times of pressure. 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)**	15/16 - May	60%	0.00%	↓	In May the CCG failed the target for TIA, there were a total of 3 high risk patients at Southport & Ormskirk which weren't assessed and treated within 24 hours.	
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Southport & Ormskirk)**	15/16 - May	60%	33.33%	↓	Southport & Ormskirk failed to achieve the target in May, with only 2 high risk patients out of 6 being assessed and treated within 24 hours.	The Trust failed the standard for TIA in month with performance of 33% against a 60% target. Intotal four patients breached the target out of six treated. The reasons for breaches were: * Two patients were offered compliant clinic slots, within 24 hours, but declined those appointments. Both were seen at a mutually agreed clinic after the 24 hour period. * One patient was seen in A&E at 08.15 and seen the following day in clinic at 10.00 * One patient attended A&E on Saturday of the first Bank Holiday weekend where there is no consultant capacity. No adverse outcomes were experienced by those patients not seen within 24 hours. Due to the number of patients within the service a small number of breaches affecting compliance against the target. Whilst the Trust have increased capacity patient choice and weekend presentations still pose a risk for future months.
Mental health						
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative) **(CCG)**	14/15 - Qtr4	95%	97.00%	↑		
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)**	15/16 - April	93%	90.07%	↓	Southport & Formby CCG a failed the target for April. In April 44 patients were not seen within 14 days out of a total of 443. Days waited were between 15 and 35. Of the 44 breaches 7 were at Aintree, 1 at The Royal Liverpool and 36 at Southport & Ormskirk. The main reasons for the breaches were patient cancellation and patient re-arranging their appointments.	Please see below for Southport & Ormskirk Hospital narrative, underperformance at Royal will be discussed with Liverpool CCG, Aintree achieved their trust target in April and May.
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Southport & Ormskirk)**	15/16 - April	93%	92.52%	↓	Southport & Ormskirk a failed the target for April. In April 47 patients were not seen within 14 days out of a total of 628. Days waited were between 15 and 27. The main reasons for the breaches were patient choice, patient cancellation, patient holidays and patient re-arranging their appointments.	The Trust failed to achieve the two week GP referral target for April, the main areas of non-compliance were upper GI, colorectal and head and neck. Non compliance with the two week wait standard is disappointing given that the Trust met the standard every month last year. The two main reasons for the breaches in month: * A number of patients had accepted appointments within the timescales yet these were not accepted by patients * The Trust experienced some capacity issues for head and neck patients resulting in leave cover arrangements by Aintree Hospital. The Trust is revising the SLA with Aintree to ensure that capacity is available to cover consultant leave. Early indications from May indicate that the Trust will be compliant . Current performance forecast predicts 95.6%
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(CCG)**	15/16 - April	93%	88.24%	↓	Southport & Formby CCG a failed the target for April (and year to date). In April 4 patients were not seen within 14 days out of a total of 34. 3. There was 1 breach due to admin delay in booking 1st appointment the rest were patient cancellation and re-arrangement.	Southport & Formby CCG missed the 93% target due to a small number of breaches (3 patient choice, 1 admin delay), 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)**	15/16 - April	93%	N/A	↔	Southport & Ormskirk no longer provide this service.	
Cancer waits – 31 days						
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	15/16 - April	96%	97.47%	↓		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Southport & Ormskirk)**	15/16 - April	96%	98.51%	↓		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	15/16 - April	94%	95.83%	↓		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Southport & Ormskirk)**	15/16 - April	94%	100.00%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	15/16 - April	94%	100.00%	↑		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Southport & Ormskirk)**	15/16 - April	94%	100.00%	↑		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	15/16 - April	98%	100.00%	↑		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Southport & Ormskirk)**	15/16 - April	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)**	15/16 - April		85.71%	↓		
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)**	15/16 - April		93.75%	↑		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	15/16 - April	90%	100.00%	↑		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(Southport & Ormskirk)**	15/16 - April	90%	100.00%	↑		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	15/16 - April	85%	80.56%	↓	The CCG failed the target for April , there were 7 breaches out of a total of 36 patients	The majority of the breaches occurred at Southport & Ormsirk Hospital, please see below for details.
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Southport & Ormskirk)**	15/16 - April	85%	83.52%	↓	The Trust have failed the target for April, there were the equivalent of 7.5 breaches out of 45.5 patients.	The Trust failed to achieve the 62 day GP referral to treatment target in April with performance at 83.5% against the 85% target. There were a number of contributory factors that impacted on performance. A robust Situational Breach Analysis Report (SBAR) for all breaches is executed each month. The main themes in April are: * An adminastrative error by another provider who incorrectly uploaded a paused patient as a breach. * Three patients would have been treated compliantky but were unfit for treatment at the time. * A number of issues regarding the head and neck pathway with another provider. Discussions have begun with a local provider regarding improvements to pathways, a revised SLA will be developed and signed. Approval for a head and neck Clinical Specialist Nurse post to support co-ordination both internally and across external providers involved in pathways. The Lung pathway is being reviewed network wide due to common issues across mulitiple providers.
Mixed Sex Accommodation Breaches						
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(CCG)**	15/16 - May	0.00	0.00	↔		
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(Southport & Ormskirk)**	15/16 - May	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)**	15/16 -May	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(Southport & Ormskirk)**	15/16 -April	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(CCG)**	15/16 -May	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(Southport & Ormskirk)**	15/16 -April	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	15/16 -May	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Southport & Ormskirk)**	15/16 -April	0	0	↔		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(CCG)**	15/16 - May	90%	87.91%	↑	Southport & Formby CCG failed to achieve the target of 90% for the fourth consecutive month, achieving 87.91%. This is an improvement on last month's figure of 85.04% This month's activity equates to 82 patients 695 not being seen within 18 weeks. Please see speciality breakdown below:- • T&O (30) • Ophthalmology (16) • Urology (9) • Gynaecology (4) • General Surgery (6) • ENT (6) • Cardiology (1) • Plastic Surgery (1) • All Other (9)	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)**	15/16 - April	90%	79.84%	↔	The Trust failed to achieve the target of 90% in April achieving 79.84%. This equates to 197 patients out of 997 not been seen within 18 weeks. These breaches were in the following specialities:- General Surgery (16) Urology (21) T&O (69) Ophthalmology (42) ENT (10) Oral Surgery (10) General Medicine (1) Dermatology (1) Gynaecology (10) All other (17)	The Trust continues to make progress toward Trust-level compliance for July reporting. At the beginning of April there were a total of 15,886 open pathways. And 1,332 patients with a wait experience of 18 weeks or longer. These figures in June are 12,634 and 805 respectively. The admitted pathway backlog is 140 and the overall list is 2,075. The Trust are still some way from their target of 10 breached patients. However, additional activity has been scheduled in June in a number of specialties which will assist the Trust reach compliance in July. The number of admitted clock stops has increased to over 1000 per month in April and May, this is driving some over performance on day cases as the Trust continues the focus on reducing the number of long waits. Actions previously advised continue to be delivered. A contract query was issued to Southport & Ormskirk in late May, regarding all aspects of RTT performance and the Trust have responded outlining their action plan and a target to achieve compliance for July 2015 reporting. See below for Trust exception narrative.

Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(CCG)**	15/16 - May	95%	95.23%	↑		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(Southport & Ormskirk)**	15/16 - April	95%	93.15%	↓	The Trust narrowly failed to achieve the target of 95% in April achieving 93.15%. This equates to 319 patients out of 4660 not been seen within 18 weeks. These breaches were in: General Surgery (23) Urology (12) T&O (33) Ophthalmology (40) ENT (35) Oral Surgery (5) General Medicine (19) Gastroenterology (8) Cardiology (44) Dermatology (43) Rheumatology (6) Gynaecology (2) Other (49)	The Trust continues to make progress toward Trust-level compliance for July reporting. At the beginning of April there were a total of 15,886 open pathways. And 1,332 patients with a wait experience of 18 weeks or longer. These figures in June are 12,634 and 805 respectively. The admitted pathway backlog is 140 and the overall list is 2,075. The Trust are still some way from their target of 10 breached patients. However, additional activity has been scheduled in June in a number of specialties which will assist the Trust reach compliance in July. The number of admitted clock stops has increased to over 1000 per month in April and May, this is driving some over performance on day cases as the Trust continues the focus on reducing the number of long waits. Actions previously advised continue to be delivered. A contract query was issued to Southport & Ormskirk in late May, regarding all aspects of RTT performance and the Trust have responded outlining their action plan and a target to achieve compliance for July 2015 reporting. See below for Trust exception narrative.
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(CCG)**	15/16 - May	92%	94.11%	↔		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(Southport & Ormskirk)**	15/16 - April	92%	93.49%	↔		
A&E waits						
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG)**	15/16 - May	95.00%	93.76%	↑	Southport & Formby CCG failed the 95% target in May reaching 94.4% and also year to date reaching 93.76%. In May 168 attendances out of 3000 were not admitted, transferred or discharged within 4 hours.	Please see below for Southport & Ormskirk Hospital narrative.
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Southport & Ormskirk)**	15/16 - May	95.00%	93.26%	↑	Southport & Ormskirk have failed the cumulative target in May, but the May month result of 93.96% was an improvement on the April month result of 92.7%. In May month 536 attendances out of 8871 were not admitted, transferred or discharged within 4 hours. The Trust have failed the target each month since October 2014.	May attendances at Southprt A&E are in line with those in May 2014, admissions from A&E are higher in May than in the same period over the last two years. The admission rate has fallen compared against the high levels experienced during the winter period 2014-15, the trust continues to face a more complex co-hort of patients resulting in a raised admissions rate. The change of pattern of attendences with a greater proportion of patients classified as major continues through May further highlight the complexity and acuity of patients presenting through the Southport site. At the July CQPG the Trust presented their A&E improvement plan, this will be monitored via the SRG and the CQPGs.

Diagnostic test waiting times						
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	15/16 - May	1.00%	0.69%	↓		
% of patients waiting 6 weeks or more for a Diagnostic Test **(Southport & Ormskirk)**	15/16 - April	1.00%	0.35%	↓		
Category A ambulance calls						
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	15/16 - May	75%	72.20%	↑	The CCG achieved the 75% target in May achieving 81.6% but failing year to date due to the April performance.	May data indicates improvement: Red 1 81.6% (green). R2 77.6% (green), all reds now green. Cumulative CCG performance is still below target.
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	15/16 - May	75%	73.40%	↑	The CCG achieved the 75% target in May achieving 77.6% but failing year to date due to the April performance.	
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	15/16 - May	95%	90.90%	↑	The CCG achieved the target in May achieving 95.0% but again are failing due to the April performance.	
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	15/16 - May	75%	76.40%	↑		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	15/16 - May	75%	75.80%	↑		
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	15/16 - May	95%	94.80%	↔	NWAS just failed to achieve the 95% target in May but there was an improvement in performance from the April figure of 93.3%	

10.2 Friends and Family – Southport and Ormskirk Hospital NHS Trust

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

Friends and Family Response Rates and Scores
Southport & Ormskirk
May 2015

Clinical Area	Response Rate (RR) Target	RR Actual (May 2015)	RR - Trajectory From Previous Month (Apr 15)	Percentage Recommended (England Average)	Percentage Recommended (May 2015)	PR Trajectory From Previous Month (Apr 15)	Percentage Not Recommended (England Average)	Percentage Not Recommended (May 2015)	PNR Trajectory From Previous Month (Apr 15)
Inpatients	30%	14.8%	↑	95%	93%	↓	2%	3%	↓
A&E	20%	5.1%	↑	87%	88%	↑	6%	8%	↑
Q1 - Antenatal Care	N/A	-	-	95%	97%	↑	1%	3%	↑
Q2 - Birth	N/A	25.8%	↑	97%	96%	↑	1%	0%	↑
Q3 - Postnatal Ward	N/A	-	-	93%	98%	↑	2%	0%	↑
Q4 - Postnatal Community Ward	N/A	-	-	98%	98%	↑	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.

- Southport & Ormskirk Hospital NHS Trust continues to experience difficulties in relation to the above three parts for both inpatients and A&E. Despite showing an inprovemnet in response rates for both inpatients and A&E compared to the previous month, the rates are still extremely poor, and the poorest in the Mersey region.
- The percentage of patients that would recommend the inpatient service in the trust has decreased from the previous month and is lower than the England average. Although higher than the national average, the percentage of people who would not recommend the inpatient service has reduced from the previous month.
- The opposite is the cae in A&E where the percentage of people who would recommend the service has increased from the previous month to 88%, and surpasses the England average. However the

percentage of people who would not recommend the A&E service has increased from the previous month and is higher than the England average.

- For maternity services, aside from the percentage of people that would not recommend Antenatal Care being higher than the England average, the trust has improved in both percentage that would recommend the service against all questions and have shown an improvement against the percentage of people who wouldn't recommend the service against all questions compared to the previous month.
- The trust compares favourable against the England average in all areas.
- Friends and Family is a standing agenda item on the Clinical Quality Performance Group (CQPG), which is a joint meeting between the trust and the CCG. An action plan has been developed by the trust, for which the Director of Nursing is accountable. This action plan seeks to address the areas of poor performance.
- The Engagement and Patient Experience Group (EPEG) have sight of the trusts friends and family data on a monthly basis and seek assurance from the trust that areas of poor patient experience are being addressed. Health Watch Sefton are members of EPEG and also attend the trust's patient experience group and directly ask the organisation specific questions about poor Friends and Family response rates and recommendations.

10.3 Serious Untoward Incidents (SUIs)

SUIs Reported at Southport & Formby CCG level

These are serious incidents involving Southport and Formby CCG patients irrespective of their location of care.

There were 6 Serious Incidents in April involving Southport and Formby CCG patients and 10 in May.

CCG SUIs

Type of Incident	Apr	May	YTD
Attempted Suicide by Outpatient (in receipt)		1	1
Pressure ulcer - (Grade 3)	3	6	9
Pressure ulcer - (Grade 4)	2		2
Sub-optimal care of the deteriorating patient		2	2
Surgical Error		1	1
Unexpected Death (general)	1	1	2
Grand Total	**6**	**11**	**17**

Incident Split by Provider

Provider / Type of Incident	Apr	May	YTD
Aintree University Hospital NHS Foundation Trust			
Unexpected Death (general)	1	1	2
Liverpool Women's NHS Foundation Trust			
Surgical Error		1	1
Mersey Care NHS Trust			
Attempted Suicide by Outpatient (in receipt)		1	1
Southport and Ormskirk Hospital NHS Trust			
Pressure ulcer - (Grade 3)	3	6	9
Pressure ulcer - (Grade 4)	2		2
Sub-optimal care of the deteriorating patient		2	2
Grand Total	**6**	**11**	**17**

Number of Never Events reported in period

One Never Event involved a Southport and Formby CCG patient. This Never event happened in the Liverpool Women's NHS Foundation Trust. It occurred in May 2015 and was a surgical error

Number of Southport & Formby CCG Incidents reported by Provider

The majority of incidents have occurred in Southport & Ormskirk Hospital (13), with one incident occurring in each of the following providers:

- Aintree University Hospital NHS Foundation Trust
- Liverpool Women's NHS Foundation Trust
- Mersey Care NHS Trust

Southport & Ormskirk Hospital Serious Incidents

Number of Serious Untoward Incidents (SUIs) reported in period

Southport and Ormskirk Hospital

Provider SUIs

Incident Type	Apr	May	YTD
Pressure ulcer - (Grade 3)	15	8	23
Pressure ulcer - (Grade 4)	8	2	10
Sub-optimal care of the deteriorating patient	1	2	3
Unexpected Death of Inpatient (in receipt)	1		1
Grand Total	**25**	**12**	**37**

Incidents Split by CCG

CCG Name / Incident Type	Apr	May	YTD
South Sefton CCG			
Pressure ulcer - (Grade 3)	1	1	2
Pressure ulcer - (Grade 4)	1		1
Southport & Formby CCG			
Pressure ulcer - (Grade 3)	3	6	9
Pressure ulcer - (Grade 4)	2		2
Sub-optimal care of the deteriorating patient		2	2
West Lancashire CCG			
Pressure ulcer - (Grade 3)	11	1	12
Pressure ulcer - (Grade 4)	5	2	7
Sub-optimal care of the deteriorating patient	1		1
Unexpected Death of Inpatient (in receipt)	1		1
Grand Total	**25**	**12**	**37**

In April and May Southport & Ormskirk Hospital Integrated Care Organisation (ICO) reported 37 serious incidents. These are incidents that involved patients under the care of that organisation and those patients may be from CCGs other than Southport and Formby CCG.

Number of Never Events reported in period

Southport & Ormskirk Hospital Integrated Care Organisation (ICO) reported zero Never Events in April and May 2015

Number of repeated incidents reported YTD

The Trust has had three incidents repeated in April and May 2015/16.

- 23xPressure ulcer – (Grade 3)
- 10xPressure ulcer – (Grade 4)
- 3xSub-optimal care of the deteriorating patient

Number of Incidents reported by CCG

The trust has had patients from 3 different CCGs involved in serious incidents.

- South Sefton CCG – 3
- Southport and Formby CCG – 13
- West Lancashire CCG - 21

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 2015/16

Indicator		A&E Attendance rate per 1000 for under 19's (12 Mths to May-15)			A&E Attendance rate per 1000 for 19-74 yrs (12 Mths to May-15)			A&E Attendance rate per 1000 for over 75's (12 Mths to May-15)			Emergency Admission rate per 1000 for under 19's (12 Mths to May-15)			Emergency Admission rate per 1000 for 19-74 yrs (12 Mths to May-15)			Emergency Admission rate per 1000 for over 75's (12 Mths to May-15)		
Code	Practice	Period	Result	Score	Period	Result	Score	Period	Result	Score	Period	Result	Score	Period	Result	Score	Period	Result	Score
N84012	AINSDALE MEDICAL CENTRE	May-15	50.20	0	May-15	105.60	3	May-15	211.67	3	May-15	26.67	3	May-15	34.08	3	May-15	134.44	3
N84014	AINSDALE VILLAGE SURGERY	May-15	52.17	0	May-15	119.01	2	May-15	197.98	3	May-15	37.87	2	May-15	38.50	2	May-15	122.83	3
N84024	GRANGE SURGERY	May-15	36.89	3	May-15	121.55	2	May-15	253.85	2	May-15	35.59	2	May-15	43.15	0	May-15	171.69	2
N84037	LINCOLN HOUSE SURGERY	May-15	62.32	0	May-15	137.58	0	May-15	289.03	0	May-15	41.16	0	May-15	44.36	0	May-15	189.87	0
N84625	THE FAMILY SURGERY	May-15	49.08	0	May-15	143.40	0	May-15	320.39	0	May-15	55.71	0	May-15	50.57	0	May-15	235.44	0
N84005	CUMBERLAND HOUSE SURGERY	May-15	39.89	3	May-15	126.18	0	May-15	319.47	0	May-15	47.49	0	May-15	41.72	2	May-15	198.03	0
N84013	CURZON ROAD MEDICAL PRACTICE	May-15	58.28	0	May-15	165.73	0	May-15	366.47	0	May-15	55.78	0	May-15	51.10	0	May-15	250.74	0
N84021	ST MARKS MEDICAL CENTRE	May-15	51.09	0	May-15	172.90	0	May-15	318.38	0	May-15	50.39	0	May-15	56.03	0	May-15	211.32	0
N84617	KEW SURGERY	May-15	43.49	2	May-15	144.52	0	May-15	315.32	0	May-15	34.09	3	May-15	45.42	0	May-15	225.23	0
Y02610	TRINITY PRACTICE	May-15	30.98	3	May-15	205.44	0	May-15	456.68	0	May-15	52.73	0	May-15	69.65	0	May-15	334.84	0
N84006	CHAPEL LANE SURGERY	May-15	52.98	0	May-15	84.24	3	May-15	217.39	3	May-15	26.49	3	May-15	29.17	3	May-15	145.69	3
N84018	THE VILLAGE SURGERY FORMBY	May-15	48.44	0	May-15	85.40	3	May-15	208.67	3	May-15	33.36	3	May-15	31.31	3	May-15	143.48	3
N84036	FRESHFIELD SURGERY	May-15	43.54	2	May-15	94.65	3	May-15	223.81	3	May-15	42.75	0	May-15	38.28	2	May-15	183.33	0
N84618	THE HOLLIES	May-15	49.83	0	May-15	93.23	3	May-15	214.13	3	May-15	30.51	3	May-15	33.93	3	May-15	149.01	3
N84008	NORWOOD SURGERY	May-15	45.40	2	May-15	117.97	2	May-15	250.26	2	May-15	36.32	2	May-15	40.95	2	May-15	173.18	2
N84017	CHURCHTOWN MEDICAL CENTRE	May-15	36.52	3	May-15	125.90	0	May-15	280.27	0	May-15	38.87	2	May-15	46.54	0	May-15	206.62	0
N84032	SUSSEX ROAD SURGERY	May-15	40.17	3	May-15	97.94	3	May-15	196.68	3	May-15	22.95	3	May-15	25.79	3	May-15	118.48	3
N84611	ROE LANE SURGERY	May-15	49.34	0	May-15	108.55	3	May-15	262.20	2	May-15	33.92	3	May-15	29.93	3	May-15	173.78	2
N84613	THE CORNER SURGERY (DR MULLA)	May-15	49.29	0	May-15	108.91	3	May-15	280.81	0	May-15	35.30	2	May-15	44.41	0	May-15	174.17	2
N84614	THE MARSHSIDE SURGERY (DR WAINWRIGH	May-15	37.45	3	May-15	116.34	2	May-15	232.27	3	May-15	39.47	0	May-15	40.58	2	May-15	173.76	2
	Southport & Formby Average		46.07			124.66			264.04			39.21			42.44			179.50	

Figure 21 Summary of Primary Care Dashboard – Example Locality Summary

Southport & Formby CCG
North Southport Practice Local Scorecard
July - 2015/16

Under Construction

		Frequency	Latest Update	N84008	N84017	N84032	N84611	N84613	N84614
Urgent Care	A&E Attendance rate per 1000 for under 19's	Monthly	May-15	45.40	36.52	40.17	49.34	49.29	37.45
	A&E Attendance rate per 1000 for 19-74 yrs	Monthly	May-15	117.97	125.90	97.94	108.55	108.91	116.34
	A&E Attendance rate per 1000 for over 75's	Monthly	May-15	250.26	280.27	196.68	262.20	280.81	232.27
	Emergency Admission rate per 1000 for under 19's	Monthly	May-15	36.32	38.87	22.95	33.92	35.30	39.47
	Emergency Admission rate per 1000 for 19-74 yrs	Monthly	May-15	40.95	46.54	25.79	29.93	44.41	40.58
	Emergency Admission rate per 1000 for over 75's	Monthly	May-15	178.18	206.62	118.48	173.78	174.17	173.76
Referrals	GP Referrals to Secondary Care - Dec 2014	Monthly	Jul-15	10.11	17.30	2.04	10.13	16.18	11.43
	C&B GP referrals to Secondary Care - Dec 2014	Monthly	Jul-15	1.68	2.60	0.58	1.01	2.48	2.10
	Non C&B Referrals to Secondary Care - Dec 2014	Monthly	Jul-15	0.73	0.05	0.00	0.41	1.30	0.57
	Cancer Fast Track Referrals - Dec 2014	Monthly	Jul-15	9.39	17.26	2.04	9.72	14.87	10.86
Prescribing	Lipid Modifying Drugs: Ezetimibe % Items	Quarterly	Q4 14/15	2.93	2.53	6.18	3.91	3.21	4.53
	Hypnotics ADQ/STAR PU (ADQ based)	Quarterly	Q4 14/15	0.23	0.5	0.52	0.31	0.16	0.41
	Antidepressants: First choice % Items	Quarterly	Q4 14/15	68.52	64.75	59.55	71.05	72.44	59.45
	Antibacterial Items/STAR PU	Quarterly	Q4 14/15	0.23	0.37	0.22	0.27	0.35	0.36
	Minocycline ADQ/1000 Patients	Quarterly	Q4 14/15	21.9	10.23	0	0	14.61	0
	NSAIDs Ibuprofen & Naproxen % Items	Quarterly	Q3 14/15	90.17	81.03	79.75	79.89	82.39	77.59
	NSAIDs ADQ/STAR PU	Quarterly	Q4 14/15	1.58	0.9	1.81	1.63	1.53	1.8
	Wound care products: NIC/Item	Quarterly	Q4 14/15	18.8	22.57	23.04	13.68	12.45	17.34
	Rosuvastatin as % All Statin	Quarterly	Q4 14/15	2.18%	3.55%	1.16%	1.95%	1.42%	1.16%
	Dosulepin as a % of All Antidepressants	Quarterly	Q4 14/15	0.00%	1.31%	1.12%	0.00%	0.46%	1.53%
	Specials per 1000 Item based ASTRO PU	Quarterly	Q4 14/15	0.26	0.30	0.51	0.02	0.31	0.12
	Urology Products Total Actual Cost	Quarterly	Q4 14/15	145.34	1551.53	0	0	242.29	164.17
	Potential Generics Sevings	Quarterly	Q4 14/15	5007.89	4155.33	682.35	1192.49	716.84	2175.64
	Enteral Sip Feeds NIC/PU	Quarterly	Q4 14/15	0.212	0.367	0.062	0.27	0.116	0.172
QoF	Estimated percentage of detected CHD prevalence	Annual	2010/11	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	Estimated percentage of detected COPD prevalence	Annual	2010/11	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	Estimated percentage of detected hypertension prevalence	Annual	2010/11	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	Estimated percentage of detected stroke prevalence	Annual	2010/11	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	Estimated percentage of detected diabetes prevalence	Annual	2008/09	#N/A	#N/A	#N/A	#N/A	#N/A	#N/A
	The contractor establishes and maintains a register of patients with atrial fibrillation	Annual	2013/14	1.91%	2.36%	2.00%	2.93%	1.82%	1.67%
	The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months	Annual	2013/14	7.66%	7.02%	5.78%	7.86%	6.19%	5.04%
	The contractor practice establishes and maintains a register of all cancer patients defined as a register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003	Annual	2013/14	2.72%	3.65%	3.26%	3.01%	3.36%	2.29%
	The contractor establishes and maintains a register of patients with coronary heart disease	Annual	2013/14	3.53%	5.13%	3.55%	4.40%	4.55%	3.49%
	The contractor establishes and maintains a register of patients aged 18 years and or over with CKD (US National Kidney Foundation: Stage 3 to 5 CKD)	Annual	2013/14	3.24%	4.00%	2.52%	6.23%	4.76%	3.60%
	The contractor establishes and maintains a register of patients with COPD	Annual	2013/14	2.01%	2.74%	1.72%	2.97%	2.32%	1.86%
	The contractor establishes and maintains a register of patients diagnosed with dementia	Annual	2013/14	0.63%	1.03%	0.52%	1.30%	0.96%	0.27%
	The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed	Annual	2013/14	4.65%	6.05%	5.56%	6.19%	6.06%	3.99%
	The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy	Annual	2013/14	0.80%	0.87%	0.57%	0.81%	0.36%	0.74%
	The contractor establishes and maintains a register of patients with heart failure	Annual	2013/14	1.01%	1.05%	1.26%	1.83%	0.83%	1.05%
	The contractor establishes and maintains a register of patients with established hypertension	Annual	2013/14	16.49%	19.95%	14.26%	15.72%	17.39%	14.73%
	The contractor establishes and maintains a register of patients aged 18 or over with learning disabilities	Annual	2013/14	0.44%	0.52%	0.17%	0.53%	0.29%	0.50%
	The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy	Annual	2013/14	0.83%	0.81%	1.55%	1.06%	0.62%	0.70%
	The contractor establishes and maintains a register of patients aged 16 or over with a BMI greater than or equal to 730 in the preceding 12 months	Annual	2013/14	6.32%	5.99%	11.11%	11.93%	8.22%	7.09%
	The contractor establishes and maintains a register of patients with peripheral arterial disease	Annual	2013/14	0.74%	0.79%	0.97%	0.86%	0.91%	0.74%
	The percentage of patients aged 15 or over whose notes record smoking status in the preceding 24 months	Annual	2013/14	84.06%	86.27%	91.87%	91.77%	91.79%	92.11%
	The contractor establishes and maintains a register of patients with stroke or TIA	Annual	2013/14	2.10%	2.71%	1.89%	3.10%	2.24%	2.09%
	The contractor establishes and maintains a register of patients with hypothyroidism who are currently treated with levothyroxine	Annual	2013/14	3.34%	3.88%	3.78%	3.99%	4.55%	4.08%

NHS Southport and Formby Clinical Commissioning Group

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Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Wednesday, 20th May 2015	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions

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

- March financial report presented – delivery of financial duties subject to external audit verification.
- Noted update in terms of CSU progress – update to GB Part II in May.
- Estates working group to be established in June.
- Discussion in terms of how to use benchmarking:
  - urgent care group
  - locality working
  - planned care (outpatient referrals)
- Noted QIPP opportunities
  - prescribing waste } as priorities
  - CHC }

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Audit Committee Meeting held on Wednesday, 20th May 2015	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions

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

- Local Counter Fraud Plan 2015/16 approved.
- Annual report and accounts approved subject to minor changes and final external audit verification. Expected sign-off date is 27th May.
- Annual Audit Letter to be presented to Governing Body in July meeting.
- New auditors appointed (KPMG); introductory meeting planned for 29th June.

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Minutes

Wednesday 20th May 2015, 9.30am to 11.30am
Family Life Centre, Ash Street, Southport

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

No	Item	Action
FR15/50	**Apologies for absence** Apologies for absence were received from Fiona Clark, Jan Leonard, Tracy Jeffes, Karl McCluskey and Malcolm Cunningham.	
FR15/51	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflicts of interest.	
FR15/52	**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.	
FR15/53	**Action points from the previous meeting** ***FR15/24 Estates Utilisation*** *– see agenda item FR15/58.* ***FR15/42 External Updates/Benchmarking and VFM reports -*** *JL/BD to explore whether a community team re cellulitis would be beneficial* – DF confirmed she had liaised with Billie Dodd and, based on the information available and one of the CQUINs with SMO, they believe cellulitis will be built in with SMO. ***FR15/45 Better Care Fund Update*** – see agenda item FR15/63. All other actions were closed as appropriate.	
FR15/54	**Month 12 Finance Report** This report presented the Finance and Resource Committee with an overview of the year end financial position for NHS Southport and Formby CCG at 31 March 2015. The financial position was £4.583m overspend on operational budget areas before the application of reserves. Regarding BPPC, MMcD said that improvements should begin to be seen as the treasury function has now been brought in-house. Re CHC, MMcD said he would like the CCG to refocus its efforts and asked for DF and DS to take control of this. DF stated she and DS are to have a telecon with the CSU to discuss CHC. MMcD stressed the importance of making this process work in order to see improved use of resources. MMcD said he would like to see a range of payments received on this and said that the CCG should aim to set a maximum payment, stating the requirement for a cost control exercise. RP said that the long term financial challenge in this area will only increase as people are living longer, and more people are diagnosed with dementia. MMcD said he felt the CCG had exceeded what it should be paying and would like assurance that high cost mental health cases have been reviewed by the June meeting.	DS/DF

No	Item	Action
	Action taken by the Committee The Committee noted the content of the report.	
FR15/55	**Case for Change** MMcD confirmed that Case for Change is now to be transferred to the QIPP Committee. **Action taken by the Committee** The Committee noted the update.	
FR15/56	**CSU Procurement** This report provided the Committee with an update on the proposal for the future procurement of commissioning support services. MMcD stated that that the CCG will no longer buy its commissioning support services from the CSU, but instead will procure services from the Lead Provider Framework (LPF). There is to be one contract with one supplier. He noted that it was important to focus on ensuring that good quality local services were retained through the LPF. MMcD confirmed that the Corporate Governance Manager and Business Manager roles have been filled by Lisa Gilbert and Judy Graves respectively, noting a couple of positions remained outstanding. **Action taken by the Committee** The Committee approved the recommendation to take the proposal to the Governing Body.	
FR15/57	**Prescribing Performance Report** This report presented the Committee with an update on prescribing spend for February 2015; the position for the month is a forecast overspend of £386k on a budget of £20.1m. In relation to Category M drugs SL stated that the analysts were working on this as there remains variation between practices. Also, there had been a problem with a coding error and a surgery in Ainsdale was picking up costs for Wigan CCG. SL is to speak to SBS regarding a refund and will advise DS accordingly. HM noted that people coming to Southport on respite were sometimes requesting 2-4 months of prescriptions and MMcD said this could be explored further, to understand the extent of the pressure and potential actions open to the CCG. MMcD said an improvement might be seen next year if the same level of uplift was maintained, and said wasting prescriptions could potentially be explored. MMcD noted that the 2015/16 budget uplift exceeded the 2014/15 trend, and highlighted that significant levels of waste exist in terms of patient use of prescribing, and that we should explore the opportunity to reduce this.	

No	Item	Action
	Action taken by the Committee	
	The Committee noted the content of this report	
FR15/58	**Estates Working Group** MMcD updated the Committee and confirmed that although the Estates Working Group had not yet been formed, he had met with Community Health Partnerships who are keen to work with the CCG to bring together a Sefton-wide Estates Working Group. He outlined that the initial focus would be on identifying options for currently unutilised parts of the estate. He then noted that there are wider issues faced eg primary care, over a 5, 10 and 15 year period. MMcD is to meet with Sam McCumiskey of GB Partnerships in June and will report back to the Committee in July. MMcD said the Council would be invited to take part in the Group, and input could be gained from their planners. HM said that consideration needed to be given to primary care buildings as many were owner occupied and/or leased properties, and that small surgeries could be amalgamated. He also questioned the cost effectiveness of leased properties. MMcD said that all options would be looked at, emphasising this was a multi-year strategy which would take place in phases.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/59	**External Updates/Benchmarking and VFM Reports** DS presented a supplementary report on benchmarking to the Committee which stated that the CCG is a clear outlier in the top 8 treatment areas listed, and further investigation was warranted. MMcD said the CCG needed to see how its peers recorded activity, particularly North and South Tyneside CCGs, and DS will look into having this discussion with the highlighted CCGs. MMcD summarised saying he would like the urgent care review team to look at how the CCG could potentially hit the target of reducing one non-elective admission to hospital per practice per week, and for localities to assess their ability in delivering this target. MMcD said this could be the focus of the June Governing Body meeting and he will meet with ME to understand the clinical impact and how to approach discussions with localities.	DS MMcD/ ME
	Action taken by the Committee	
	The Committee noted the update.	
FR15/60	**CCG Assurance** MMcD advised the Committee that a Q3 meeting had been held in April and a Q4 meeting is scheduled for 24th June.	
	Action taken by the Committee	
	The Committee noted the update.	

No	Item	Action
FR15/61	**QIPP Update** A QIPP Committee has now been formed with the first meeting held on 12th May. **Action taken by the Committee** The Committee noted the update.	
FR15/62	**IFR Update** MMcD stated that the CCG should be receiving the IFR reports on a quarterly basis and as yet none had been provided this quarter; RM will contact the CSU and this item is to be deferred to June's agenda. **Action taken by the Committee** The Committee noted the update.	RM
FR15/63	**Better Care Fund Update** The CCG has been asked to review its plans, and MMcD said the CCG will work closely with Sefton Council to achieve the best it can out of the combined savings. HN emphasised the importance of educating patients, particularly those attending GP surgeries inappropriately. HM suggested an advertising website where local GPs gave advice on a more personal basis. MMcD confirmed that engagement with the public will be taken through to EPEG and the Big Chat, and with regard to targeting and educating patients, MMcD will liaise with Lyn Cooke regarding communications via social media. **Action taken by the Committee** The Committee noted the update.	MMcD/ LC
FR15/64	**Quality Premium Dashboard** This report outlined the Quality Premium requirements for 2015/16 and proposed the process for reporting and accountability. RP asked if GPs knew what the requirements were, and suggested having one target and delivering one message which GPs could focus in on. HM felt this would be an additional burden on GPs, however suggested targets be printed out on an A4 sheet of paper and given to GPs for ease of reference; it was suggested that this be laminated, and possibly made into a bookmark. HN asked for Billie Dodd (BD) to come to the next meeting to explain how the CCG can deliver this. MMcD said BD should be advised of the idea of a laminated card, and how to get support at locality meetings. HM is to proof read the card once prepared. **Action taken by the Committee** The Committee noted the contents of the report.	MMcD/ BD/HM

No	Item	Action
FR15/65	**Review of Annual Work Plan** The work plan was updated following feedback from the meeting in March.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/66	**Committee Self Assessment Checklist** MMcD and HN provided their comments on this checklist, which was approved by the Committee. HN noted that as the Terms of Reference were due for review in March 2015, this is to be deferred to June. In the meantime MMcD will review the ToR to assess whether it reflects the Committee's responsibilities.	MMcD
	Action taken by the Committee	
	The Committee approved the checklist, noting the Terms of Reference will be brought to the June meeting for review	
FR15/67	**Any Other Business** No other business was discussed.	
	Date of next meeting Wednesday 17th June 2015, 9.30am to 11.30am Family Life Centre, Ash Street, Southport	

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Agenda

Wednesday 17th June 2015, 9.30am to 11.30am
Family Life Centre, 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		
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Malcolm Cunningham	Head of Primary Care & Contracting	MC
David Smith	Deputy Chief Finance Officer	DS
James Bradley	Head of Strategic Finance Planning	JB
Susanne Lynch	CCG Lead for Medicines Management	SL

No	Item	Lead	Report	Receive/ Approve	Time
General business					
FR15/68	Apologies for absence	Chair	V	R	9.30am
FR15/69	Declarations of interest regarding agenda items	All	V	R	
FR15/70	Minutes of the previous meeting and key issues	Chair	R	A	
FR15/71	Action points from the previous meeting	Chair	R	R	
Reports received by way of assurance (taken as read)					
FR15/72	Month 2 Finance Report	MMcD	R	R	9.40am
FR15/73	IFR Update	JL	R	R	9.50am
FR15/74	CCG Assurance Framework	KMcC	R	R	10.00am
FR15/75	Prescribing Performance Report	SL	R	R	10.10am
FR15/76	Respiratory Business Case	JL	R	A	10.20am
FR15/77	External Updates/Benchmarking and VFM Reports	DS	V	R	10.30am
FR15/78	QIPP Update	MMcD	V	R	10.40am
FR15/79	Better Care Fund Update	MMcD	V	R	10.50am

No	Item	Lead	Report	Receive/ Approve	Time
FR15/80	SRG and Transformation Fund Update	JL	R	R	11.00am
Formal approval by Committee required					
FR15/81	Review of Terms of Reference	MMcD	R	A	11.10am
Closing business					
FR15/82	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting.*				11.20am
	Date of Next Meeting Wednesday 22nd July 2015, 9.30am to 11.30am Family Life Centre, Southport				

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Minutes

Wednesday 20th May 2015, 9.30am to 11.30am
Family Life Centre, Ash Street, Southport

Membership		
Helen Nichols	Lay Member (Chair)	HN
Roger Pontefract	Lay Member	RP
Dr Hilal Mulla	GP Governing Body Member	HM
Dr Martin Evans	GP Governing Body Member	ME
Colette Riley	Practice Manager	CR
Martin McDowell	Chief Finance Officer	MMcD
Ex-officio Member		
Fiona Clark	Chief Officer	FLC
In attendance		
Debbie Fagan	Chief Nurse & Quality Officer	DF
David Smith	Deputy Chief Finance Officer	DS
Susanne Lynch	CCG Lead for Medicines Management	SL
Apologies		
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Ruth Moynihan	PA to Chief Finance Officer	RM

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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	✓	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	A	A					
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A	A	A	A	A	A					
Fiona Clark	Chief Officer	A	A	A	A	A	A					
David Smith	Deputy Chief Finance Officer	✓	✓	✓	✓	✓	✓					
James Bradley	Head of Strategic Finance Planning	✓	✓	✓	A	N	N					
Susanne Lynch	CCG Lead for Medicines Management	✓	✓	A	✓	✓	✓					
Karl McCluskey	Chief Strategy & Outcomes Officer	A	A	A	A	A	A					
Malcolm Cunningham	Head of Primary Care & Contracting	A	✓	✓	✓	A	A					

No	Item	Action
FR15/50	**Apologies for absence** Apologies for absence were received from Fiona Clark, Jan Leonard, Tracy Jeffes, Karl McCluskey and Malcolm Cunningham.	
FR15/51	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflicts of interest.	
FR15/52	**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.	
FR15/53	**Action points from the previous meeting** ***FR15/24 Estates Utilisation*** *– see agenda item FR15/58.* ***FR15/42 External Updates/Benchmarking and VFM reports -*** *JL/BD to explore whether a community team re cellulitis would be beneficial* – DF confirmed she had liaised with Billie Dodd and, based on the information available and one of the CQUINs with SMO, they believe cellulitis will be built in with SMO. ***FR15/45 Better Care Fund Update*** – see agenda item FR15/63. All other actions were closed as appropriate.	
FR15/54	**Month 12 Finance Report** This report presented the Finance and Resource Committee with an overview of the year end financial position for NHS Southport and Formby CCG at 31 March 2015. The financial position was £4.583m overspend on operational budget areas before the application of reserves. Regarding BPPC, MMcD said that improvements should begin to be seen as the treasury function has now been brought in-house. Re CHC, MMcD said he would like the CCG to refocus its efforts and asked for DF and DS to take control of this. DF stated she and DS are to have a telecon with the CSU to discuss CHC. MMcD stressed the importance of making this process work in order to see improved use of resources. MMcD said he would like to see a range of payments received on this and said that the CCG should aim to set a maximum payment, stating the requirement for a cost control exercise. RP said that the long term financial challenge in this area will only increase as people are living longer, and more people are diagnosed with dementia. MMcD said he felt the CCG had exceeded what it should be paying and would like assurance that high cost mental health cases have been reviewed by the June meeting.	DS/DF

No	Item	Action
	Action taken by the Committee	
	The Committee noted the content of the report.	
FR15/55	**Case for Change** MMcD confirmed that Case for Change is now to be transferred to the QIPP Committee.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/56	**CSU Procurement** This report provided the Committee with an update on the proposal for the future procurement of commissioning support services. MMcD stated that that the CCG will no longer buy its commissioning support services from the CSU, but instead will procure services from the Lead Provider Framework (LPF). There is to be one contract with one supplier. He noted that it was important to focus on ensuring that good quality local services were retained through the LPF. MMcD confirmed that the Corporate Governance Manager and Business Manager roles have been filled by Lisa Gilbert and Judy Graves respectively, noting a couple of positions remained outstanding.	
	Action taken by the Committee	
	The Committee approved the recommendation to take the proposal to the Governing Body.	
FR15/57	**Prescribing Performance Report** This report presented the Committee with an update on prescribing spend for February 2015; the position for the month is a forecast overspend of £386k on a budget of £20.1m. In relation to Category M drugs SL stated that the analysts were working on this as there remains variation between practices. Also, there had been a problem with a coding error and a surgery in Ainsdale was picking up costs for Wigan CCG. SL is to speak to SBS regarding a refund and will advise DS accordingly. HM noted that people coming to Southport on respite were sometimes requesting 2-4 months of prescriptions and MMcD said this could be explored further, to understand the extent of the pressure and potential actions open to the CCG. MMcD said an improvement might be seen next year if the same level of uplift was maintained, and said wasting prescriptions could potentially be explored. MMcD noted that the 2015/16 budget uplift exceeded the 2014/15 trend, and highlighted that significant levels of waste exist in terms of patient use of prescribing, and that we should explore the opportunity to reduce this.	

No	Item	Action
	Action taken by the Committee The Committee noted the content of this report	
FR15/58	**Estates Working Group** MMcD updated the Committee and confirmed that although the Estates Working Group had not yet been formed, he had met with Community Health Partnerships who are keen to work with the CCG to bring together a Sefton-wide Estates Working Group. He outlined that the initial focus would be on identifying options for currently unutilised parts of the estate. He then noted that there are wider issues faced eg primary care, over a 5, 10 and 15 year period. MMcD is to meet with Sam McCumiskey of GB Partnerships in June and will report back to the Committee in July. MMcD said the Council would be invited to take part in the Group, and input could be gained from their planners. HM said that consideration needed to be given to primary care buildings as many were owner occupied and/or leased properties, and that small surgeries could be amalgamated. He also questioned the cost effectiveness of leased properties. MMcD said that all options would be looked at, emphasising this was a multi-year strategy which would take place in phases. **Action taken by the Committee** The Committee noted the update.	
FR15/59	**External Updates/Benchmarking and VFM Reports** DS presented a supplementary report on benchmarking to the Committee which stated that the CCG is a clear outlier in the top 8 treatment areas listed, and further investigation was warranted. MMcD said the CCG needed to see how its peers recorded activity, particularly North and South Tyneside CCGs, and DS will look into having this discussion with the highlighted CCGs. MMcD summarised saying he would like the urgent care review team to look at how the CCG could potentially hit the target of reducing one non-elective admission to hospital per practice per week, and for localities to assess their ability in delivering this target. MMcD said this could be the focus of the June Governing Body meeting and he will meet with ME to understand the clinical impact and how to approach discussions with localities. **Action taken by the Committee** The Committee noted the update.	DS MMcD/ ME
FR15/60	**CCG Assurance** MMcD advised the Committee that a Q3 meeting had been held in April and a Q4 meeting is scheduled for 24th June. **Action taken by the Committee** The Committee noted the update.	

No	Item	Action
FR15/61	**QIPP Update** A QIPP Committee has now been formed with the first meeting held on 12th May.	
	Action taken by the Committee	
	The Committee noted the update.	
FR15/62	**IFR Update** MMcD stated that the CCG should be receiving the IFR reports on a quarterly basis and as yet none had been provided this quarter; RM will contact the CSU and this item is to be deferred to June's agenda.	RM
	Action taken by the Committee	
	The Committee noted the update.	
FR15/63	**Better Care Fund Update** The CCG has been asked to review its plans, and MMcD said the CCG will work closely with Sefton Council to achieve the best it can out of the combined savings. HN emphasised the importance of educating patients, particularly those attending GP surgeries inappropriately. HM suggested an advertising website where local GPs gave advice on a more personal basis. MMcD confirmed that engagement with the public will be taken through to EPEG and the Big Chat, and with regard to targeting and educating patients, MMcD will liaise with Lyn Cooke regarding communications via social media.	MMcD/ LC
	Action taken by the Committee	
	The Committee noted the update.	
FR15/64	**Quality Premium Dashboard** This report outlined the Quality Premium requirements for 2015/16 and proposed the process for reporting and accountability. RP asked if GPs knew what the requirements were, and suggested having one target and delivering one message which GPs could focus in on. HM felt this would be an additional burden on GPs, however suggested targets be printed out on an A4 sheet of paper and given to GPs for ease of reference; it was suggested that this be laminated, and possibly made into a bookmark. HN asked for Billie Dodd (BD) to come to the next meeting to explain how the CCG can deliver this. MMcD said BD should be advised of the idea of a laminated card, and how to get support at locality meetings. HM is to proof read the card once prepared.	MMcD/ BD/HM
	Action taken by the Committee	
	The Committee noted the contents of the report.	

No	Item	Action
FR15/65	**Review of Annual Work Plan** The work plan was updated following feedback from the meeting in March.	
	Action taken by the Committee The Committee noted the update.	
FR15/66	**Committee Self Assessment Checklist** MMcD and HN provided their comments on this checklist, which was approved by the Committee. HN noted that as the Terms of Reference were due for review in March 2015, this is to be deferred to June. In the meantime MMcD will review the ToR to assess whether it reflects the Committee's responsibilities.	MMcD
	Action taken by the Committee The Committee approved the checklist, noting the Terms of Reference will be brought to the June meeting for review	
FR15/67	**Any Other Business** No other business was discussed.	
	Date of next meeting Wednesday 17th June 2015, 9.30am to 11.30am Family Life Centre, Ash Street, Southport	

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Wednesday, 20th May 2015	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions

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

- March financial report presented – delivery of financial duties subject to external audit verification.
- Noted update in terms of CSU progress – update to GB Part II in May.
- Estates working group to be established in June.
- Discussion in terms of how to use benchmarking:
  - urgent care group
  - locality working
  - planned care (outpatient referrals)
- Noted QIPP opportunities
  - prescribing waste } as priorities
  - CHC }

FR15/70

NHS
Southport and Formby
Clinical Commissioning Group

Action Tracker
Finance and Resource Committee – June 2015

THIS MONTH

Agenda Item No	Action	Lead	Time
FR15/54	***Month 12 Finance Report –*** DS/DF to provide update on CHC following telecon with CSU.	DS/DF	June 2015
FR15/59	***External Updates/Benchmarking and VFM Reports*** 1. DS to have discussions with North & South Tyneside CCGs to see how they record activity. 2. MMcD to meet with ME to gain understanding of the clinical impact and how to approach discussions with localities regarding reduction in non-elective admissions.	DS MMcD/ ME	June 2015
FR15/62	***IFR Update*** – RM to contact CSU to locate reports; action superseded with JL advising receipt of reports for presentation at June meeting.	RM/JL	June 2015
FR15/63	***Better Care Fund Update*** – MMcD to liaise with Lyn Cooke regarding communications via social media in respect of patient education.	MMcD/ LC	June 2015
FR15/64	***Quality Premium Dashboard*** – MMcD to liaise with Billie Dodd re production of a laminated reference card for GPs. HM to proof read once prepared.	MMcD/ BD/HM	June 2015
FR15/66	***Committee Self Assessment Checklist*** – MMcD to review the Terms of Reference and bring to June meeting.	MMcD	June 2015

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE FINANCE AND RESOURCE COMMITTEE JUNE 2015

Agenda Item: FR15/72	**Author of the Paper:**
Report date: 10 June 2015	James Bradley Head of Strategic Financial Planning james.bradley@southportandformbyccg.nhs.uk Tel: 0151 247 7070

Title:
Financial Position of NHS Southport and Formby Clinical Commissioning Group – Month 2

Summary/Key Issues:
This paper presents the Finance and Resource Committee with an overview of the financial position for NHS Southport and Formby Clinical Commissioning Group as at 31 May 2015.

Recommendation
The Finance and Resource Committee is asked to receive the finance update.

	X
Receive	X
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
X	To place clinical leadership at the heart of localities to drive transformational change.
X	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
X	To achieve financial duties and commission high quality care.

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
	Helping people to recover from episodes of ill health or following injury
X	Ensuring that people have a positive experience of care
X	Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Finance and Resource Committee
May 2015

1. Executive summary

This report focuses on the financial performance for Southport and Formby CCG as at 31 May 2015 (Month 2). At this early stage of the year the forecasted out-turn is breakeven before the application of reserves and contingency.

The CCG experienced significant financial pressures in the last financial year and a number of risks continue into the new financial year. Although budgets have been increased for growth, there are cost pressures emerging which will need close management if the CCG is to achieve the planned surplus.

In addition, plans to achieve the CCG's QIPP requirement of **£6.151m** have not yet been agreed, and progress against this is being monitored by the QIPP Committee.

Table A – Financial Dashboard

Report Section	Key Performance Indicator		This Month	Prior Month
1	Business Rule (Forecast Outturn)	1% Surplus	✓	n/a
		0.5% Contingency Reserve	✓	n/a
		2.5% Non-Recurrent Headroom	✓	n/a
3	Surplus	Financial Surplus / (Deficit) before the application of reserves - £'000	£0.00m	n/a
4	QIPP	Unmet QIPP to be identified > 0	£6.151m	n/a
5	Running Costs (Forecast Outturn)	CCG running costs < National 2015/16 target of £22.07 per head	✓	n/a
6	BPPC	NHS - Value YTD > 95%	99.3%	n/a
		NHS - Volume YTD > 95%	90.5%	n/a
		Non NHS - Value YTD > 95%	84.0%	n/a
		Non NHS - Volume YTD > 95%	93.4%	n/a

2. Resource allocation

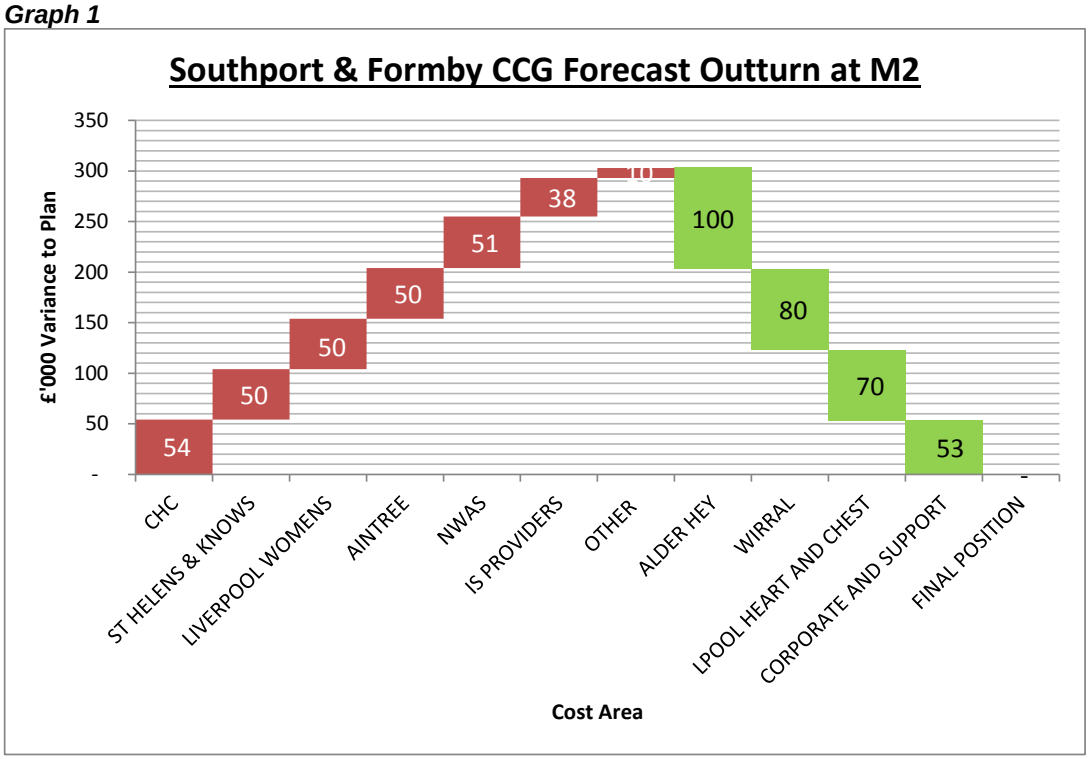
The Resource Allocation for the Financial Year 2015/16 is **£176.617m**. There have been no amendments to this allocation during Month 2.

3. Financial position and forecast

The main cost pressures are shown below in **Graph 1**, notably Continuing Healthcare, Independent Sector and Acute Care. A full breakdown of the CCG position is detailed in **Appendix 1.**

The forecast financial position is based on data received for the year to date. For Acute Commissioning budgets, this is data up to the end of April 2015 and for other budgets, data for the first two months of the financial year. It should be noted that at this stage in the financial year, forecasting can be difficult and subject to variation.

Graph 1



Acute Commissioning

Whilst the financial reporting period relates to the end of May, the CCG has based its reported position on activity information received from Acute Trusts to the end of April 2015.

Southport and Ormskirk NHS Trust

The contract for 2015/16 is still yet to be agreed with the Trust. The element of the contract that covers activity reported under national rules (Payment by Results) has been agreed and the Trust has presented data in relation to this activity. The latest contract offer has been reflected in the budget, but contract negotiations are ongoing regarding the locally negotiated prices for a number of services. The Trust is requesting another £0.400m from the CCG.

The CCG has received month one data from the Trust which shows an underspend of £0.184m against a budget that has been split equally between all months. Further phasing work is underway to determine an appropriate pattern of activity. This will be reported from June onwards. Due to the uncertainty, our forecast and year to date expenditure assumes a balanced position.

Aintree NHS Foundation Trust

The forecast out-turn overspend at Aintree hospital is £0.050m. This is projected using month one data received by the Trust. The month one data shows an overspend for both Aged Related Macular Degeneration (ARMD) outpatient appointments and drugs. There are also overspends within excluded drugs at the Trust. ARMD continues to be an area of significant growth for the CCG.

Liverpool Women's NHS Foundation Trust

The forecast overspend at Liverpool Women's is £0.05m. This is projected using the month one activity received by the Trust. The month one data shows an overspend within deliveries and IVF cycles.

St Helens & Knowsley NHS Trust

The forecast out-turn overspend is projected to be £0.05m. This is based on the month one activity data received from the Trust which shows overspend within planned care.

Independent Sector Providers

The forecast out-turn overspend for Independent Sector providers is £0.038m. This is projected using on month one data received from the providers. The majority of this is with Ramsay Healthcare. There are also forecast overspends within Spire Healthcare.

Continuing Health Care (Adult) / Funded Nursing Care

This area continues to be a high risk for the CCG, and annual budgets have been increased in 2015/16 by 5% from the activity levels seen in the latter part of last year.

The current out-turn forecast for this budget is an overspend of £0.050m. Forecasting based on one months' worth of data is challenging. The reported forecast reflects the current number of patients and average package costs, and builds in 5% (pro rata) growth between now and the end of the year. If growth in patient numbers or prices is not realised, then the forecast position will be reduced.

A working group involving both the CCG and the Commissioning Support Unit meets regularly to improve processes within the CHC team and to instigate changes to control costs and activity for this high risk area of spend.

4. QIPP

The QIPP savings target for Southport and Formby CCG is **£6.151m** for 2015/16. QIPP savings can be achieved through a reduction in either programme or running costs.

The CCG established a 1% Transformation Fund in the budgets. This was set up to fund transformational initiatives that would result in more efficient delivery of healthcare and improvements to quality. There are a number of schemes being reviewed currently, and these are outlined in **Table B**. Further detail is provided in a separate paper to be tabled at this Committee.

Table B – Transformation Fund – list of proposals

Financial Year 2015/16	Southport and Formby £000
Resource	1,800
Commitments:	
Mersey Care contract	375
Intermediate Care	200
Management support (external / internal)	200
Total Commitments	**775**
Balance available	**1,025**
Further proposals:	
IV therapy services at S+F	140
Telehealth in nursing homes	140
Early Supported Discharge (stroke rehab)	180
Respiratory primary care training scheme	75
Acute Frailty Visiting Service	214
GPSI in Community Geriatric Medicine	200
Treatment room development	170
Connected communities	87
Total	**1,206**
Funding shortfall	**- 181**

In addition to the transformational initiatives outlined above, a number of other initiatives are also being implemented. This includes:

- Primary care investment focused on frail and elderly patients
- Community geriatrician scheme
- Continued focus on areas of comparatively high spend (eg outpatient care, review of high cost continuing healthcare packages)

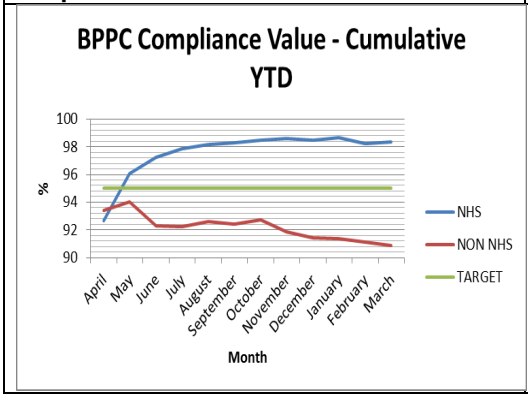
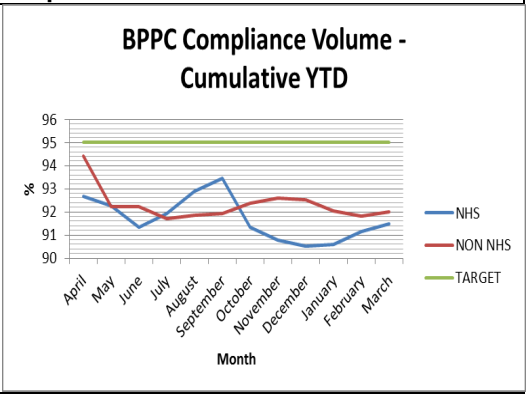
5. CCG running costs

The CCG is currently operating within its running cost target of £2.606m. The target has been reduced in 2015/16 to £22.07 per head (from £24.81 per head in 2014/15). Plans agreed by the Governing Body to meet this target have been implemented and the relevant budgets reduced.

The current year forecast for these budgets is an underspend of £0.046m due to vacant posts.

6. Compliance with the BPPC target

The NHS is required to adhere to the Better Payment Practice Compliance Target as part of the wider public sector drive to be a good citizen. The full year performance is reported in the annual report and subject to scrutiny by the external auditors. Cumulative performance for the last 12 Months is below the 95% target for all areas, except payments to NHS providers by value. This is detailed in **Graphs 2 and 3** below.

Graph 2	Graph 3
	

7. Evaluation of risks and opportunities

The CCG's primary risk is non-achievement of the QIPP requirement. £6.151m of savings must be realised in 2015/16 in order to achieve financial targets. In addition, there are a number of other risks that require monitoring and managing:

- Acute cost per case contracts – The CCG has experienced significant growth in acute care in previous years. Although historic growth has been factored into plans, there is a risk that activity will continue to grow beyond budgeted levels.

- Southport & Ormskirk NHS Trust – There remains a number of contract issues with S&O relating to the prices for some services that aren't governed by national prices. The difference across the four services where the parties have not reached agreement is £0.400m. The CCG is seeking a solution with the Trust without recourse to an independent party for decision.

- Continuing Healthcare Costs – The CCG experienced significant growth in costs for continuing healthcare in 2014/15. The CCG has increased its budgets by 5%, and is focussing on reviewing high cost packages. The risks of overspending is augmented not only by increases in patient numbers, but also increases in the price. The framework is being renewed in year, and may result in increased prices. A number of providers are already pursuing higher prices.

- Continuing Healthcare restitution claims – The CCG has contributed to a national risk pool in line with the values previously notified by NHS England. Reserves were set aside for this purpose. There is a risk that claims made nationally will exceed the value of the risk pool and further contributions from CCGs will be sought.

- Estates – The methodology for charging estates costs is expected to change in 2015/16. Previously, the costs had been based on historic charges. In 2015/16, the organisation that administers the LIFT buildings will be charging based on actual usage. The CCG has set aside reserves to cover estates costs, but up to date cost estimates have not been received by the CCG.

- Prescribing / Drugs costs - The final position has now been received for 14/15 and this was higher than expected and accrued for in the year end accruals by £0.180m, which has created a cost pressure in 15/16. Growth of 3% was added to the budgets for 15/16.

- Better Care Fund – Sefton Council has predicted growth in demand for social care and there is an anticipation that this growth will require funding from the Better Care Fund.

8. Reserves budgets / risk adjusted surplus

Reserve budgets are set aside as part of the Budget Setting exercise to reflect planned investments, known risks and an element for contingency. In order to meet the required planned surplus the CCG has to deliver the full QIPP requirement, and it is envisaged at this stage of the year that the contingency reserves will be called upon to mitigate risks that have been highlighted in **section 7**. Any overspends that are identified during the year will increase the savings requirement from that presented in **Table C.**

A summary of the forecast financial position as at Month 2 is outlined in **Table C.**

Table C – Summary Reserves Position

£'000	Rec	Non Rec	Total
Planned Surplus	1,800	0	1,800
Unidentified QIPP	(6,151)	0	(6,151)
Unallocated Contingency	1,581	0	1,581
Non Recurrent QIPP	0	1,193	1,193
Adjusted Surplus	**(2,770)**	**1,193**	**(1,577)**
In Year Savings Requirement			**(3,377)**

9. Recommendations

The Finance and Resource Committee is asked to note the finance update, particularly that:

- The overall financial position at this stage of the year is that the CCG will not meet its required surplus position, unless it is able to realise in year savings of £3.337m.
- This position assumes all other risks identified are managed in line with budgets during the year.
- In order to deliver the financial duties going forward the CCG needs to deliver on the recurrent QIPP target of £6.151m in 15/16.

Appendices

Appendix 1 – Financial position to Month 2
Appendix 2 – Detailed breakdown of provider costs

APPENDIX 1

01V NHS Southport and Formby Clinical Commissioning Group Month 02 Financial Position

Cost centre Number	Cost Centre Description	Annual Budget	Budget To Date	Actual To Date	Variance to date	End of Year	
						Expenditure Outturn	FOT Variance
		£000	£000	£000	£000	£000	£000
COMMISSIONING - NON NHS							
603501	Mental Health Contracts	829	138	138	0	829	0
603506	Child and Adolescent Mental Health	163	27	27	0	163	0
603511	Dementia	93	15	15	0	93	0
603521	Learning Difficulties	1,397	233	233	0	1,397	0
603531	Mental Health Services – Adults	0	0	0	0	0	0
603541	Mental Health Services - Collaborative Commissioning	426	426	426	0	426	0
603596	Collaborative Commissioning	409	68	68	0	409	0
603661	Out of Hours	1,065	178	178	0	1,065	0
603682	CHC Adult Fully Funded	7,478	1,246	1,224	(22)	7,578	100
603684	CHC Adult Joint Funded	1,403	234	235	1	1,463	60
603685	CHC Adult Joint Funded Personal health Budgets	111	18	22	4	141	30
603687	CHC Children	448	75	81	6	506	58
603691	Funded Nursing Care	3,300	550	495	(55)	3,106	(194)
603711	Community Services	466	78	78	0	466	0
603721	Hospices	871	145	145	0	871	0
603726	Intermediate Care	435	72	72	0	435	0
603796	Reablement	979	163	163	0	979	0
Sub-Total		**19,873**	**3,667**	**3,600**	**(67)**	**19,927**	**54**
CORPORATE & SUPPORT SERVICES							
605251	Administration and Business Support (Running Cost)	127	21	20	(1)	146	19
605271	CEO/Board Office (Running Cost)	450	75	70	(5)	426	(24)
605276	Chairs and Non Execs (Running Cost)	251	42	42	0	256	5
605296	Commissioning (Running Cost)	1,085	181	178	(3)	1,070	(15)
605316	Corporate costs	274	46	39	(6)	246	(28)
605346	Estates & Facilities	42	7	7	0	42	0
605351	Finance (Running Cost)	262	44	42	(2)	259	(2)
605391	Medicines Management (Running Cost)	18	3	3	(0)	18	0
605426	Quality assurance	35	6	5	(0)	35	0
605266	BUSINESS INFORMATICS	63	11	10	(0)	63	(0)
	Sub-Total Running Costs	**2,606**	**434**	**416**	**(18)**	**2,560**	**(46)**
603646	Commissioning Schemes (Programme Cost)	776	129	133	4	808	32
603656	Medicines Management (Programme Cost)	531	88	77	(12)	491	(39)
603810	Nursing and Quality Programme	127	21	21	(0)	127	0
603776	Non Recurrent Programmes (NPfIT)	258	43	43	0	258	0
603676	Primary Care IT	174	29	29	0	174	0
605371	IM & T	0	0	0	0	0	0
	Sub-Total Programme Costs	**1,866**	**311**	**303**	**(8)**	**1,859**	**(7)**
Sub-Total		**4,472**	**745**	**719**	**(26)**	**4,419**	**(53)**
SERVICES COMMISSIONED FROM NHS ORGANISATIONS							
603571	Acute Commissioning	80,323	13,325	13,375	50	80,323	0
603576	Acute Childrens Services	2,194	366	339	(27)	2,094	(100)
603586	Ambulance Services	4,749	792	800	8	4,800	51
603616	NCAs/OATs	1,306	218	218	0	1,306	0
603631	Winter Pressures	0	0	(0)	(0)	0	0
603566	Mental Health Winter Resilience	0	0	0	0	0	0
603756	Commissioning - Non Acute	27,545	4,591	4,591	(0)	27,555	10
603786	Patient Transport	8	1	1	0	8	0
Sub-Total		**116,126**	**19,292**	**19,323**	**32**	**116,086**	**(39)**
INDEPENDENT SECTOR							
603591	Independent Sector	4,309	718	762	44	4,347	38
Sub-Total		**4,309**	**718**	**762**	**44**	**4,347**	**38**
PRIMARY CARE							
603651	Local Enhanced Services and GP Framework	2,302	384	375	(9)	2,302	0
603791	Programme Projects	263	44	44	0	263	0
Sub-Total		**2,565**	**427**	**419**	**(9)**	**2,565**	**0**
PRESCRIBING							
603606	High Cost Drugs	1,549	258	258	0	1,549	0
603666	Oxygen	158	26	26	(0)	158	0
603671	Prescribing	21,871	3,645	3,645	(0)	21,871	0
Sub-Total		**23,577**	**3,929**	**3,929**	**0**	**23,577**	**0**
Sub-Total Operating Budgets pre Reserves		**170,921**	**28,779**	**28,753**	**(26)**	**170,922**	**0**
RESERVES							
603761	Commissioning Reserve	3,896	(106)	(80)	26	3,896	0
Sub-Total		**3,896**	**(106)**	**(80)**	**26**	**3,896**	**0**
Grand Total I & E		**174,817**	**28,673**	**28,673**	**0**	**174,817**	**0**
RRL Allocation		(176,617)	(28,973)	(28,973)	0	(176,617)	0
(Surplus)/Deficit		(1,800)	(300)	(300)	0	(1,800)	0

APPENDIX 2

01V NHS Southport and Formby Clinical Commissioning Group Month 02 Contract Summary

Description	Annual Budget	Budget To Date	Actual To Date	YTD Variance			Forecast Variance (Most Likely)		
				Month 02	Month 01	Movement	Month 02	Month 01	Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000
ACUTE CHILDRENS SERVICES									
ACUTE CHILDRENS SERVICES	2,194	366	339	(27)	0	(27) ▼	(100)	0	(100) ▼
Sub-Total	**2,194**	**366**	**339**	**(27)**	**0**	**(27)**	**(100)**	**0**	**(100)**
ACUTE COMMISSIONING									
AINTREE UNI HOSP NHS FT	5,557	926	956	30	0	30 ▲	100	0	100 ▲
AINTREE ANTICOAGULENT CLINIC	0	0	0	0	0	(0)	0	0	0
ANY QUALIFIED PROVIDER	268	45	45	(0)	0	(0)	0	0	0
C MANC UNI HOS NHS FT	94	16	11	(5)	0	(5) ▼	0	0	0
COUNTESS OF CHESTER FT	13	2	8	6	0	6 ▲	0	0	0
LANCS TEACH HOSP NHS FT	406	68	68	(0)	0	(0)	0	0	0
LIVP HRT/CHST HOSP NHST	1,382	230	213	(17)	0	(17) ▼	(60)	0	(60) ▼
LIVP WOMENS NHS FT	1,186	198	223	25	0	25 ▲	100	0	100 ▲
R LIV/BRG UNI HOSP NHST	5,391	899	899	(0)	0	(0)	0	0	0
SOUTHPORT/ORMSKIRK NHST	62,983	10,434	10,435	0	0	0	0	0	0
ST HEL/KNOWS TEACH NHST	1,554	259	290	31	0	31 ▲	100	0	100 ▲
UNI HOSP SMAN NHS FT	71	12	15	3	0	3 ▲	0	0	0
WALTON CENTRE NHS FT	104	17	17	0	0	(0)	0	0	0
WIRRAL UNIV TEACH HOSP	222	37	14	(23)	0	(23) ▼	(60)	0	(60) ▼
WRIGHT/WGN/LEIGH NHS FT	1,092	182	182	0	0	(0)	0	0	0
NHS HALTON CCG	0	0	0	0	0	0	0	0	0
NHS KNOWSLEY CCG	0	0	0	0	0	0	0	0	0
OTHER ACUTE	0	0	0	0	(0)	0	0	0	0
Sub-Total	**80,323**	**13,325**	**13,375**	**50**	**1**	**50**	**180**	**0**	**180**
COMMISSIONING - NON ACUTE									
CHESH/WIRRAL PART NHSFT	1,222	204	204	0	0	(0)	0	0	0
AINTREE UNI HOSP NHS FT	328	55	55	0	0	0	0	0	0
LPOOL COMM HC NFT	2,875	479	479	(0)	(0)	0	0	0	0
MERSEY CARE NHST	12,150	2,025	2,025	0	0	(0)	0	0	0
NHS 111 SERVICE	201	34	34	1	(0)	1	10	0	10 ▲
SOUTHPORT/ORMSKIRK NHST	10,651	1,775	1,775	(0)	0	(0)	0	0	0
S&O ANTICOAGULENT CLINIC	0	0	0	0	0	0	0	0	0
STTFFS/SHRPS HC NHS FT	0	0	0	0	0	0	0	0	0
Sub-Total	**27,427**	**4,571**	**4,572**	**1**	**(0)**	**1**	**10**	**0**	**10**
AMBULANCE SERVICES									
NW AMBUL SVC NHST	4,749	792	800	8	(0)	8 ▲	51	0	51 ▲
Sub-Total	**4,749**	**792**	**800**	**8**	**(0)**	**8**	**51**	**0**	**51**
Grand Total	**114,694**	**19,053**	**19,086**	**33**	**1**	**32**	**141**	**0**	**141**

01V NHS Southport and Formby Clinical Commissioning Group Month 02 IS Provider Summary

Description	Annual Budget	Budget To Date	Actual To Date	YTD Variance			Forecast Variance (Most Likely)		
				Month 02	Month 01	Movement	Month 02	Month 01	Movement
	£000	£000	£000	£000	£000	£000	£000	£000	£000
RAMSAY HEALTHCARE UK	3,288	548	586	38	0	38 ▲	150	0	150 ▲
ISIGHT LTD	703	117	129	12	(0)	12 ▲	50	0	50 ▲
SPIRE HEALTHCARE LTD	235	39	33	(6)	(0)	(6) ▼	0	0	0
Fairfield	27	5	5	(0)	(0)	0	0	0	0
British Pregnancy Advisory Service	32	5	5	0	1	(1)	0	0	0
Other Cost Per Case IS Providers	23	4	4	(0)	(0)	0	0	0	0
Sub-Total	**4,309**	**718**	**762**	**44**	**(0)**	**44**	**200**	**0**	**200**

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE FINANCE AND RESOURCE COMMITTEE JUNE 2015

Agenda Item: FR15/73	**Author of the Paper:**
Report date: 4th June 2015	Helen Jones Service Manger helen.jones52@nhs.net 0151 514 6655

Title: Individual Exceptional Funding Request Annual Report 2014/2015

Summary/Key Issues: The Individual Exceptional Funding Request (IEFR) service is commissioned from the Northwest Commissioning Support Unit. The service manages applications for exceptional funding which fall outside of the CCGs contracts or are thought to be exceptional cases. The report provides a summary of activity for the year and describes the types of requests being received and the outcome of the requests.

Recommendation

The Committee is asked to receive the report

	X
Receive	X
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
X	To achieve financial duties and commission high quality care.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	X			Engagement as part of commissioning policy development
Clinical Engagement	X			Engagement as part of commissioning policy development and via IEFR Panel.
Equality Impact Assessment	X			Engagement as part of commissioning policy development
Legal Advice Sought			X	
Resource Implications Considered	X			
Locality Engagement		X		
Presented to other Committees		X		

Links to National Outcomes Framework *(x those that apply)*	
	Preventing people from dying prematurely
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
	Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS

North West
Commissioning Support Unit

Individual Exceptional Funding Request (IEFR) Service

NHS Southport & Formby Clinical Commissioning Group Annual Report

April 2014 to March 2015

Service Manager
IEFR Team
May 2015

1 Introduction

1.1 The following information is provided to inform the CCG about activity and trends and therefore inform commissioning decisions.

1.2 This activity report provides information relating to April 2014 to March 2015.

1.3 This report provides a snapshot of activity as at 1st April 2015. The IEFR system is a live database so the data presented here is only representative of the time the system is accessed to extract the data for this report.

1.4 IEFR activity refers to all types of activity including High Cost Drug, IEFR, IVF, PLCP and unknown.

1.5 The service provided to the CCG was agreed in a service specification (CSC007) and refreshed in the autumn of 2014. The scope of the services is the management of applications for exceptional funding for residents within the CCGs footprint which fall outside the Commissioning Groups' contracts with their local, regional and national providers of clinical services or are exceptional cases.

1.6 Through the policies approved by the CCG this service component will be responsible for delivering a service for referring clinicians to make applications for treatments and interventions that are not routinely commissioned. We will be cognisant of relevant CCG resource allocation principles or policies when processing applications for funding non-contract activity to ensure that resources are deployed to achieve optimal health gain for the population.

1.7 The service also provides a Medicines Management review component to the service. Applications are clinically triaged and processed promptly via an efficiently organised and robust team process that is continually reviewed and updated to improve efficiency and productivity. Protocols and templates support the robustness of the team's process for drug IEFR applications to ensure decision-making is consistent, follows due process and able to withstand scrutiny.

1.8 The majority of the cases were triaged and completed with a turnaround time of less than 7 working days by the medicines management IEFR team. A number of cases were referred to the IEFR panel for wider discussion. The team provide an evidence base and narrative to be included all decision outcome correspondence to ensure accuracy of the clinical content prior to dissemination to the referrer.

2 Summary of activity

2.1 Between the 1st April 2014 and the 31st March 2015, the Individual Exceptional Funding Request Department received a total of 69 requests for NHS Southport and Formby CCG.

2.2 The following report captures the activity against those new cases where the latest status date has been completed. 9 were approved and 53 were declined.

Status	Count of Status
Approved	9
Not Approved	53
Grand Total	**62**

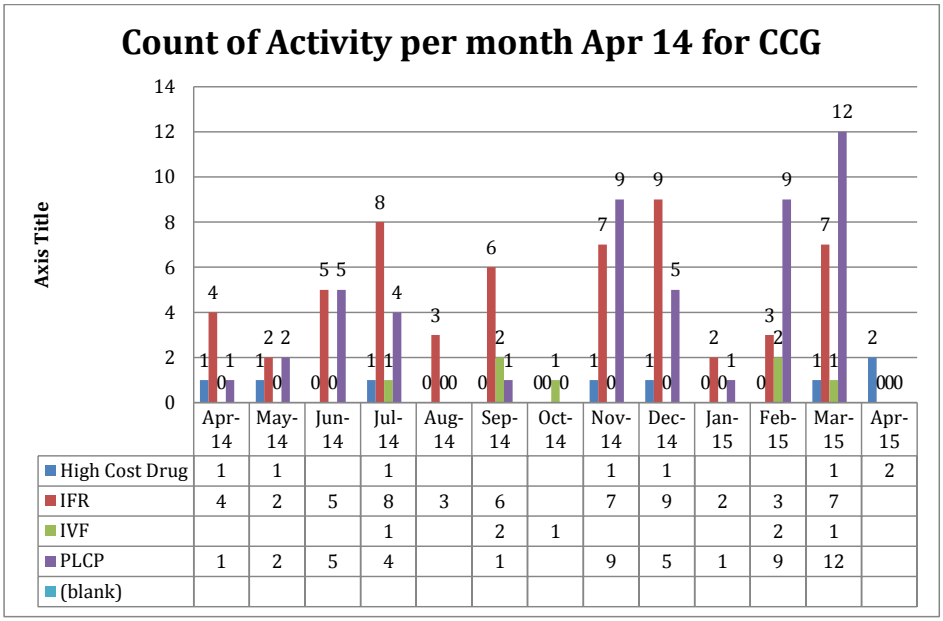
Table 1: Cases by status

Please note

The data presented from this point forward deals exclusively with approved and not approved activity only.

3 Activity by Category

3.1 The following table provides a breakdown of IEFR activity by category over the past year.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
High Cost Drug	1	1		1				1	1			1	2
IFR	4	2	5	8	3	6		7	9	2	3	7	
IVF				1		2	1				2	1	
PLCP	1	2	5	4		1		9	5	1	9	12	
(blank)													

Chart 1 – Count of activity during year 2014-2015

3.2 A comparison of the CCGs activity has been made with the Merseyside Area using a base of per 1,000 head of population.

	High Cost Drugs	IFR	IVF	PLCP
NHS Southport & Formby CCG	0.06	0.30	0.03	0.17
NHS Halton CCG	0.008	0.22	0.03	0.22
NHS Knowsley CCG	0.01	0.07	0.01	0.06
NHS Liverpool CCG	0.03	0.21	0.07	0.26
NHS South Sefton CCG	0.03	0.19	0.05	0.15
NHS St Helens CCG	0.05	0.38	0.04	0.30
Merseyside Area	0.03	0.21	0.05	0.21

Table 2 – Comparison of Activity per 1,000 head pf population

3.3 As can be seen from table 2 NHS Southport & Formby CCG receives higher levels of HCD and IFR applications compared to the Area as a whole.

4 Activity by Decision

4.1 The following chart shows the number of IEFR requests between 1st April 2014 and 31st March 2015 that were approved and not approved.

4.2 With a total of 9 approvals from 62 applications, this equals a 14.5% approval rate based on the combined number of approved and not approved cases.

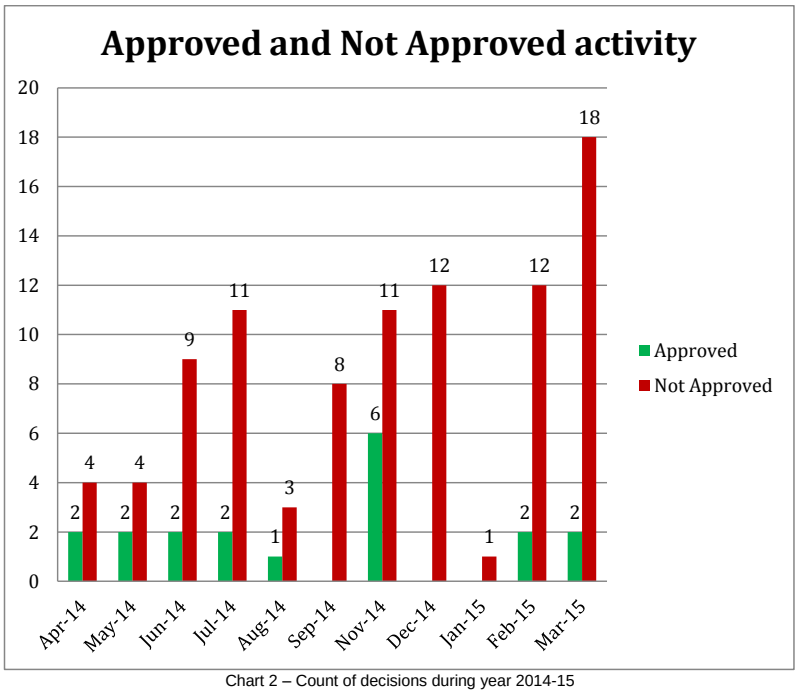


Chart 2 – Count of decisions during year 2014-15

4.3 A comparison of the CCGs decisions has been made with the Merseyside Area.

	Approved	Not Approved	Approval Rate
NHS Southport & Formby CCG	9	53	14.5%
Merseyside Area	81	497	14.0%

Table 3 – Comparison of decisions

4.4 As can be seen the approval rate for NHS Southport & Formby CCG is only slightly higher than the Merseyside Area as a whole.

	High Cost Drugs	IFR	IVF	PLCP
NHS Southport & Formby CCG	14%	19%	0%	5%
NHS Halton CCG	0%	30%	0%	0%
NHS Knowsley CCG	100%	21%	100%	9%
NHS Liverpool CCG	44%	11%	18%	3%
NHS South Sefton CCG	75%	7%	25%	4%
NHS St Helens CCG	50%	27%	0%	0%
Merseyside Area	47%	19%	22%	3.5%

T able 4: Approved conversion as a percentage

4.5 One of the main contributory factors of a low approval rate is the fact that applications received often lack the required information that evidences exceptionality.

4.6 In addition applicants fail to use the commissioning policies to check whether or not their patients meets the criteria before submitting an application resulting in a higher number of inappropriate referrals being received.

5 Breakdown of applications by subject

5.1 The table in Appendix A shows the breakdown of applications by subject between 1st April 2014 and 31st March 2015, by approved and not approved. This excludes applications which are now being dealt with by NHS England and cancer drug requests as they are now dealt with by the Cancer Drugs Fund (NHS England).

5.2 These requests do include withdrawn cases and inappropriate cases. Examples of why cases are withdrawn include – patient death; treatment pathway changed; further information requested has not provided; change of responsible commissioner.

5.3 There are a number of reasons as to why a funding request is not approved:

- The treatment requested is not routinely commissioned.
- The patient does not fulfil the Cheshire and Merseyside Commissioning Criteria, 2014/2015.
- The treatment is commissioned by NHS England as indicated in the Manual for Prescribed Specialised Services.
- IEFR is not the appropriate funding route for this type of treatment.
- There has not been enough information supplied to enable a fully informed decision, therefore, further information is required.

- The evidence base is weak in supporting the requested intervention.
- The request is for a second opinion which is available under Patient Choice in the NHS.
- There is a local service commissioned by the CCG that can meet the needs of the request, therefore it is appropriate to refer the patient there in the first instance.
- The patient is outside of area for the CCG, therefore it is an inappropriate referral.

5.4 Top Treatments requested

Treatment	Requested
Laser hair removal	5
IVF	3
Varicose Vein Surgery	3
Functional electrical stimulator	3
Abdominoplasty	2
Breast Implant Removal and Replacement	2
Continuous Positive Airways Pressure	2
Lymphodema Treatment	2

T able 5: Top Treatments requested

5.5 Top Approvals

Treatment	Approved
Support and aftercare following surgery	1
Hip arthroscopy and cell therapy	1
8 days of Day Care to assess eating disorder	1
Back Brace	1
Pressure relief bespoke foot orthotics	1
Continuous Positive Airways Pressure	1
Teriparatide	1
Counselling	1
Functional electrical stimulator	1

T able 6: Top Treatments Approved

5.6 Top Declined applications

Treatment	Not Approved
Laser hair removal	5
Varicose Vein Surgery	3
IVF	3
Lymphodema Treatment	2
Breast Implant Removal and Replacement	2
Abdominoplasty	2
Functional electrical stimulator	2

T able 7: Top Treatments Not Approved

6 Key Performance Indicator Compliance – 2014-15

6.1 The Key Performance Indicators (KPIs) provide a measurable indication to the CCG to demonstrate how effectively the Commissioning Support Unit is achieving its business objectives. The CCG agreed two KPIs for the year 2014-2015 these were:

- 95% of all IEFR applications are processed with 56 days of receipt by the CSU
- 100% of IEFR decision letters will be sent out within 10 working days of the clinical decision (from triage or panel) being made. These letters are sent out on behalf of the CCG.

The tolerance of 95% was agreed as some very complex cases may require longer than the 56 days particularly if additional specialist opinion is sought in order to be able to make an informed decision.

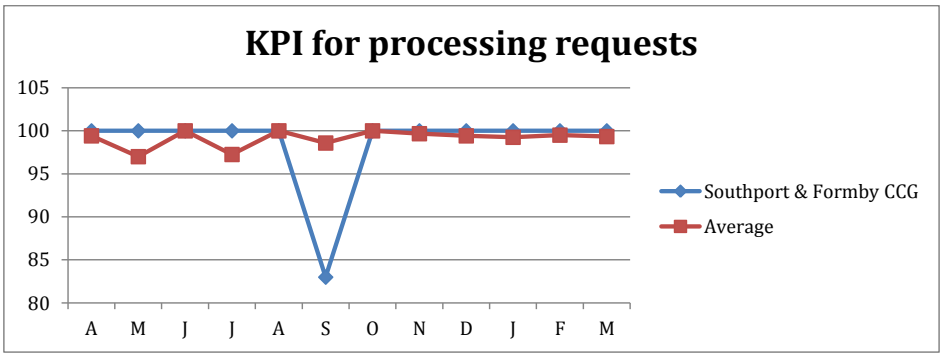


Chart 3: Monthly KPI results for processing requests

6.2 In respect of the 56 working day turnaround for processing the requests, the CSU were 92% complaint for this KPI (above the 95% tolerance level). However the KPI fell below the target on one occasion. This was due to an increase in activity/unexpected demands upon the team during these months. This also affected the KPI for letters being sent within 10 working days. The Customer Solutions Centre now has plans in place to address any unpredictable increase in volumes and has implemented corrective actions to improve performance which can be seen from the more recent KPI results.

6.3 The yearly average turnaround time for sending letters is 5 working days. This performance is in line with the average performance across all CCGs which is also 5 working days.

7 Financial Data

7.1 Financial data is not routinely collected by CSU, although estimated costs are initially collected.

8 Review of 2014/15

Update of Clinical Commissioning Policies

8.1 The clinical commissioning policies development was commissioned by all Cheshire and Merseyside CCGs to update the Procedures of Limited Clinical Value and the Fertility policy. This was a seven stage evidence based process:

Stage 1	Policy Stimulation - practice or evidence
Stage 2	Evidence Review
Stage 3	Equality Impact Assessments
Stage 4	Production of a Potential Policy for CCG Primary Approval
Stage 5	CCG Engagement
Stage 6	Public, referrers and providers engagement
Stage 7	Findings and Decision Point by CCG,
Stage 8	Policy Implementation via provider contracts (Monitoring from April)

8.2 The CSU produced a final composite document and an individual document for each CCG for use with providers, member GP practices and other stakeholders. Commissioning decisions will always require review due to changes in treatment options, pathways, funding streams, protocols and patient populations. The CCG will want to consider in 2015, how, and on what footprint and when these current policies will next be reviewed.

8.3 Treatments and procedures which are known at this time to require further review are:

- Varicose veins (The Public Heath Team produced a Varicose Veins – Next Steps document for CCG's consideration. If CCGs wish to commission the team to conduct another review please contact JohnP.Hampson@cheshirewestandchester.gov.uk .)
- Surrogacy
- Egg preservation without a cancer diagnosis
- Management of the Public health requirements for anti-viral treatments/HIV patients which are subject to guidance most recently produced by the GM Sexual health network
- Autologous Chrondroytce implantation
- Grommets for adults
- Green light laser therapy
- Klinfelters syndrome in men (as there is now a better understanding of this which means emerging technologies are identifying infertility)
- Lateral meniscus/allograft in place of joint replacement

Lessons Learned

8.4 Data Input - The need for accurate data input has been identified via errors highlighted through the annual reporting. Thankfully the vast majority of these errors were made at the beginning of the last financial year and thus show how far the team has developed and improved during this time.

8.5 Appeal Panels – As a result of Appeal Panels it has been agreed that to ensure there is a robust documentation trail the formal agenda should include declarations of interest of panel members and a copy of the Terms of Reference from the service specification. It was also recommended that a document is produced detailing the process beyond the Appeals Panel in order to put into context where the Appeals Panel sits. Various updates to the Appeal Panel Terms of Reference were recommended which have been incorporated accordingly. It was also noted that more clarity was required within the decision letters that are sent out. The team now ensure that a clear explanation is provided as to how the decision was reached.

8.6 No Appeals Panels were held for NHS Southport & Formby CCG during the reporting period. This demonstrates that the current process is operating at a high standard and follows robust policies and procedures.

8.7 The CCG should continually engage with member practices and providers to ensure that they understand the commissioning policies that are in place.

Medicines Management Individual Funding Request Team

8.8 2014-2015 was a productive year for the team. Applications were clinically triaged and processed promptly via an efficiently organised and robust team process that is continually reviewed and updated to improve efficiency and productivity. Protocols and templates support the robustness of the team's process for drug IEFR applications to ensure decision-making is consistent, follows due process and able to withstand scrutiny.

8.9 A large number of medicines-related IEFRs were processed during the year and the majority were triaged and completed with a turnaround time of less than 7 working days by the medicines management IEFR team. A small number were referred to the IEFR panel for wider discussion. The team provide the narrative to be included all decision outcome correspondence to ensure accuracy of the clinical content prior to dissemination to the applicant.

8.10 The majority of IEFRs are for licensed drugs but for 'off-label' indications or where there is no CCG commissioning policy in place. For highly specialised interventions NHS England's Manual for Prescribed Services and commissioning policies are consulted. Should the drug be commissioned by NHS England the applicant is informed whether an NHS England policy exists or whether an IEFR is required to be submitted into their process for consideration.

8.11 An IEFR request proforma specifically designed for drug applications which require written authorisation for submission into the IEFR process by applicants' organisation Drug & Therapeutic Committee or equivalent was updated. As a consequence, an improvement in the quality of applications and the time taken to respond to an application with a decision outcome has improved efficiency of the service provided. There are occasions when the applicant has needed to be approached for additional clinical information in order to make a fair and reasonable decision following due process, but these occasions have reduced in frequency over the preceding 12 months and are now few and far between. An improved working relationship with clinicians to assist in achieving timely decision has ensued.

8.12 The team received a refresher session on searching and evaluation of literature for evidence in January 2015 delivered by UKMi. This is particularly useful when a request is for a rarely used drug for a particular condition in preparation for a panel decision. All drug requests that are referred to go to panel are supported by a structured evidence review proforma, to ensure applications take a standardised approach to decision making.

Appendix A

Treatment	Approved	Not Approved	Merseyside Approved	Merseyside Not Approved
8 days of Day Care to assess eating disorder	1		1	
Abdominoplasty		2		16
Apronectomy		1		9
Asperger's Assessment		1		6
Autism Spectrum Assessment		1		1
Back Brace	1			1
Bariatric Assessment		1		3
Bespoke Spinal Jacket incorporating Special Features		1		1
Bespoke Surgical Boots		1		1
Bilateral Breast Reduction		1		1
Botulinum Toxin Injections		1		3
Breast Implant Removal and Replacement		2		2
Capsaicin patch		1		2
Continuous Positive Airways Pressure	1		1	2
Counselling	1		1	2
Egg Donation		1	3	5
Excision of Cyst		1		11
Exogen Bone Stimulator		1	1	
Facial Feminisation Surgery		1		1
Fertility preservation treatment		1	3	3
Foam Sclerotherapy/ Avulsions		1		3
Functional Electrical Stimulator	1	2	2	3
Gastric Band		1		1
Golimumab		1		1
Hip arthroscopy and cell therapy	1		1	
Hydrotherapy		1		1
Infliximab		1	4	1
Insulin Pump		1	4	1
Intravenous Immunoglobulin		1		1
IVF		3	3	35
IVF/ICSI		1		2
Labioplasty		1		2
Laser Hair Removal		5	1	20

Laser Treatment for Acne Scarring		1		3
Lymphodema Treatment		2		2
Mandibular implant overdenture		1		1
Neurophysiotherapy		1		1
Ostenil Injections		1		1
Pinnoplasty		1	2	6
Pressure relief bespoke foot orthotics	1		1	
Reduction Mammoplasty		1		2
Removal and Replacement of Breast Implants		1		1
Second opinion		1	1	3
Support and aftercare following surgery	1		1	
Surgical Assessment		1		3
Teriparatide	1		1	
Thigh lift		1		2
Varicose Vein Surgery		3	1	82
Vascular opinion to consider options		1		1
Grand Total	**9**	**53**		

Table A: Applications by Subject

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE FINANCE AND RESOURCE COMMITTEE JUNE 2015

Agenda Item: FR15/74	**Author of the Paper:**
Report date: June 2015	Karl McCluskey Chief Strategy & Outcomes Officer Karl.mccluskey@southportandformbyccg.nhs.uk 0151 247 7006

Title: Summary of CCG Assurance Framework for 2015/16

Summary/Key Issues: This paper sets and describes the key elements of the 2015/2016 assurance framework for the CCG.

Recommendation
The Finance and Resource Committee are asked to note the revision to the assurance framework and consider any appropriate actions to support the assurance process going forward.

	X
Receive	X
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
X	To place clinical leadership at the heart of localities to drive transformational change.
X	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
X	To publish plans for community services and commission for March 2016.
X	To commission new care pathways for mental health.
X	To achieve Phase 1 of Primary Care transformation.
X	To achieve financial duties and commission high quality care.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	X			The CCG will need to progress engagement in support of the assurance framework.
Clinical Engagement	X			The CCG will need to progress engagement in support of the assurance framework.
Equality Impact Assessment				
Legal Advice Sought	X			The CCG will need to progress engagement in support of the assurance framework.
Resource Implications Considered				
Locality Engagement	X			The CCG will need to progress engagement in support of the assurance framework.
Presented to other Committees				

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 Finance and Resource Committee
June 2015

1.0 Introduction

1.1 This paper sets out a summary revised guidance on the CCG Assurance Framework for 2015/16.

2.0 Background

2.1 NHS England's first assurance framework was based on the CCG authorisation process and was structured around six domains:

1. are patients receiving clinically commissioned, high quality services?
2. are patients and the public actively engaged and involved?
3. are CCG plans delivering better outcomes for patients?
4. does the CCG have robust governance arrangements?
5. are CCGs working in partnership with others?
6. does the CCG have strong and robust leadership?

2.2 This process successfully provided assurance about the CCG capability but also added significant value as part of CCG development.

2.3 The publication of the *NHS Five Year Forward View* in October 2014 set out a new strategic direction, describing how the health service needs to change and, linked to that, NHS England has worked with Monitor and the NHS Trust Development Authority to develop a more joined up approach to planning and supporting local health economies.

2.4 The National Information Board framework for action *Personalised Health and Care 2020*3, published alongside the *Forward View*, outlined the increasing importance of technology and information in the delivery of safe, efficient and effective care. As commissioners of secondary care, and with responsibility for the GP IT budget, the CCG is uniquely placed to achieve safe, digital record keeping and the digital transfer of patient information across care settings within the local health economy. The CCG will need to understand how it can fulfil obligations for digital interoperability.

2.5 The CCG is already responsible for commissioning out-of-hours Primary Medical Care Services in accordance with the direction from NHS England to do so on its behalf. Another change in the scope of commissioning responsibilities is that NHS England has determined that CCGs should have a much greater role in commissioning some of the services for which NHS England has statutory responsibility. Specific additional assurance will be required for such delegated functions which, from April 2015, will include primary care.

2.6 A new assurance framework is therefore required to address these changes. This will strengthen the focus on the CCG's track record and ongoing performance in delivering improvements for patients. It will continue to assess the CCG's capability as well as ensuring its fitness to take on additional roles and responsibilities.

2.7 This new framework also acknowledges that CCGs have different starting positions, with different populations and challenges, requiring different leadership responses. Some are operating in an extremely difficult environment, within challenged health economies or with legacy financial issues. Assurance covers the overall delivery of the CCG, and will take place continuously throughout the year, rather than as a one-off inspection.

2.8 This framework describes a continuous assurance process that aims to provide confidence to internal and external stakeholders and the wider public that the CCG is operating effectively to commission safe, high-quality and sustainable services within resources, delivering on statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients.

3.0 Principles

3.1 A set of broad principles has been identified, which should underpin how CCG assurance is undertaken.

- Assurance should be transparent and demonstrate to internal and external stakeholders and the wider public the effective use of public funds to commission safe and sustainable services.
- Assurance is primarily about providing confidence.
- Assurance should build on what the CCG is already doing to hold itself accountable locally to their communities, members and stakeholders, for both statutory requirements and for national and local priorities.
- Assurance should minimise bureaucracy and additional reporting requirements by drawing on available data and aligning with other regulatory and planning processes – there should be minimal additional paperwork.
- Assurance should be proportionate and respect the time and priorities of the CCG and NHS England teams.
- Assurance should be summative and take place over the year as on-going conversations.
- The tone, process and outcomes need to focus on development as well as performance.
- Accountability, learning and development between CCGs and NHS England will be integral to the process.
- The framework will be based on a nationally consistent methodology and format whilst allowing room for local context and variation.
- Whilst uncompromising on the facts which describe the quality of services patients are receiving, NHSE will want to test understanding of the reasons for variation and, where a problem is found, clear on the consequences and actions which the CCG and NHS England will need to take.

4.0 Components

4.1 The new assurance framework recognises that assurance is a continuous process that considers the breadth of the CCG's responsibility. It will consist of the following components:

4.2 **Well-led organisation:** this will assess the extent to which a CCG:

- has strong and robust leadership;
- has robust governance arrangements;
- involves and engages patients and the public actively;
- works in partnership with others, including other CCGs;
- secures the range of skills and capabilities it requires to deliver all of its commissioning functions, using support functions effectively, and getting the best value for money; and
- has effective systems in place to ensure compliance with its statutory functions.

4.3 **Performance: delivery of commitments and improved outcomes:** a key focus of assurance will be;

- how well CCGs deliver improved services maintain and improve quality, and ensure better outcomes for patients.
- delivery of key Mandate requirements and NHS Constitution standards
- meeting standards for all aspects of quality, including safeguarding, and digital record keeping and transfers of care.

4.4 This focus on quality, performance and outcomes will be continuous throughout the year, and will be underpinned by a set of delivery metrics which will constitute the CCG scorecard.

4.5 **Financial management:** the monitoring of the CCG financial management capability and performance will be continuous throughout the year, including;

- an assessment of data quality and contractual enforcement
- Immediate remedial action will be required when financial problems become evident
- Such action could include the use of special measures and NHS England's statutory powers of direction, described later in the framework.

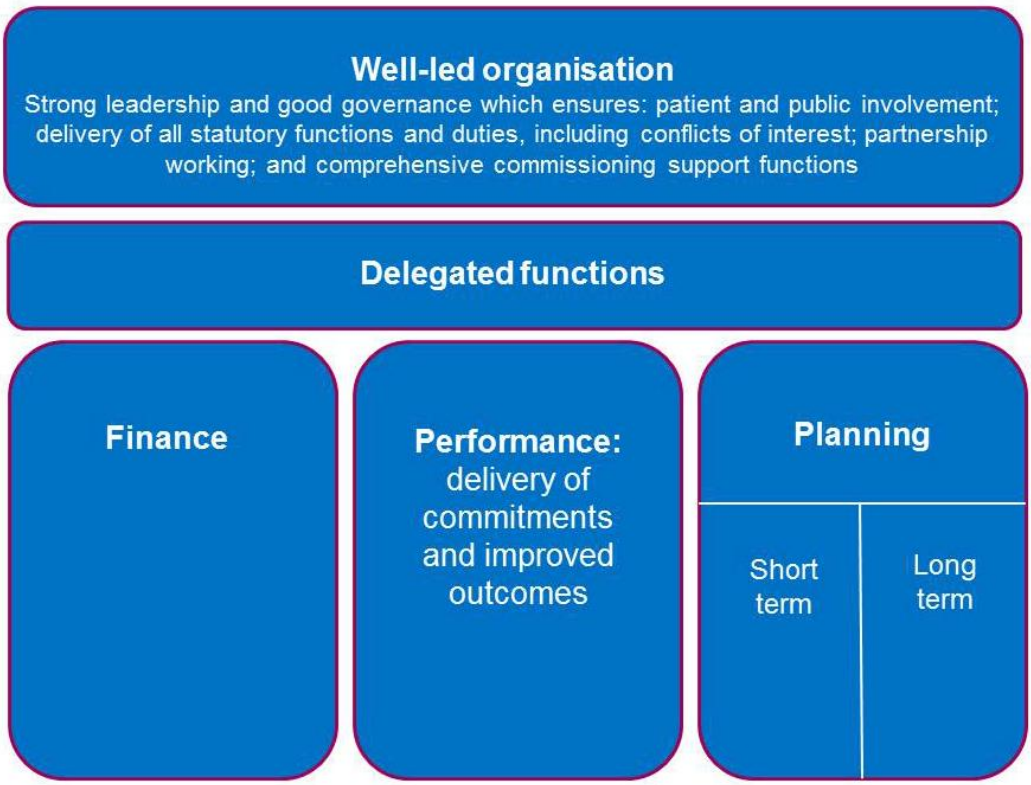
4.6 **Planning:** the assurance of a CCG's plans will be a continuous process, covering not only annual operational plans, and related plans such as those relating to System Resilience Groups and the Better Care Fund, but also longer term strategic plans, including progress with the implementation of the *Forward View*.

4.7 Progress towards moving secondary care providers from paper-based to digital processes and the extent to which NHS Number and discharge summaries are being transferred digitally across care settings will be specific measures during 2015/16, towards the ambition for a paperless NHS.

4.8 **Delegated functions**: specific additional assurances will be required from The CCG where it has taken responsibility for delegated functions. From April 2015 it will include primary care and may, in time, include other services. An annual review of the assurance of delegated functions will be required prior to the NHS England business planning process for 2016/17. This is in addition to the assurances needed for out-of-hours Primary Medical Services, given this is a directed rather than delegated function

4.9 In addition, there are particular statutory functions for which NHS England will require more detailed focus as part of the assurance process in a particular year. In 2015/16 these will include safeguarding of vulnerable patients and NHS Continuing Healthcare.

4.10 The figure overleaf illustrates the components of the assurance framework.



5.0 The Assurance Process

5.1 The CCG is a statutory organisation responsible to their governing body for the delivery of both their statutory and constitutional duties, and improvements in the health outcomes of their population. NHS England will therefore approach assurance from the assumption that the CCG will deliver against these requirements. This will underpin the approach to assurance, and the agreed improvement plan and support that is made available.

5.2 The information and metrics used as the basis for the assurance process will be subject to discussion between the CCG and NHS England. It will be important to take into account the variety of circumstances which may explain the reasons for variation between this CCG and others.

5.3 The new assurance process introduces a more risk-based approach which differentiates high performing CCGs, those whose performance gives cause for concern, and those in between. It will provide a robust, supportive and structured framework for those in more challenged circumstances, with a lighter touch approach for the best performers. A continuous assurance approach will help to identify emerging patterns of poor performance or any areas of potential risk, with less reliance on fixed points. The process will use information derived from a variety of sources including, where necessary, face-to-face visits. The nature of the oversight, including the expected frequency of assurance meetings, will be agreed between NHS England and the CCG, depending on circumstances, the range of risks identified, and on the leadership response.

5.4 CCGs operating within a distressed health economy, in challenged circumstances, or with performance issues, will have more frequent assessments including of those areas described above that will be continuously reviewed.

5.5 At the end of the year all information will be consolidated into a statutory assurance report by NHS England.

5.6 For co-commissioning functions and for out-of-hours services, the CCG will be required to prepare a quarterly self-certification of compliance against five key areas:

1. governance and the management of potential conflicts of interest,
2. procurement,
3. expiry of contracts,
4. availability of services,
5. outcomes.

5.7 For delegated arrangements and out-of-hours services, the self-certification will be required to be signed off by the CCG governing body. For joint commissioning arrangements the self–certification will be signed off by the joint committee of the CCGs or of the CCG and NHS England. The process will reflect the flexibility of NHS England to respond differently in different circumstances.

5.8 A national moderation process will take place to provide confidence that the framework has been applied consistently across all CCGs, and that issues are being handled and escalated using the same approach.

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

Local Insight

5.10 'Areas for discussion' will also be agreed based on performance against the areas of assurance. They can also be generated from the information which the CCG produces and makes available locally to patients and the public such as CCG board papers and the CCG constitution - including internal and external audits and financial and strategic plans.

5.11 Another key source of insight will be intelligence received from local partners and other organisations, such as the Care Quality Commission, the NHS Trust Development Authority and Monitor reviews and reports, plus relevant local Joint Strategic Needs Assessments, Joint Health and Wellbeing Strategies and insights from quality surveillance groups. Local HealthWatch organisations also play a crucial role in highlighting issues of local concern and opportunities for improving services. In addition, the CCG can also demonstrate how it has worked in partnership with neighbouring CCGs, including inviting a peer assessment of their ways of working.

5.12 This intelligence will also give insight into concerns about delivery and outcomes, and an opportunity to provide constructive challenge to ensure that the CCG is meeting statutory responsibilities. Key local partners, including local authority and Health and Wellbeing Board members, will also be important contributors to the 360 degree stakeholder survey.

5.13 The CCG has a statutory duty to prepare an annual report for each financial year on how it has discharged functions. The annual report will be an important source of local insight to inform the annual assessment of the CCG, particularly regarding compliance with statutory duties including the publication of financial information. The CCG is expected to include a section on statutory compliance within their annual report, which makes a self-certification about continued delivery of statutory duties.

Outputs of Assurance

5.14 NHS England will make a periodic assessment under each component of the assurance framework on the basis of the evidence presented. These assessments will take into account any information which NHS England has received as a result of a request for further information or improvement trajectories.

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

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

5.16 Clear principles have been developed to underpin these assurance categories, providing consistent 'rules' to be followed by NHS England's teams when making assessments. They will be clear on the trigger points for each category, but will allow for judgements to be made on the basis of local intelligence.

5.17 Where NHS England is fully assured by the CCG's performance across all five of the individual areas, the assessment will be 'assured as outstanding'. For CCGs that are 'assured as outstanding', the ongoing assurance process will be relatively light touch. Provided key performance indicators are maintained, NHS England's support would only be at the request of the CCG.

5.18 Where there are minor concerns with the performance of the CCG, but overall the CCG is well led and demonstrates good organisational capability, or if a CCG has a higher level of risk but it is managing it effectively, the headline assessment will be 'assured as good'. NHS England would expect these CCGs to produce their own improvement plan, and to report to NHS England on their progress. However, support would be at the request of the CCG.

5.19 A CCG that has more serious performance or financial challenges and a high level of risk will be assessed as 'limited assurance, requires improvement.' These CCGs would be required to develop an improvement plan which will be approved and monitored by NHS England. This plan would also include a clear indication from NHS England as to the consequences at each step if the plan fails to deliver, and NHS England may take action to intervene if delivery is below plan at any point.

5.20 The improvement plan would also include the additional help and support the CCG should access to ensure delivery, for example support from well-performing CCGs in a 'buddying' arrangement.

5.21 In some circumstances, as laid out in s.14Z21 of the NHS Act 2006 (as amended), NHS England has the ability to exercise statutory powers of direction where it is satisfied that (a) a CCG is failing or (b) is at risk of failing to discharge its functions.5 In these circumstances, the assessment should be that the CCG is 'not assured'.

5.22 For CCGs that are assessed as 'not assured', NHS England will conduct a thorough assessment, working with the CCG, to identify the underlying causes. NHS England will then specify the remedial actions required in the improvement plan. Where a CCG is 'not assured' due to a lack of confidence in the leadership of the CCG, NHS England will work with the CCG to identify how new leadership can be put in place. Where there is confidence in the leadership, NHS England will define a prescriptive set of parameters within which the CCG will operate, and will maintain direct oversight of the organisation until the 'not assured' status is lifted.

5.23 NHS England could, of course, take action to intervene with a CCG which has been assessed as being in any of the four assurance categories at any time, should an urgent problem arise, including issuing formal directions. However, it is most likely to take such action in relation to those CCGs in the 'limited assurance' and 'not assured' categories.

5.24 Interventions will be tailored to the circumstances of the individual CCG, but could include:

- requirement to have plans signed off by NHS England;
- NHS England attendance at meetings and joint decision-making;
- placement of an improvement director into the CCG;
- direction over how a CCG conducts its functions;
- removal of functions to NHS England or another CCG;
- removal of the Accountable Officer; and, in extreme cases,
- dissolution of the CCG.

5.25 At the end of the year the outputs of the assurance process will be consolidated into a statutory assurance report to be published by NHS England. CCGs will also be expected to publish their individual assurance reports.

Special Measures

5.26 Alongside the four assurance categories NHS England may apply a new special measures regime designed to address persistent and chronic performance challenges, financial challenges and / or governance difficulties due to the CCG's lack of capability and capacity to provide leadership to deliver sustained improvement. The application of special measures will usually result from issues that have persisted over a period of two quarters, unless action is required sooner, such as when financial problems are identified. It is most likely to be applied to those CCGs in the 'limited assurance' and 'not assured' categories.

5.27 A CCG placed in special measures will be required to agree with NHS England, and to deliver, a sustainable improvement plan, with the assistance of a range of intensive support options. This could include, for example, support from a well performing CCG, which could act as a 'buddy' for the CCG in special measures. The CCG should have made significant progress in its recovery plan in a maximum of 12 months and, following a review, should exit special measures at this point, if not sooner, even though there may be ongoing deliverables to be achieved as part of the improvement plan.

5.28 Not all CCGs with the same set of issues are likely to be in special measures, as the trigger is the CCG's grip of its situation. If the CCG has not clearly identified, and is not managing the risks arising from its challenges, a decision will be made on whether special measures should be applied.

5.29 In exceptional circumstances NHS England may need to exercise its statutory powers of direction immediately, without a CCG having previously been placed in special measures, or during the special measures process, if the CCG's situation deteriorates.

5.30 For any CCG that is in special measures or under direction, the self-certification process for delegated functions will only be of limited reliance and therefore the discharge of any delegated functions by the CCG in this category will be subject to continuous assurance. For these CCGs, NHS England will also consider reversing the delegation of functions.

5.31 *The Forward View into Action: Planning for 2015/16* described how NHS England, Monitor and the NHS Trust Development Authority will, together, develop a new success regime to support challenged local health economies. NHS England is working with Monitor and the NHS Trust Development Authority to ensure this regime is complementary with 'special measures'.

6.0 Governance of the CCG Assurance Process

6.1 NHS England's Commissioning Committee will oversee this assurance on behalf of the Board. The Committee will need to be assured that the process for CCG assurance is robust, fair and consistent, and will receive the annual report for 2015/16 at the end of the year. This report will outline headline assurance ratings for all CCGs and any areas of interest or concern.

6.2 The Committee will be underpinned by management's CCG Assurance Oversight Group. This group will undertake an active role in the assurance process throughout the year, taking responsibility for:

- operational oversight of the assurance process, ensuring that it is robustly
- and consistently delivered;
- approving any changes to the status of any CCG including interventions,
- taking powers of direction, lifting existing conditions and placing a CCG
- into special measures; and,
- identifying emerging risks or issues.

6.3 The table overleaf sets out the Assurance Categories.

Table 1.0 CCG Assurance Categories

	Assured as outstanding	Assured as good	Limited assurance, requires improvement	Not assured
Explanation of assurance category	CCG can demonstrate that it is continuing to perform well across the five components of assurance. It may have some identified challenges but is proactively managing them.	There are minor concerns with the performance of the CCG, but overall the CCG is well led and in good organisational health, or if a CCG has a higher level of risk but it is managing it effectively.	CCG has serious / persistent / chronic performance or finance challenges and it may not demonstrate the capability or capacity to manage the associated risks to make sustained improvement on its own.	NHS England is satisfied that a CCG is failing or is at risk of failing to discharge its functions
Support level	None	Some support may be required for specific issues	Extensive, from a range of provider options	Formal direction by NHS England
Number / level of issues and unmitigated risks	LOW	MEDIUM	HIGH	VERY HIGH
Action plan – time to recover	None	3-6 months	Up to 12 months	As appropriate
Funding for support and ownership of improvement	n/a	CCG	CCG	CCG / NHS England

7.0 Recommendation

7.1 The Committee is requested to note the revision to the assurance framework and consider any appropriate actions to support the assurance process going forward.

Karl McCluskey
June 2015

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE FINANCE AND RESOURCE COMMITTEE JUNE 2015

Agenda Item: FR15/75	**Author of the Paper:**
Report date: June 2015	Susanne Lynch Head of Medicines Management Susanne.lynch@southportandformbyccg.nhs.uk Tel: 0151 247 7146
Title: Prescribing Update	
Summary/Key Issues: This paper presents the Committee with an update on prescribing spend for March 2015 (month 12).	
Recommendation The Finance and Resource Committee is asked to note the report	*X* Receive X Approve Ratify

Links to Corporate Objectives *(x those that apply)*	
	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
X	To achieve financial duties and commission high quality care.

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			MMOG

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
	Treating and caring for people in a safe environment and protecting them from avoidable harm

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Finance and Resource Committee
March 2015

1. Executive Summary

The Southport and Formby CCG position for month 12 (Mar 2015) is an overspend of £442k or 2.20% on a budget of £20.1m (Appendix 1).

2. Introduction and Background

This is an update on the management of the Southport and Formby prescribing budget.

3. Key Issues

The Southport and Formby CCG prescribing budget is overspent. A significant increase in the prescribing of Endocrine System drugs compared to the previous FY (£291 and 12,761 items) along with Nutrition & Blood (£173k and 9,245 items), Respiratory System (£100k and 10,793 Items) and Gastro-Intestinal System (£61k and 11,990 items – see Appendix 2.) has contributed towards this. Adjustments for High Cost Drugs, Weighted Practice list Size and Category M Pressure accounts for an increase of £59k.

4. Conclusions

An increase in spend on chronic disease areas and an increase in weighted population has significantly contributed to this year's overspend.

5. Recommendations

The Committee is asked to note the contents of the report.

Appendices

Appendix 1

SFCCG Monitoring Report and Budget Adjustments YTD Month 12 Mar 15

Prescriber Code	Prescriber Name	Total 14/15 Budget	Original Budget with high Cost Drugs Adjustment	Original Budget with Pop Shift Adjustment	Original Budget with Cat M Pressure	Adjusted 14/15 Budget (HCD, CatM & Pop shift)	Variance	% Variance	Difference to Original Budget
N84005	CUMBERLAND HOUSE SURGERY	£1,366,043	£1,355,439	£1,390,170	£1,351,932	£1,365,454	£70,254	5.15%	-£590
N84013	CURZON ROAD MEDICAL PRACTICE	£892,848	£901,041	£860,457	£875,536	£851,339	£74,385	8.74%	-£41,509
N84617	KEW SURGERY	£509,882	£510,349	£513,701	£505,120	£509,406	-£4,092	-0.80%	-£477
N84021	ST MARKS MEDICAL CENTRE	£2,395,608	£2,398,245	£2,337,909	£2,398,647	£2,343,585	£99,237	4.23%	-£52,024
Y02610	TRINITY PRACTICE	£737,875	£741,293	£794,443	£714,165	£774,151	£59,167	7.64%	£36,276
Central Southport	**Central Southport**	**£5,902,257**	**£5,906,367**	**£5,896,679**	**£5,845,400**	**£5,843,933**	**£298,953**	**5.12%**	-£58,323
N84006	CHAPEL LANE SURGERY	£1,256,946	£1,252,591	£1,255,704	£1,279,719	£1,274,122	£8,660	0.68%	£17,176
N84036	FRESHFIELD SURGERY	£509,174	£490,938	£498,686	£503,789	£475,065	-£33,104	-6.97%	-£34,109
N84618	THE HOLLIES	£686,406	£683,345	£707,074	£689,599	£707,207	£6,055	0.86%	£20,802
N84018	THE VILLAGE SURGERY FORMBY	£1,620,435	£1,644,302	£1,634,117	£1,640,246	£1,677,794	£63,157	3.76%	£57,359
Formby	**Formby**	**£4,072,961**	**£4,071,176**	**£4,095,581**	**£4,113,353**	**£4,134,188**	**£44,768**	**1.08%**	£61,227
N84017	CHURCHTOWN MEDICAL CENTRE	£2,070,543	£2,057,717	£2,065,414	£2,035,589	£2,017,634	£94,397	4.68%	-£52,909
N84008	NORWOOD SURGERY	£1,317,198	£1,311,787	£1,346,785	£1,313,413	£1,337,589	£4,955	0.37%	£20,392
N84611	ROE LANE SURGERY	£413,974	£416,374	£441,349	£416,453	£446,227	-£4,800	-1.08%	£32,253
N84613	THE CORNER SURGERY (DR MULLA)	£583,449	£587,017	£583,679	£588,565	£592,362	£1,044	0.18%	£8,913
N84614	THE MARSHSIDE SURGERY (DR WAINWRIGHT)	£441,204	£443,750	£433,084	£434,917	£429,343	£8,242	1.92%	-£11,861
North Southport	**North Southport**	**£4,826,368**	**£4,816,644**	**£4,870,311**	**£4,788,938**	**£4,823,156**	**£103,837**	**2.15%**	-£3,212
N84012	AINSDALE MEDICAL CENTRE	£2,033,275	£2,034,979	£2,067,743	£2,044,836	£2,081,008	-£18,294	-0.88%	£47,733
N84014	AINSDALE VILLAGE SURGERY	£573,037	£571,347	£568,114	£576,393	£569,779	£27,439	4.82%	-£3,258
N84024	GRANGE SURGERY	£1,748,852	£1,719,345	£1,755,347	£1,779,404	£1,756,393	£17,479	1.00%	£7,541
N84037	LINCOLN HOUSE SURGERY	£377,494	£384,418	£366,647	£390,832	£386,908	£18,320	4.73%	£9,414
N84625	THE FAMILY SURGERY	£468,452	£469,798	£470,412	£462,911	£466,217	-£7,882	-1.69%	-£2,235
South Southport	**South Southport**	**£5,201,110**	**£5,179,887**	**£5,228,264**	**£5,254,375**	**£5,260,305**	**£37,062**	**0.70%**	£59,195
Southport & Formby CCG	**Southport & Formby CCG**	**£20,002,696**	**£19,974,074**	**£20,090,835**	**£20,002,066**	**£20,061,584**	**£484,619**	**2.42%**	£58,887
	Ainsdale minus Wigan Prescribing Costs								
	£59,991.82								
					Adj Bud + Risk	**Total Cost**			
Risk Pool	**£101,427**	**Risk Pool**	**£42,539**	**Total Budget**	**£20,104,123**	**£20,546,202**	**£442,079**	**2.20%**	

Appendix 2

Endocrine System Drugs

	Period Name	Values					
	Financial 2013/2014		Financial 2014/2015				
BNF Name	Items	Cost	Items	Cost	Items Variance	Cost Variance	Cat M Drug
Aviva (Reagent)_Strips	2205	£76,190	2438	£87,662	233	£11,472	#N/A
Carbimazole_Tab 20mg	479	£18,340	398	£26,581	-81	£8,241	#N/A
Carbimazole_Tab 5mg	722	£11,913	694	£21,273	-28	£9,361	#N/A
Contour Next (Reagent)_Strips	2445	£58,212	3971	£97,144	1526	£38,932	#N/A
Dapagliflozin_Tab 10mg	60	£2,113	1053	£36,737	993	£34,624	#N/A
Dexameth_Tab 2mg	342	£1,657	367	£12,145	25	£10,488	#N/A
Ethinylestr_Tab 10mcg	10	£6,292	13	£12,578	3	£6,287	#N/A
Hydrocort_Tab 10mg	770	£79,316	884	£104,844	114	£25,528	*
Ins Lantus SoloStar_100u/ml 3ml Pf Pen	3019	£148,528	3292	£161,441	273	£12,913	#N/A
Ins NovoRapid_FlexPen 100u/ml 3ml Pf Pen	2174	£84,497	2363	£91,924	189	£7,427	#N/A
Levothyrox Sod_Tab 25mcg	22603	£75,833	26202	£82,580	3599	£6,747	*
Linagliptin_Tab 5mg	664	£18,594	1773	£46,641	1109	£28,046	#N/A
Liothyronine Sod_Cap 5mcg			10	£5,339	10	£5,339	#N/A
Liothyronine Sod_Tab 20mcg	67	£13,148	98	£23,496	31	£10,348	#N/A
Liraglutide_Inj 6mg/ml 3ml PF Pen	584	£50,254	649	£58,571	65	£8,317	#N/A
Metformin HCl_Oral Soln 500mg/5ml S/F	32	£2,117	189	£20,815	157	£18,699	#N/A
Metformin HCl_Tab 500mg	30749	£77,600	31016	£104,477	267	£26,877	*
Mobile (Reagent)_Strips	1205	£45,024	1444	£56,387	239	£11,363	#N/A
OneTouch Verio (Reagent)_Strips	61	£1,579	212	£7,299	151	£5,720	#N/A
Prednisolone_Tab Solb 5mg	549	£19,620	599	£24,833	50	£5,213	#N/A
Sitagliptin_Tab 100mg	6068	£185,614	6769	£203,775	701	£18,162	#N/A
Grand Total	246643	£2,337,370	259404	£2,628,268	12761	£290,899	#N/A

Nutrition & Blood

	Period Name / Values						
	Financial 2013/2014		Financial 2014/2015				
BNF Name	Items	Cost	Items	Cost	Items Variance	Cost Variance	Cat M Drug
Adcal-D3_Tab Chble (Tutti-Frutti)	10902	£32,937	13745	£40,198	2843	£7,260	#N/A
Ascorbic Acid_Tab 500mg	398	£1,466	353	£7,163	-45	£5,697	#N/A
Ensure Compact_Liq (3 Flav)			363	£37,197	363	£37,197	#N/A
Ensure Plus Juce_Liq Feed (6 Flav)	1147	£22,786	1355	£33,723	208	£10,937	#N/A
Hydroxocobalamin_Inj 1mg/ml 1ml Amp	7570	£8,166	8412	£18,595	842	£10,428	*
Jevity 1.5kcal_Liq	139	£40,917	164	£46,845	25	£5,928	#N/A
Jevity Plus_Liq	74	£29,029	114	£41,270	40	£12,241	#N/A
Neocate LCP_Pdr	188	£20,705	304	£46,371	116	£25,667	#N/A
PaediaSure Plus Fibre_Liq (3 Flav)	74	£13,215	116	£22,137	42	£8,921	#N/A
Phlexy-10_Tab 1.4g			10	£6,392	10	£6,392	#N/A
Thiamine HCl_Tab 100mg	7406	£16,923	8035	£30,380	629	£13,456	#N/A
Vit B Co_Tab	722	£15,502	755	£24,543	33	£9,041	#N/A
Grand Total	150157	£1,211,413	159402	£1,384,629	9245	£173,215	#N/A

Respiratory System

	Period Name / Values						
	Financial 2013/2014		Financial 2014/2015				
BNF Name	Items	Cost	Items	Cost	Items Variance	Cost Variance	Cat M Drug
Beclomet Diprop/Formoterol_Inh100/6(120D	428	£13,675	720	£23,066	292	£9,390	#N/A
Carbocisteine_Cap 375mg	3001	£41,405	3741	£48,336	740	£6,931	*
Clenil Modulite_Inha 100mcg (200D)	6386	£51,435	7309	£58,475	923	£7,041	#N/A
Fluticasone/Salmeterol_Inh 125/25mcg120D	2554	£103,786	2833	£111,425	279	£7,639	#N/A
Fluticasone/Salmeterol_Inh 250/25mcg120D	3650	£232,436	4122	£262,455	472	£30,019	#N/A
Fostair_Inh 100mcg/6mcg (120D) CFF	1032	£31,521	1626	£51,013	594	£19,492	#N/A
Seretide 500_Accuhaler 500mcg/50mcg(60D)	2720	£116,426	3148	£134,652	428	£18,226	#N/A
Symbicort_Turbohaler 200mcg/6mcg (120 D)	1271	£57,340	1529	£70,038	258	£12,697	#N/A
Tiotropium_Pdr For Inh Cap 18mcg	9542	£324,447	9814	£331,560	272	£7,114	#N/A
Grand Total	163388	£2,552,507	174181	£2,652,418	10793	£99,910	#N/A

Gastro-Intestinal System

	Period Name / Values						
	Financial 2013/2014		Financial 2014/2015				
BNF Name	Items	Cost	Items	Cost	Items Variance	Cost Variance	Cat M Drug
Laxido_Oral Pdr Sach (Orange) S/F	4029	£25,528	5762	£32,968	1733	£7,439	#N/A
Loperamide HCl_Cap 2mg	3752	£7,748	3728	£14,774	-24	£7,026	*
Mag Hydrox_Mix	2713	£11,569	2589	£16,951	-124	£5,382	#N/A
Mebeverine HCl_Tab 135mg	5006	£24,661	4907	£51,916	-99	£27,256	*
Grand Total	279862	£1,357,377	291852	£1,418,557	11990	£61,180	#N/A

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE FINANCE AND RESOURCE COMMITTEE JUNE 2015

Agenda Item: FR15/76	**Author of the Paper:**
Report date: June 2015	Jenny Kristiansen Respiratory Managerial Lead Email: jenny.kristiansen@southportandformbyccg.nhs.uk Tel: 0151 247 7282

Title: Improving Respiratory Care in the Primary Care Setting

Summary/Key Issues:
The need for up to date respiratory training for all primary care clinicians has been established. The Respiratory Programme Lead has identified an evidence based training programme, with full support of the Clinical Lead. The overall aim of the programme is to support practices in improving their asthma and COPD management in order to deliver improved patient outcomes and reduce unplanned admissions by running an intensive back to basics training and mentorship programme.

This project was presented and agreed at SIR Group and is currently being delivered across South Sefton CCG constituent practices.

Recommendation

The Committee is asked to approve funding for the project described within this paper.

	X
Receive	
Approve	X
Ratify	

Links to Corporate Objectives *(x those that apply)*	
X	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
X	To achieve financial duties and commission high quality care.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	X			Discussed at Respiratory Steering Group
Clinical Engagement	X			Dr Kati Scholtz
Equality Impact Assessment		X		
Legal Advice Sought			X	
Resource Implications Considered	X			
Locality Engagement		X		
Presented to other Committees	X			Service Improvement & Redesign Committee January 2015

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

Ref No	Office use
Cost Centre	Office use

Case for change – Front Sheet

Scheme Title	Improving Respiratory Care in the Primary Care Setting
Programme or Locality Clinical lead	Dr Kati Scholtz
Programme or Locality Area	Programme
CCG Programme Lead or Locality Manager	Jenny Kristiansen - Respiratory Programme Lead
Funding Requirement	£ 83,965
Source of funding identified via checklist	

Which national & CCG commissioning priorities does scheme meet?

All schemes must address a minimum of 1 priority area from Section A & Section B		
NHS Outcome Framework		If relevant state NOF indicator / improvement area
1 Preventing people dying prematurely		
2 Enhancing quality of life those with LTCs		2& 2.1
3 Helping people recover – ill health or injury		
4 Ensure positive experience of care		4.9
5 Treatment in a safe environment, free avoidable harm		
CCG Priorities		
CCG Strategic Priorities	Tick	CCG Strategic Priorities – Equity of Access
Frail Elderly		Mental Health
Unplanned Care	x	Children's
Primary Care		Cancer
CCG Transformational Scheme	Tick	CCG System
Virtual Ward (Integrated Locality Care)		18 Weeks to Referral
Primary Care Transformation	X	Reduce A&E Admissions / Admissions
Patient Self Care		NHS Constitution (Please state details below)
Other (Please state below)		

Authorisation

Checklist MUST be completed and signed off before Case for change referenced document is issued by PMO			
Tick	Authorisation Gateways Completed	Authorised Signatory	Date
Level 1 £0-£50,000	Authorised checklist approved via SMT to proceed to Case for change		
	Case for change – Signed via SMT		
Level 2 & 3 £50,000 +	Additional sign off required – Service Improvement and Redesign committee	Agreed	Jan 2015

LEVEL ONE – CASE FOR CHANGE

1. Case Outline

1.1 Case of need - Why is the Case for Change being proposed? (Guide 40 words)

The need for up to date respiratory training for all primary care clinicians has been established. The Respiratory Programme Lead has identified an evidence based training programme, with full support of the Clinical Lead. The overall aim of the programme is to support practices in improving their asthma and COPD management in order to deliver improved patient outcomes and reduce unplanned admissions by running an intensive back to basics training and mentorship programme.
This project was presented and agreed at SIR Group and is currently being delivered across South Sefton CCG constituent practices.

1.2 Describe the new pilot/service/service proposed and its key features? Please include any evidence for similar schemes that demonstrate potential benefits of this scheme.

1.2.1 Proposed Project Objectives:

At the end of this project the participating practices of the Southport & Formby CCG will be able to:

- Accurately diagnose respiratory conditions in children and adults
- Undertake respiratory disease assessments and implement patient specific management regimes that will reduce the risk/rates of acute exacerbations and unplanned hospital admissions

1.2.2 The project will be delivered by::

- 5 face to face workshops over 12 months
- Enrolment onto a bespoke respiratory e learning course
- A practice based clinical mentorship/nurse consultant clinic
  Supporting materials.

1.2.3 Proposed provider - evidence

Outcomes achieved in neighbouring CCGs are as follows:

- The Blackburn with Darwen project won the Nursing Standard Innovations in Respiratory Care Award and the first Aneurin Bevan Project won the British Journal of Nursing Nurse of the Year Award for Innovation in Practice.
- The Wirral Health Commissioning Consortium Adult Asthma project demonstrated a 48% reduction in unplanned admissions, the findings of which are in the process of being prepared for publication and submission for various awards.
- The Health First COPD Smoking Cessation Project demonstrated a 65% quit rate and the findings of this project have been presented across the UK at 6 of the Nursing in Practice Conferences.

1.3 Describe resources required to deliver proposal? (Guide 40 words)

Describe Level of Clinical time / expertise required? Outline any additional support required. E.g. Investment on IT equipment / Staff training Staff training: • Clinical time of Practice Nurses – 5.5 days and 3 mentorship clinics and 30 hours e-learning • HCA session – 2 days • GP – Lunchtime sessions per practice

1.4 Proposed implementation timetable.

Milestone	Owner	Date of Completion
Recruit nurses onto training - 1st session to be held end of July	Jenny K	15.6.15
Arrange payments to practice for back fill	Jenny K	End of July 2015
Book trainings sessions - 11 days across S&F for 35 nurses - e learning details to be shared with nurses at 1st session (end of July)	Jenny K	5th August 2015
Arrange nurse mentorship dates with nurses - confirmation schedule shared with Jenny K	Jenny K	End of July 2015
Health Care Assistant training - 2 day	Jenny K	End of July 2015
Monitoring	Jenny K	TBC
Evaluation	Jenny K	TBC

2 . Costing & Invest to Save potential

2.1 Provide a summary of current and proposed costs. Also demonstrate any savings and shifts in expenditure across care settings, so that contracts can be adjusted accordingly. Spreadsheets can be included in appendices

2.1.1 Training Programme

Activity	Amount
E learning - 12 month course, assessment at each module. Accredited by Royal College of Nursing 40 places at £350 plus VAT	Free
Face to face education sessions – 11 days 22 nurses per day (2 groups – 5.5 days per nurse)	£7,920
Nurse mentorship 40 days (2 per practice) @ £600 (Nurse consultant) per day	£28,800
Nurse Mentorship - Nurse Practitioner £300 per day – 20 days	£7,200
Nurse Consultant Audit/clinics 3 surgeries (5 days @ 600	£3,600
Health Care Assistant Training sessions- (5 sessions)	£3,600

DRAFT

Final overall project report and admin	£1,200
Room booking for training 11 full days	£2,000
3 x PLT & other CCG related sessions	2,160
Care home education - number of face to face and workshops (3 sessions)	£2,220
Total	£ 58,700

2.2.3 Backfill payment to practices

Activity	Amount
Backfill payment to practices 5.5 days per nurse 35 nurses x £17.50 per hour x 5.5 days (41.25 hours) =£721.87 per nurse	£25,265

2.2.4 Project total - £83,965

3. Define Key Benefits / Outcomes

3.1 List the main benefits associated with the Case for Change.

3. 1.Patient

- Reduction of exacerbations
- Improvement in Quality of life
- Improvement in education and self- management
- Optimisation of medicines & symptom control

3.2 Locality

- Improved patient management
- Reduction of Practice Nurse and GP appointments following patient review
- Improvement in patients taking control of their condition
- Upskilling practice staff

3.3.CCG

- Reduction of inappropriate admissions & A&E attendances
- Equity of care across South Sefton and Southport & Formby CCGs
- Upskilled workforce

3.4.Wider System

- Reduction on all urgent care services / provision

DRAFT

4. Evaluation

4.1 Describe how project will demonstrate delivery against 2-3 key outcomes. Please state key performance indicators. Please confirm baseline (Previous 12 months) and quantify planned impact. If proposal is based on scheme elsewhere please use findings to inform KPIs and activity modelling.

	£ Forecast for 2014/15	Admissions
2014/15 Forecast	2,669,836	1,908
40% reduction	-1,067,934	-763

Reporting requirements depend on value of the case and must include performance against above KPIs.

☐ Level 1 Case - 6 month progress report and full year report must be submitted to PMO

☐ Level 2 & 3 Case – As above, with PMO monitoring above KPIs on monthly or quarterly basis.

5. Patient & Public Involvement

Have patients / patient groups been involved in shaping this case?

YES / NO

If YES who has been involved and how have they contributed to case? (Guide 40 words)

The Respiratory Steering Group have been involved in shaping the case, this includes a patient representative.

6. Conflicts of Interest

Does this case for change need to go to the Approvals panel?

YES / NO

If YES provide a brief outline of reasons why? (Guide 40 words)

7. Privacy Impact Required?

Will any information be shared outside of NHS?

YES / NO

If YES provide details?

8. Equality Impact Assessment

Please confirm that changes linked to this scheme have been reviewed in line with EIA guidance?

YES / NO

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE FINANCE AND RESOURCE COMMITTEE JUNE 2015

Agenda Item: FR15/80	**Author of the Paper:**
Report date: June 2015	Billie Dodd Head of Development billie.dodd@southportandformbyccg.nhs.uk 01704 387034
Title: SRG Allocations and Transformational Funds	
Summary/Key Issues: This paper provides the Committee with information relating to the Distribution of System resilience funding and proposals for the transformational fund.	
Recommendation The Committee is asked to approve the plans for the distribution of System Resilience Funding and the proposals for Transformational Funds.	X Receive Approve X Ratify

Links to Corporate Objectives *(x those that apply)*	
X	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
X	To achieve financial duties and commission high quality care.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement		X		
Clinical Engagement	X			Schemes suggested by clinicians and monitored
Equality Impact Assessment		X		
Legal Advice Sought			X	
Resource Implications Considered	X			
Locality Engagement	X			Locality Managers to engage localities
Presented to other Committees	X			Will go to SIR Committee in July

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

System Resilience Funding

The System Resilience Group (SRG) is a collaborative group which includes the Southport and Ormskirk ICO, West Lancashire CCG, NAWS, Social services and mental health to support the urgent care system to co-operative and improve performance.

Table A below outlines the plans for spend. The CCG have allocated £900k in its baseline with £620k going to the ICO. The remaining £280k being used within the SRG (this does not include the £25K arbitration funds).

Table A

Funding available		**£000**
System resilience		900
Arbitration fine (SFCCG element)		25
		925
Proposed expenditure	**£000**	
S&O Trust (CERT)	620	
Community geriatrician	205	
UCAT dashboard	11	
Social Worker	0.5	
Total		836.5
Remaining balance		88.5

The Rapid Access Geriatrician scheme has been developed with GPs and the Acute trust and will provide clinic sessions on 4 days a week for referrals of 3 patients per day (a 5th session will be used for admin time spread across the week) . In addition to this there will be telephone access and email availability. There will be a team supporting the scheme detailed and costed below

5 PA's Consultant	96,582
1 WTE B4 med sec	27,039
0.4 WTE B6 CERT nurse	16,554
0.4 WTE B6 physio	16,554
0.4 WTE HCA	8,786
Non pay	30,000
Management cost	9,776
Total	£205,291 pa

Transformational Fund

The transformational fund has been developed to support additional commissioned services to improve patient care in Southport and Formby and to support strategic objectives. This is an on-going process but the aim is to allocate resource as soon as possible to ensure schemes are in place as early in the year as possible. The Schemes have been developed by clinicians and will have clinical sponsorship. They will also be presented for clinical critique and July's Service Improvement and Re-design Committee.

Table B below provides the detail, please note that several schemes are still in the process of being collated and fully developed and figures may fluctuate depending on negotiations with provider and other variables including recruitment of staff. The intention is to inform the Committee of proposals and that schemes will be developed by clinicians and supported by management and finance colleagues.

Table B

Financial Year 2015/16	**Southport and Formby £000**	**Comments**
Resource	1,800	
Commitments:		
Mersey Care contract	375	
Intermediate Care	200	Figures tbc
Management support (external / internal)	200	Includes funding for Deloitte sustainability review and any further agreed staffing associated with Transformational schemes (eg. Emily Ball, Pharmacy support)
Total Commitments	**775**	
Balance available	**1,025**	
Further proposals:		
IV therapy services at S+F	140	£25k for 6 month pilot treating 3 conditions. £140k for all suitable conditions
Telehealth in nursing homes	140	In-year investment to focus on top 15 homes - total cost for all care homes - c. £450k
Early Supported Discharge	180	Estimate of value based on draft business case. However, it may need to be jointly commissioned with West Lancashire CCG. The figure here is only an estimate of the SFCCG proportion.

Respiratory primary care training scheme	75	
Acute Frailty Visiting Service	214	Local GPs working OOH's to provide visits (Dr Leonard proposal from May SIR) lead Moira McGuiness
GPSI in Community Geriatric Medicine	200	Working with The rapid access scheme and Acute care geriatricians, based in each locality (Dr Leonard proposal may SIR) lead Billie Dodd
Treatment room development including lymphodoema training	170	Facing the future together has identified an opportunity to develop treatment room functions to increase District Nursing time and resource. Paper to FtFT board 30th June 2015. Lead Billie Dodd
Connected Communities	87	Develop existing scheme across all localities. Lead Jane Uglow
Total	**1,206**	
Funding shortfall	**(181)**	

Other schemes - removed, but may be pursued in future years

Southport health shop	150	2017 start date

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE FINANCE AND RESOURCE COMMITTEE JUNE 2015

Agenda Item: FR15/81	**Author of the Paper:**
Report date: June 2015	Martin McDowell Chief Finance Officer Martin.mcdowell@southportandformbyccg.nhs.uk 0151 247 7065
Title: Finance and Resource Committee Terms of Reference	
Summary/Key Issues: To review the Terms of Reference	
Recommendation The Committee is asked to review and approve any changes to the Terms of Reference.	*X* Receive ☐ Approve X Ratify ☐

Links to Corporate Objectives *(x those that apply)*	
	To place clinical leadership at the heart of localities to drive transformational change.
	To develop the integration agenda across health and social care.
	To consolidate the Estates Plan and develop one new project for March 2016.
	To publish plans for community services and commission for March 2016.
	To commission new care pathways for mental health.
	To achieve Phase 1 of Primary Care transformation.
X	To achieve financial duties and commission high quality care.

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

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

Southport and Formby

Finance and Resources Committee

Terms of Reference

1. Authority

1.1. The Finance and Resource Committee shall be established as a committee of the Governing Body to perform the following functions on behalf of the CCG Governing Body.

1.2. The principal functions of the Committee are as follows:

- The Committee shall be authorised by the CCG Governing Body to undertake any activity within these terms of reference and act within the powers delegated to it in line with the Scheme of Reservation and Delegation.

- To provide assurance to the Governing Body that there are appropriate systems in place which operate in order to enable the Committee to fulfil its monitoring requirements.

- To provide regular reports to the Governing Body on a timely basis and to provide an annual report on the work carried out by the Committee including a self-assessment of how it has discharged its functions and responsibilities.

2. Membership

2.1. The following will be members of the Committee:

- Lay Member (Governance) (Chair)
- Clinical Governing Body Member (Vice Chair)
- Clinical Governing Body Member
- Lay Member (Patient Experience and Engagement)
- Practice Manager Governing Body Member
- Locality Clinical Representatives
- Chief Financial Officer
- Head of Primary Care and Corporate Performance
- Head of CCG Corporate Delivery and Integration
- Head of CCG Development
- Chief Nurse

The Chief Officer shall be an ex-officio member of the Committee

2.2. The Chair of the Governing Body will not be a member of the Committee although he/she will be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee's operations.

2.3. Members are expected to personally attend a minimum of 60% of meetings held and can send a deputy to attend in their absence as required.

2.4. Relevant Officers from the CCG will be invited to attend in line with agenda items. Officers from other organisations including Cheshire and Mersey Commissioning Support Unit (CMSCU) and from the Local Authority Public Health team will also be invited to attend in line with agenda items.

3. Responsibilities of the Committee

The Finance and Resources Committee is responsible for the following.

3.1. Advising the Governing Body on all financial matters and to provide assurance in relation to the discharge of statutory functions in line with the Prime Financial Policies

3.2. Reviewing the overall financial position of the CCG to ensure that the organisation meets its statutory financial duties.

3.3. Overall financial management of the organisation including the delivery of investment plans, monitoring of reserves, and delivery of financial recovery plans and cost improvement plans.

3.4. Ensuring that the performance of commissioned services is monitored in line with CCG expectations.

3.5. Monitoring key performance indicators (e.g. any outlined in the NHS Operating Framework).

3.6. Advising the Governing Body on the approval of annual financial plans.

3.7. Monitoring and advising appropriate courses of action with regard to other key areas of CCG business (notably procurement, contracting and monitoring progress of Foundation Trust (FT) applications of local providers.

3.8. Supporting the work of the Audit Committee through review of financial arrangements as required.

3.9. Determining banking arrangements

3.10. Approving arrangements for exceptional/novel treatments which shall include arrangements for review and consideration of Individual Funding Requests (IFRs)

3.11. Reviewing and approving requests for Ex-Gratia payments

3.12. To receive recommendations from the local Individual patient review (IFR) panel and approve as appropriate.

4. Duties of the Committee

The Committee is delegated by the Governing Body to undertake the following duties and any others appropriate to fulfilling the purpose of the Committee (other than duties which are reserved to the Governing Body or Membership alone).

4.1. Oversee the development of the short and medium-term strategies for the CCG including assessment of the assumptions underpinning the financial models.

4.2. To ensure the delivery of financial balance and that the organisation meets its statutory financial targets.

4.3. Ensure that the Finance and Performance Plans are consistent with and complementary to the CCGs Annual Budget, Commissioning Plan ("One Plan") and Strategic Plan.

4.4. To monitor implementation of the annual financial plan to ensure that the total resource available to CCG is invested in high quality services that support the achievement and delivery of specified priorities.

4.5. Approving any variations to planned investment within the limits set out in the detailed financial policies of the CCG, ensuring that any amended plans remain within the overall CCG budget and do not adversely affect the strategic performance of the CCG.

4.6. Monitoring Financial and Operational Performance across all commissioned services on an exception basis, assessing potential shortfalls and risk and recommending actions to address them.

4.7. Monitoring Key Performance Indicators (KPIs) relating to CCG performance, for example as outlined in the NHS Operating Framework and One Plan.

4.8. Monitoring delivery of any QIPP programmes and agreeing corrective action if required.

4.9. Monitor key risks facing the CCG, understand the financial consequences and make recommendations for inclusion on the CCG risk register accordingly.

4.10. Oversee the development and delivery of capital investment plans including any schemes progressed through the LIFT or 3PD initiatives.

4.11. Oversee the development and implementation of the Estates strategy.

4.12. Oversee the development and implementation of Human Resource strategies, plans and policies.

4.13. Maintain an overview of recruitment, retention, turnover and sickness trends.

4.14. To ensure that services provided by other organisations, notably Cheshire and Merseyside CSU, are being delivered as per the CCG's expectations and to advise on remedial action where necessary.

4.15. To review, monitor and agree corrective action for all agreed financial performance indicators (KPIs to be determined based on CCG finance regime when published).

4.16. To review the CCG procurement strategy and advise on an appropriate course of action regarding commissioning of new services / re-tendering arrangements for existing services.

4.17. To review and monitor progress regarding contracting arrangements with healthcare providers.

4.18. To monitor progress of local provider plans, particularly aspirant FTs, to advise the Governing Body in terms of key issues and any recommend decisions as appropriate.

4.19. The Committee will review monthly reports detailing performance of commissioned services against core standards, national and local targets and the CCGs Strategic Plans, review may be on an exception basis.

4.20. To receive and consider the approval of business cases and proposals from the Service Improvement and Re-Design Committee and to approve such cases and proposals up to a value of £200K (subject to budgetary resources being available)

4.21. To recommend business cases to the Governing Body for approval when the value of the business case or proposal exceeds £200K

4.22. To review and approve plans for Emergency Planning and Business Continuity

4.23. To produce an Annual Report of the key work programmes of the Committee to the Governing Body on an annual basis.

5. Establishment of Sub-Groups of the Committee

5.1. The Committee will undertake regular review of its workload and will from time to time establish sub-groups to ensure that it conducts its business in an effective and appropriate manner. These sub groups will be required to provide key update reports as stipulated by the Finance and Resources Committee and submit ratified notes of meetings to the Finance and Resources Committee.

6. Administration

6.1. The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee's business.

6.2. The agenda for the meetings will be agreed by the Chair of the Committee and papers will be distributed one week in advance of the meeting.

6.3. The Secretary will take minutes and produce action plans as required to be circulated to the members within 10 working days of the meeting.

7. Quorum

7.1. Meetings with at least 50% of the Committee membership, at least one Clinical Governing Body Member, at least one Lay Person and either the Chief Officer or Chief Finance Officer in attendance shall be quorate for the purposes of the CCG's business.

7.2. The quorum shall exclude any member affected by a Conflict of Interest. If this has the effect of rendering the meeting inquorate then the Chair shall decide whether to adjourn the meeting to permit the co-option of additional members.

Frequency and notice of meetings

The Committee shall meet at least 8 times a year. Members shall be notified at least 10 days in advance that a meeting is due to take place.

8. Reporting

The ratified minutes of the Finance and Resources Committee will be submitted to the Governing Body private meeting. Exception reports will also be submitted at the request of the Governing Body. The minutes and key issues arising from this meeting will be submitted to the Audit Committee.

9. Conduct

9.1. All members are required to maintain accurate statements of their register of interest with the Governing Body. Members should notify the committee chair of any actual, potential or perceived conflicts in relation to the agenda, in advance of the meeting.

9.2. In the event that there is a Conflict of Interest declared before or during a meeting the procedure for dealing with Conflicts of Interest as set out in the NHS Southport and Formby CCG Constitution shall apply.

9.3. All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

10. Review

Date:	April 2014
Version No.	**3**
Review dates	November 2013 March 2014 September 2014 March 2015

NHS
Southport and Formby
Clinical Commissioning Group

Audit Committee Minutes

Wednesday 20th May 2015, 2.30pm to 4.00pm
Family Life Centre, Southport

Members		
Helen Nichols	Lay Member (Chair)	HN
Roger Pontefract	Lay Member	RP
Paul Ashby	Practice Manager	PA
Jeff Simmonds	Lay Member and Governing Body Member	JS
In Attendance		
Martin McDowell	Chief Finance Officer	MMcD
David Smith	Deputy Chief Finance Officer	DS
Ken Jones	Chief Accountant	KJ
Ian Roberts	Senior Manager, PricewaterhouseCoopers	IR
Elizabeth Tay	Audit Manager, PricewaterhouseCoopers	ET
Apologies		
Mark Jones	Audit Director, PricewaterhouseCoopers	MJ
Minutes		
Ruth Moynihan	PA to Chief Finance Officer	RM

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

Name	Membership	Oct 14	Jan 15	April 15	May 15	July 15	Oct 15	Jan 16
Helen Nichols	Lay Member (Chair)	A	✓	✓	✓			
Roger Pontefract	Lay Member	✓	✓	✓	✓			
Paul Ashby	Practice Manager	✓	✓	✓	✓			
Colette Riley	Practice Manager	✓						
Jeff Simmonds	Lay Member and Governing Body Member	✓	A	✓	✓			
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓			
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	A	N			
David Smith	Deputy Chief Finance Officer	✓	A	✓	✓			
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	✓	N	A	N			
Ken Jones	Chief Accountant	✓	✓	✓	✓			
Debbie Fairclough	Head of Client Relations, CMCSU	A	A	A	N			
Roger Causer	Senior Local Counter Fraud Specialist, MIAA	A	N	N	N			
Wendy Currums	Local Counter Fraud Specialist, MIAA	✓	✓	✓	N			
Adrian Poll	Audit Manager, MIAA	✓	✓	✓	N			
Elizabeth Tay	Audit Manager, PricewaterhouseCoopers	A	✓	✓	✓			
Mark Jones	Audit Director, PricewaterhouseCoopers	A	A	A	A			
Ian Roberts	Senior Manager, PricewaterhouseCoopers		✓	A	✓			

No	Item	Action
A15/43	**Apologies for absence** Apologies for absence were received from Mark Jones.	
A15/44	**Declarations of interest** Declarations of interest were received from CCG officers who hold dual posts in both Southport and Formby CCG and South Sefton CCG.	
A15/45	**Advance notice of items of other business** There were no items of other business advised to the Chair.	
A15/46	**Minutes of the previous meeting** The minutes of the previous meeting were approved as a true and accurate record and signed-off by the Chair.	
A15/47	**Action points from previous meeting** ***A15/09 Internal audit counter fraud progress report*** *– WC to speak with RC re the plan of action on counter fraud, as well as the response for the action of Counter Fraud Policy 2013/14* – this is to be deferred to July. ***A15/10 Finance training for Committee members*** – a Q&A session will form part of the Governing Body development meeting in June. ***A15/33 Conflicts of Interest Policy*** *– MMcD to discuss refreshing of declarations with DFr* - to be deferred to July. ***A15/34 Register of Interests 2014/15*** *– MMcD to discuss version control with DFr* – to be deferred to July. All other actions were closed as appropriate.	
A15/48	**Counter Fraud Plan 2015/16** The Counter Fraud Plan 2015/16 was presented to the Committee for approval. **Action by the Committee** The Committee approved the plan.	
A15/49	**Report on follow-up actions to audits** All internal audit, external audit and counter fraud issues raised have been assigned owners and are in progress. **Action by the Committee** The Committee noted the update and HN requested sight of the action plan in place.	KJ

No	Item	Action
A15/50	**Approval of Annual Report, Annual Governance Statement and Annual Accounts** KJ presented these papers stating that formal accounts were submitted to NHSE on 23rd April, and that the CCG has been working with PwC since that date, reviewing both the content and substance of these papers. IR assured the Committee that all of these figures had been audited. An extensive discussion took place in relation to the Annual Report and Annual Accounts. A small number of minor amendments were agreed and will be implemented prior to sign off. IR and ET reported that there are still a small number of outstanding issues that required completion before the final audit opinion could be confirmed. The CCG is aiming to submit the above as a single document by the deadline of midday on Friday 29th May. Action by the Committee The Committee approved the signing of the following by the Chief Officer, subject to confirmation that the small number of outstanding items are resolved to external audit satisfaction: • Annual Report • Annual Governance Statement • Annual Accounts The approval of the reports was delegated to the Vice Chair of the Committee, given the Chair's absence between 25th May and sign-off date.	
A15/51	**External Audit Report** **ISA 260 -** IR presented the ISA 260 and advised the Committee that the majority of the audit work was complete, and PwC expected to issue an unqualified audit opinion on the financial statements, and an unqualified conclusion on the CCG's use of resources, on Wednesday 27th May. IR said the accounts were a true and clear view of the CCG's activities and IR said despite challenges ahead PwC were confident that that CCG Audit Committee is sighted on the CCG's financial position. **Letter of Representation** – MMcD said he believed this to be a true and accurate reflection of the CCG's financial position, and on that basis would recommend that he signed the letter on behalf of the CCG. IR said from his perspective the audit had been a good one, and expressed his appreciation at how open, helpful and constructively the CCG finance team had worked with PwC. HN thanked PwC for fulfilling their role as external auditors, and also to the CCG's finance team for the hard work required during the year leading up to the submission of the accounts. Action by the Committee The Committee noted the content of this report and agreed to the signing of the letter of representation by the Chief Finance Officer.	

No	Item	Action
A15/52	**Review of Annual Work Plan 2015/16** The work plan had been updated following feedback from the meeting in April.	
	Action by the Committee	
	The Committee noted the update.	
No	**Item**	**Action**
A15/53	**Any Other Business** MMcD confirmed the physical signing of the Annual Return was planned to take place at the Governing Body meeting on Wednesday 27th May.	
	Date of next meeting Wednesday 15th July 2015, 9.30am to 11.00am Family Life Centre, Southport	

NHS
Southport and Formby
Clinical Commissioning Group

Ainsdale & Birkdale Locality Meeting

Thursday, 23 April 2015 at 12.30pm at
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	CN
Dr Lindsay McClelland	GP, Ainsdale Village Surgery	LMc
Dr Ian Kilshaw	GP, The Grange Surgery	IK
Dr Octavia Stevens	GP, Ainsdale Village Surgery	OS
Paul Ashby	Practice Manager, Ainsdale Medical Centre	PA
Melanie Wright	Locality Development Manager, S&F CCG	MW
Jane Uglow	Locality Development Manager, S&F CCG	JU
Nina Price	Practice Manager, The Grange Surgery	NP
Kay Walsh	Medicines Management	KW
Natalie Dodsworth	Practice Manger, The Family Surgery	ND
Janice Lloyd	Practice Manager, Lincoln House Surgery	JL
In attendance		
Maureen Collins	Service Manager, Southport & Ormskirk ICO	MC
Judith Malkin	Assistant Director, Community S&O	JM
Angela McQueen	Ainsdale District Nursing	AMc
Joanne Mart	Ainsdale District Nursing	JM
Lisa Laird	Ainsdale District Nursing	LL
Dr Gina Halstead	GP, South Sefton CCG	GH
Apologies		
Karen Ridehalgh	Practice Manager, Ainsdale Village Surgery	KR
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Name	Practice / Organisation	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Dr G Gana	Lincoln House Surgery	✓											
Dr S Shyamsundar	Lincoln House Surgery	✓											
Dr I Kilshaw	The Grange Surgery	✓											
Dr K Naidoo	The Family Surgery	✓											
Dr C Nugent	Ainsdale Medical Centre	✓											
Dr L McClelland	Ainsdale Village Surgery	✓											

Name	Practice / Organisation	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Dr O Stevens	Ainsdale Village Surgery	✓											

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/27	**Apologies for Absence** were noted.	
15/28	**Community Services – District Nursing/Community Matrons** Judith Malkin and Maureen Collins attended the meeting to discuss District Nursing and Community Matrons. Ms Malkin hoped to attend on a more regular basis as a 'catch up' and to discuss any concerns and sought formal arrangements for MDT and discussion of any concerns. Community Matrons issues related mostly to staffing and recruitment is ongoing. Obtaining bloods from housebound patients: Ms Malkin advised that the District Nurses will attend on 3 occasions, but acknowledged the problems in gaining access and surrounding dementia patients. General discussion took place over individual practices' concerns around attendance at weekly MDT meetings; this is good practice although the District Nurses present did mention that the timing of meetings can be difficult. A Community Phlebotomy Service was discussed. Ms Malkin advised this is being considered. Ms Malkin went on to say that the Community Matron role may not be what is wanted by the locality and discussions will need to take place with them to be able to deliver what is appropriate for the locality. Ms Malkin will work with Mrs Wright/Mrs Uglow on this.	MW/JM/JU
15/29	**Locality Development in Seaforth and Litherland** Dr Gina Halstead presented details of the locality development that has taken place in Seaforth & Litherland to the Group. Services for housebound patients had been improved and some of the £50k locality monies had been used to recruit nurses to manage chronic diseases or practice nurses had extra capacity. They also undertook a Stoma Project which saved enough money to finance the nurse and a Respiratory Programme with a Specialist Pharmacist who offers services to housebound patients. A business case had been generated for a 'signing in' machine and all reception staff have been trained in 'Every Contact Counts'. (Public Health research shows that reception staff are often better placed to advise patients on these matters.)	

No	Item	Action
15/30	**Minutes of Previous Meeting and Action Tracker** were agreed. The minutes attendance tracker was amended to reflect Dr Kilshaw's attendance at last month's meeting.	
15/31	**Chair's Update** Local Quality Contract – Dr Naidoo discussed the email received from Dr Niall Leonard; Dr Naidoo asked for practice leads to discuss at individual practice level. Dr Naidoo discussed the suggestion of having a Board representative at the locality meetings. After discussion with all the Locality Members - it was of the opinion of all the Members that we did not require a Board Member to be present at our Locality meetings for now, as we have sufficient Representation; the Locality Group's views are fed back to the Board via a number of channels: Dr Kilshaw feeds back via Dr Martin Evans, Paul Ashby, Practice Manager is a Board Member and regularly attends the meetings. Martin McDowell, Melanie Wright and Jane Uglow can also feedback the locality views, together with Dr Naidoo himself as Chair. Mrs Wright to feed this back to the Board.	MW
15/32	**Locality Manager's Update** • **Away Day** – Mrs Wright discussed the possibility of having an Locality Away Day in order to spend some time producing an Action Plan for the Locality. JU reminded the group of locality prioritiy setting undertakend at a wide group meeting in the previouse year. This is something the locality needs to develop into an action plan for 2015/16. Dr Naidoo and Dr McClelland raised AF and anticoagulation as an area the Locality could consider. It was agreed to have a longer meeting next month – 12:30 to 2:00pm to progress this. • **Provider Representation at Locality Meetings** – Mrs Wright asked the Group if they would like to take this forward. It was suggested that providers could attend on a quarterly basis and focus on quality and patient issues and this was agreed. • **Locality Engagement** – Mrs Wright and Mrs Uglow have been asked to boost their contact with each locality and will be contacting practices individually to arrange this.	
15/33	**Quality and Patient Safety** An issue around higher levels of detection of low folic acid levels was raised. Mrs Wright agreed to raise with the Trust.	MW
15/34	**Medicines Management** Prescribing data for Month 11 (to end Feb 15) was presented by Kay Walsh to the Group. All practices except for The Family Surgery are showing an overspend. Dr McClelland requested a breakdown of these figures. Both Dr McClelland and Dr Stevens commented that looking at a comparison between practices would be beneficial to see what areas need looking at and information is needed on individual medicines. Kay Walsh agreed to discuss this further with them & then feed the comments back to the Medicines	KW/LMc/OS

No	Item	Action
	Management team. Natalie Dodsworth commented that having had this data drilled down in the past enabled them to reduce spending. It was agreed to add the discussion of data as an agenda item. As a way of improving communication to prescribers, a Sefton Prescriber Update listing Joint Medicines Operational Group decisions will be circulated on a regular basis. KW asked if everybody had seen the March one, all confirmed that they had.	Agenda Item
15/35	**Any Other Business** • Electronic letters – Dr McClelland discussed the duplication of letters. KW has previously escalated this and been told that further confirmation that the system is robust is still required before the paper duplicates can be stopped. Kay Walsh agreed to share contact details for Merseyside Informatics with Mrs Wright to follow up on this. • Optimise – Kay Walsh advised that this is the new system that is replacing Scriptswitch; it is being trialled at the moment and will hopefully be rolled out in the Autumn. Natalie Dodsworth commented that this could mean falling 6 months behind; Kay Walsh agreed to feedback the locality's concerns but also said that extra technical support has been recruited.	KW/MW KW
15/36	**Date and Venue for Next Meeting** Thursday, 14 May 2015 at 12:30pm to 2:00 pm at The Family Surgery.	

Dates for your diary – future meetings *Second Thursday of each calendar month (from May)*
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

Ainsdale & Birkdale Locality Meeting

Thursday, 14 May 2015 at 12.30pm at
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 Lindsay McClelland	GP, Ainsdale Village Surgery	LMc
Dr Ian Kilshaw	GP, The Grange Surgery	IK
Dr Octavia Stevens	GP, Ainsdale Village Surgery	OS
Paul Ashby	Practice Manager, Ainsdale Medical Centre	PA
Jane Uglow	Locality Development Manager, S&F CCG	JU
Nina Price	Practice Manager, The Grange Surgery	NP
Kay Walsh	Medicines Management	KW
Gemma Hopkins	The Family Surgery	GH
In attendance		
Martin McDowell	Chief Finance Officer, S&F CCG	MM
Karl McCluskey	S&F CCG	KM
Apologies		
Karen Ridehalgh	Practice Manager, Ainsdale Village Surgery	KR
Dr Gladys Gana	GP, Lincoln House Surgery	GG
Melanie Wright	Locality Development Manager, S&F CCG	MW
Natalie Dodsworth	Practice Manger, The Family Surgery	ND
Janice Lloyd	Practice Manager, Lincoln House Surgery	JL
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Name	Practice / Organisation	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Dr G Gana	Lincoln House Surgery	✓	A										
Dr S Shyamsundar	Lincoln House Surgery	✓	✓										
Dr I Kilshaw	The Grange Surgery	✓	✓										
Dr K Naidoo	The Family Surgery	✓	✓										
Dr C Nugent	Ainsdale Medical Centre	✓	✓										
Dr L McClelland	Ainsdale Village Surgery	✓	✓										
Dr O Stevens	Ainsdale Village Surgery	✓	✓										

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/37	**Apologies for Absence** were noted.	A&B Locality Attendance sheet Ma
15/38	**Minutes of Previous Meeting & Action Tracker** The minutes of the previous meeting held on 23 April were agreed as an accurate record. The Action Tracker was updated.	FINAL Minutes A&B Locality April 2015.do
15/39	**Chair's Update** Dr Naidoo attended the Locality Leads Meeting on 28 April 2015 to discuss Community Services with members of the Southport & Ormskirk NHS Trust. It was noted that a Community Phlebotomy service is something to consider for the future. CERT and their role and how this would link in with the Community Matron were covered yesterday at the WCG meeting and we are awaiting the outcome. Karl McCluskey informed Group that as a CCG we have escalated a raft of concerns around ICO and services and a range of quality and performances issues around Acute services. This resulted in a recent Board to Board meeting between the CCG and the Trust during which the CCG has set a series of milestones for the Trust to meet by the end June. This gateway meeting will provide decision points as to further continuation of this work or commit to the procurement of these services. **Locality Quality Contract** Dr Naidoo noted that he had to send his apologies to the WCG meeting on 13 May. Dr Naidoo raised a few concerns regarding the LQC, Frail & Elderly over 75 yrs proposal scheme which may attract a payment of £200 per patient, subject to Governing Body approval. Payment under this scheme would be based on the Practice prevelance rate of over 75 yr olds. Under this proposal 2 Practices: The Family Surgery and Kew Surgery, would recieve less income (Practice prevalence rates are 5.6% and 6% respectively). Whilst those practices with high prevalence of over 75 yrs stand to make a significant financial gain. It is Dr Naidoo's understanding that the introduction of the LQC in June 2014, was on the basis that no Practice would suffer a financial loss and any changes would be equitable and transparent. Dr Naidoo accepts that no two practice populations and prevalence are the same and believes that a practice with a lower prevalence of over 75yr old patients should not be prejudiced or financially penalised because of this. Consideration should be given to the two practices who under this proposal would suffer financial loss. Dr Naidoo recommended the GB consider how the LQC could be adapted to allow these	

No	Item	Action
	practices to provide a service reflective of their populations (higher prevalence rate of 0-5 yr olds). Dr Naidoo also recommended that any new LQC proposal should also be discussed with the LMC to ensure fairness. Dr Naidoo informed the group of his Practices involvement in the piloting of GP direct referral pathway into S&O Children's Community Nursing Service (CCNT pilot). This has been designed to help to reduce unplanned admissions and A&E attendances. The Practice participation has been without financial gain and has not been part of an enhance service. Dr Naidoo wishes the GB members to agree a LQC that is fair to all practices so no practice is put at a disadvantage or penalised for their current practice population prevalence. Information has been noted by members of the locality and the GB members present at the meeting. **PMS Review** A discussion took place regarding the NHS England changes to PMS Contracts, a leter will be sent to PMS practices which will detail the financial changes and the option for practices to transfer their contract from PMS to GMS. Dr Naidoo asked for financial information to be presented in an understandable format and for guidance for individual practices on when it is best to leave PMS without suffering a financial loss. Martin McDowell commented that there is a piece of work for the CCG to test how this can be made easier; Dr Naidoo agreed to be a 'test' surgery and work with the CCG on this.	
15/40	**Chief Finance Officer's Report** Martin McDowell confirmed that the CCG is on target to deliver its financial duties for 2015/16 subject to external audit which is currently being undertaken. MMcD gave an overview of the national financial position, noting that a number of NHS Trust providers are forecasting deficits for 2015/16, including the local trust. He outlined that the NHS faces a challenging financial year. From the CCG's perspective, our required savings target is in the region of £6m which is around 3.5% of our allocation. He outlined that the previous discussion on cost / effectiveness in terms of asthma treatment as a good example in terms of how we look for opportunities to identify whether we are getting value from our spending on healthcare. He outlined localities were best placed to help review the information and add local intelligence to help inform decision-making. As an example, he noted that if all practices across the CCG could avoid one urgent admission to hospital per week, then the CCG could potentially save up to £1.5m. He also noted that the Governing Body had been keen to establish a transformation and innovation fund earmarked to specifically avoid admission to hospital. He noted according to the formula used to allocate spending to the CCG, we are seemingly over-funded and as a result will receive	

No	Item	Action
	limited funding in the short-term. He also noted that in his view, greater financial pressure was noticeable in Southport and Formby due to high proportion of elderly residents and he felt that the current formula didn't adequately reflect the local demographic. He concluded by noting the challenge but felt that opportunities lay ahead in terms of delivering greater value for money from our existing resources.	
15/41	**Medicines Management** KW reported that an issue has been identified with the PACT data for Ainsdale Village and it would appear that prescribing for Dr. McClelland's previous practice has been being attributed to Ainsdale Village. This has only just come to light and steps are being taken to address the situation.	
15/42	**Locality Planning** Dr Lindsay McClelland discussed the proposals from the WCG meeting held yesterday on 13 May for the following: • ECG interpretation service • One stop AF service for echo/anti-coagulation etc • Breathlessness service – for patients where it is unknown if cause is cardiac or respiratory • NOACS (part of CCG wide pathway) • Patient template for self management. The Locality Group discussed which area they would like to take forward. Dr Shyamsundar commented that Aintree Hospitals have a hotline for GPs for different specialities which was very useful to prevent admissions. The Locality Group agreed to look at the following to prevent admissions: • AF to look at data/identify patients • NOACS Discussion took place over how this will be actioned and the timeframes involved. Karl McCluskey advised that he will discuss with Dr Stuart Bennett, Clinical Lead Cardiology to see what we can do quickly and what will it look like on a sustainable basis. The group acknowledge Respiratory is another area to be considered at a locality level however, it may be more effective to focus their efforts in one area. KMc agreed to link back with Dr Bennett and agree a programme of work. All agreed to circulate ideas before the next meeting, including prevalence for AF for each practice and any help on costings to link in with Jane Uglow.	KMc / ALL ALL
15/43	**Any Other Business** Nil	

No	Item	Action
15/44	**Date and Venue for Next Meeting** Thursday, 11 June 2015 at 12:30pm to 2:00 pm at The Family Surgery.	

Dates for your diary – future meetings *Second Thursday of each calendar month (from May)*
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 7th May 2015

Venue: Formby Village Surgery

Attendees		
Dr Chris Bolton	(Chair), GP, The Village Surgery	CB
Dr Sarah Lindsay	GP, Freshfield Surgery	SL
Sue Lowe	Practice Manager, The Village Surgery	SLo
Stewart Eden	Practice Manager, Chapel Lane Surgery	SE
Susanne Lynch	Medicines Management, S&F CCG	SLy
Moira McGuinness	Locality Manager, S&F CCG	MM
Colette Riley	Practice Manager, The Hollies	CR
Lisa Roberts	Practice Manager, Freshfield Surgery	LR
Dr Deborah Sumner	GP, The Hollies Surgery	DS
Yvonne Sturdy	Nurse Practitioner, The Village Surgery	YS
In attendance:		
Dr Emily Ball	GP, Trinity Surgery (presentation for S&F CCG)	EB
Judith Malkin	Assistant Director, Southport & Formby ICO	JM
Maureen Collins	Locality Service Manager, Southport & Formby ICO	MC
Apologies		
Dr Doug Callow	GP, Chapel Lane Surgery	DC
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Dr D Callow	Chapel Lane Surgery	✓	A										
Dr T Quinlan	Chapel Lane Surgery	A	A										
Dr C Bolton	The Village Surgery	✓	✓										
Dr J Reddington	The Village Surgery	A	A										
Dr S Johnson	The Village Surgery	A	A										
Dr L Grant	The Village Surgery	A	A										
Dr D Mortimer	The Village Surgery	A	A										
Dr J Eldridge	The Hollies Surgery	A	A										
Dr D Sumner	The Hollies Surgery	A	✓										
Dr T Brettel	The Village Surgery	A	A										
Dr S Lindsay	Freshfield Surgery	✓	✓										

✓ Present
A Apologies

L Late or left early

No	Item	Action
15/38.	**Welcome, apologies and introductions**	
15/39.	**Minutes of the last meeting** The minutes from the last meeting on 2 April 2015 were agreed as an accurate record.	FINAL 2015 Formby Minutes
15/40.	**Matters Arising:** • Map of Medicine Dr Bolton advised that the Partners at The Village Surgery have agreed in principle to Map of Medicine as long as it can be turned off. Susanne Lynch explained that she has met with Map of Medicine and iMersey to discuss. There is a lot more than can be put on the system; some of it is out of date however the National Pathways are present. The Map sits on the desktop and a sidebar appears in the consultation which gives prompts as you see patients however this can be deactivated or ignored. SLy advised that there is a further meeting which includes the Clinical Leads after which it should be taken forward.	
15/41.	**ICO** • Community Services Judith Malkin, Assistant Director, Southport & Ormskirk ICO, attended the meeting today to discuss Community Services. Mrs Malkin is hoping to have a forum such as today, going forward, to discuss problems that arise, to have an opportunity to work more closely, to resolve issues with the practices and give information to support each locality. Mrs Malkin asked the locality group for their experiences of the Community Services in this area. Dr Bolton asked for clarification of what community services the ICO provides. Mrs Malkin confirmed that the vast majority are provided by the ICO including district nurses, community matrons, rapid response and CERT. Some specialist services are exceptions to this for example the Community IV and respiratory services which are provided by LCH. Discussion took place over the level of access practices have to district nurses and it was agreed that there are discrepancies across the practices; particularly with regard to the attendance at MDTs. Both Dr Bolton and Colette Riley agreed that they set the meetings with the district nurses to ensure their attendance. Mrs Malkin confirmed that she would be happy to provide staffing information so that each practice knows who supports their team and the financial envelope for the locality. Dr Bolton asked for each practice to share any issues they have; discussion took place regarding treatment rooms and availability of appointments. Mrs Malkin confirmed that there is a review going on at present. Attendance at MDTs was raised by Stewart Eden. Dr Bolton suggested the possibility of having the Community Matron in with CERT. Moira McGuinness confirmed that GP's will be able to refer direct to LCH for Community IV for cellulitis and UTI for a 6 month period. If successful the service may need to go out to	

No	Item	Action
	procurement. Moira McGuinness also discussed the possibility of having District Nurses/Community Matron attend the locality meetings; Mrs Malkin would support this.	
15/42.	**Prescribing update** Susanne Lynch presented the budget information. Dr Bolton queried prescribing budgets for those that have patients that cross CCG boundaries. SLy to look into this. New inhalers: there is COPD Pan Mersey Guidance that SLy will circulate to all practice nurses in the form of a flowchart. Mar 15 Medicines Management Update	SLy SLy
15/43.	**Local Quality Contract** Dr Ball is completing a piece of work relating to the over 75s as services are stretched and not fit for purpose. Presentations are attached for information. The first clinical recommendation is around identifying and screening over 75s with identifiable frailty; concentrating on those in their own homes, then around creating a Frailty Register and targeting patients over 75 on 10 or more medications to have a pharmacist review for STOPP START. An 'Away Day' will be planned aimed at discussing all the issues that we know need reviewing but do not have the time to do. This will cover topics such as how tasks can be delegated to non-clinical staff, collaborative working within and between practices and looking at what we do well and sharing best practice around Frail & Elderly and DOLs. Moira McGuinness discussed the Care Homes across Southport & Formby with the top 10 admission rates being targeted with part of South Sefton CCG's Care Home Innovation programme for telemedicine; this is to be discussed at the Wider Constituent Group meeting next week.	frailelderlyspe SAFE1.xls
15/44.	**Local Profiles** The Group discussed the attached Primary Care Information Pack.	SF PCIP_Dec v2.pdf
15/45.	**Respiratory Services** Colette Page informed the Group of the Respiratory services being offered for a whole package of training for nurses provided by Tracey Kirk including e-learning and mentoring in practice for COPD and asthma. At present South Sefton CCG are taking this forward however it is not available for Southport & Formby yet and Dr Kati Scholtz is leading on this.	
15/46.	**Locality Priorities 2015/16** This will be discussed at the Wider Consistency meeting on 13 May 2015; Southport & Formby CCG have submitted two priorities to NHS England surrounding avoidable emergency admissions and a reduction in mental health – these are not set in stone at this time.	
15/47.	**Quality and Patient Safety**	

No	Item	Action
	Please email Dr Callow with any issues in his absence.	
15/48.	**Locality Business** Dr Bolton discussed the recent meeting with Community Services last week and various suggestions were discussed surrounding different services to look at including MCAS as a local service, sexual health, aural toilet services and joint injections. Dr Bolton also mentioned possibility of an occupational health service for staff across the localities. **Governing Body** Colette Riley will circulate information from the Board.	CR
15/49.	**AOB** • Dr Bolton discussed problems with the Eating Disorder Services; he has had complex cases and feels the service is not fit for purpose. MM to look into this. • Susanne Lynch advised that the Peer Review for anti-microbials is due.	MM ALL
	Date of next meeting: **Thursday 4 June 2015 at 1.15pm** **Formby Village Surgery.**	

NHS
Southport and Formby
Clinical Commissioning Group

Formby Locality Meeting Minutes

Date: Thursday 4th June 2015

Venue: Formby Village Surgery

Attendees		
Dr Chris Bolton	(Chair), GP, The Village Surgery	CB
Sue Lowe	Practice Manager, The Village Surgery	SL
Susanne Lynch	Medicines Management, S&F CCG	SLy
Moira McGuinness	Locality Manager, S&F CCG	MM
Colette Riley	Practice Manager, The Hollies	CR
Lisa Roberts	Practice Manager, Freshfield Surgery	LR
Louise Davies	Practice Nurse, Freshfield Surgery	LD
Yvonne Sturdy	Nurse Practitioner, The Village Surgery	YS
In attendance:		
Becky Williams	Chief Analyst, S&F CCG	BW
Apologies		
Dr Doug Callow	GP, Chapel Lane Surgery	DC
Dr Sarah Lindsay	GP, Freshfield Surgery	SL
Stewart Eden	Practice Manager, Chapel Lane Surgery	SE
Dr Deborah Sumner	GP, The Hollies Surgery	DS
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Dr D Callow	Chapel Lane Surgery	✓	A	A									
Dr T Quinlan	Chapel Lane Surgery	A	A	A									
Dr C Bolton	The Village Surgery	✓	✓	✓									
Dr J Reddington	The Village Surgery	A	A	A									
Dr S Johnson	The Village Surgery	A	A	A									
Dr L Grant	The Village Surgery	A	A	A									
Dr D Mortimer	The Village Surgery	A	A	A									
Dr J Eldridge	The Hollies Surgery	A	A	A									
Dr D Sumner	The Hollies Surgery	A	✓	A									
Dr T Brettel	The Village Surgery	A	A	A									
Dr S Lindsay	Freshfield Surgery	✓	✓	A									

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/50.	**Welcome, apologies and introductions**	
15/51.	**Minutes of the last meeting** The minutes from the last meeting on 7 May 2015 were agreed as an accurate record.	FINAL 2015 Formby Minutes
15/52.	**Matters Arising:** • Prescribing budgets – cross boundaries. Susanne Lynch advised that budgets are done on list size and Dr Bolton questioned whether it is taken into account when out of CCG area when they are set. SLy replied that it is done by weighted population figures and they are waiting for new population figures at present. • COPD/Respiratory – Dr Bolton discussed the recent spirometry event that was very informative. Discussion took place over usefulness of this and whether this could be rolled out to all nurses and possibly GPs. Awaiting information from Dr Scholtz – Colette Riley will follow up.	CR
15/53.	**CCG EOL Lead** Dr McClelland has sent apologies so this item will be rescheduled.	
15/54.	**Locality Profiles** Discussion took place over profile data. Becky Williams asked for feedback on the data: to look at any inaccuracies; are they reflective of the population; what can we do differently to change how community services are delivered; to ask cross-practice, if some have better data, what are they doing differently. Group discussed coding around mental health with regards to coding of low mood as opposed to depression; it was agreed that practices need to ensure that coding is a true reflection.	
15/55.	**CCG/Locality Priorities** Moira McGuinness advised that the locality need to choose an area to focus on to form an Action Plan. At the WCG meeting it was agreed that the CCG as a whole would focus on 2 areas of CVD and that each locality should then choose another area. Dr Bolton noted the low prevalence of osteoporosis in the locality however the higher prevalence of fractures and suggested that this is an area that could be looked into. The discussion surrounding depression continued and it was agreed that Formby would look into depression and osteoporosis and form their Action Plan. For depression the group agreed to a 'depression register' and for each practice to review data / coding / prescribing for this area. Discussion took place over how this will benefit the locality and SLy and MM commented that benefits findings would help evidence where services should be commissioned; therefore the more accurate the information to more beneficial it is to the locality; for example if coding proves that more IAPT appointments are needed the data to demonstrate this. Discussion then took place over availability of appointments with new IAPT service. No practice reported any patients who have been seen yet by the new service. Dr Bolton suggested looking into number of referrals / number of appointments available. For osteoporosis it was agreed that practices would need to start by	

No	Item	Action
	looking at patients with fractures initially. Dr Bolton to discuss further with Moira McGuinness. MM to send out email to locality to advise of areas agreed to be Locality's Action Plan.	CB/MM MM
15/56.	**Prescribing Update** Susanne Lynch discussed the Month 12 budget figures noting that Southport & Formby have gone against Department of Health predicted budgets for Category M drugs. There are variances between practices and high cost drugs are down. SLy is waiting for new weighted population figures from April as there has been lots of patient movement since the last figures from January. Group discussed costs of drugs and SLy advised that we will receive a larger uplift for next year. It was also noted that there is a high cost of drugs for EOL patients. Anti-microbial audit must be done next month.	 ALL
15/57.	**Quality and Patient Safety** Colette Riley discussed problems with a diabetic Type 1 patient who had not been seen by a consultant for 2 years. Patient received an appointment with Dr Akhtar who has left the trust and patient arrived for an appointment that had been cancelled. CR to email Dr Callow with details to follow up. Dr Bolton also commented on a patient who had a poor discharge experience from hospital. The family are following up through PALS.	 CR
15/58.	**Locality Business** **Governing Body** Colette Riley provided a written update for the locality group as attached.	 GB Feedba 4JUN15.do
15/59.	**AOB** • Yvonne Sturdy raised discussion regarding setting of budgets and whether this could be done on a 6 monthly basis as practices have to deal with changing demographics. • Community IV for UTIs/cellulitis/respiratory will start the second week in July. • Tracy Jeffes, Chief Delivery & Integration Officer, S&F CCG will attend the next meeting to discuss locality development. • Merseycare will attend to discuss the legalities of DOLs. • Becky Williams advised that the Commissioning Support Unit will no longer exist from April 2016 so the CCG needs to commission all support services again for example, business intelligence which includes the portal – BW is currently drawing up the specification for this that will be the same as the existing for hopefully better and quicker. • Becky Williams noted that there will now be a Data Analyst named for each locality who will attend future meetings.	
	Date of next meeting: **Thursday 9 July 2015 at 1.15pm** **Formby Village Surgery.**	

NHS
Southport and Formby
Clinical Commissioning Group

Central Locality Meeting Minutes

Date: Tuesday 28th April 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 Halina Obuchowicz	GP, Kew Surgery	HO
Dr Louise Campbell (Chair)	GP, Trinity Practice	LC
Dr Wendy Coulter	GP, Kew Surgery	WC
Dr Kati Scholtz	CCG Board Member	KS
Moira McMcGuinness	Locality Development Manager, S&F CCG	MM
Dr Shaun Meehan	GP, St Marks Medical Centre	SM
Rachel Cummings	Practice Manager, Cumberland House	RC
Joyce Lloyd	Practice Manager, St Marks Medical Centre	JD
Kathy Rimmer	District Nurses, Curzon Road	KR
Sejal Patel	Pharmacist, S&F CCG	SP
Apologies		
Sharon Forrester	Locality Development Manager, S&F CCG	SF
Roy Boardman	Business Manager, St Marks Medical Centre	RB
Dawn Bradley-Jones	Practice Manager, Trinity Practice	DBJ
Kate Wood	Practice Manager, Kew Surgery	KW
Alix Shore	Community Matron	AS
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

Name	Practice / Organisation	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Dr M Bond	Curzon Road Medical Practice	✓											
Dr A Farrell	Curzon Road Medical Practice	A											
Dr G Hedley	St Marks Medical Centre	A											
Dr S Meehan	St Marks Medical Centre	✓											
Dr G Stubbens	St Marks Medical Centre	A											
Dr I Hughes	Cumberland House	✓											
Dr H Obuchowicz	Kew Surgery	✓											
Dr W Coulter	Kew Surgery	✓											

Name	Practice / Organisation	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Dr L Campbell	Trinity Practice	✓											
Dr G Kumble	Trinity Practice	A											

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/27.	**Welcome, Apologies & Introductions** Apologies were noted. Central Attendance sheet April 2015.pdf	
15/28.	**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 201503 MINUTES Central Loc	
15/29.	**Chair's Update** Dr Campbell informed the Group of the Facing the Future Together meeting to be held tonight. Dr Campbell asked the Group for any questions they would like to be raised. The following questions were raised:- • Dr Meehan would like to ask about the pressure the district nurses have around administration that could be spent seeing patients. • Rachel Cummings would like to discuss attendance at MDT/GSF meetings – the district nurses are always invited but never attend. • Dr Hughes discussed the long waiting times for ear syringing at the treatment rooms. Dr Campbell herself would like to discuss lymphoedema services. Moira McGuinness will look into the services that are in place and feedback. Community IV Services – Moira McGuinness updated the Group on these services that are being delivered by Liverpool Community Health. During this 6 month trial direct referrals can be made to the Community IV team for cellulitis and UTIs. This will be monitored over the 6 months and then taken forward. **Governing Body Update** There have been no meetings since last locality meeting. Dr Scholtz updated the Group as follows: **Respiratory -** Historically the 'Hospital at Home' team (provided by Community Respiratory Team) has only taken patients with spirometry but they will now take patients without spirometry although this has to be a historical diagnosis. Simply telephone the same number and ask to be transferred to the Community Respiratory Team who will not decline the	MM / SF MM KS

No	Item	Action
	referral. This has only been in effect since last week; Dr Scholtz will circulate the details. Also with regards to Respiratory, UHA are providing a helpline for Southport & Formby GP for respiratory issues – no age restrictions. Again, Dr Scholtz will circulate these details.	KS
15/30.	**Quality and Patient Safety** DOLS Dr Campbell would like to discuss the legalities of the DOLS and ensure everybody is aware of them. Issues usually surround when a patient dies under a DOLS as the death has to be referred to the Coroner and a death certificate cannot be signed by the GP. There are also issues if a patient doesn't have family an Independent Mental Health Practitioner needs to be appointed and they should be present for any DNR status discussions. DOLS themselves are the responsibility of the Local Authority and Care Homes however there is no system in place with the GPs to monitor patients who are under these. Dawn Bradley Jones has circulated papers on this. Moira McGuinness suggested that she raise this at the End of Life meeting at Queenscourt. Dr Campbell further noted that reception staff at Trinity Practice have been prompted to ask if a DOLS is in place when deaths in a care home are reported.	
15/31.	**Medicines Management** Sejal Patel presented the Month 11 prescribing budgets for discussion.	
15/32.	**Any Other Business** • Psychiatry Assessments & ECGS – Dr Campbell discussed that there have been complaints about Psychiatry doing ECGs for their patients if the reading raises concerns they are asking the patients' GP to refer into cardiology. It was thought these patients should remain the responsibility of Psychiatry services and referrals into cardiology should be their responsibility. It was suggested to contact Rachel McKnight; • Immunology screening – Dr Obuchowicz is concerned that reports come back without the attachments they refer to. • Discharge of Urology patients with new catheters – Dr Obuchowicz and the District Nurses have raised this as a recurring theme that patients are being discharged with catheters in situ with little information communicated to GP or DN as to why it was put in or what follow up is planned. Often it is the patient themselves calling the DN informing the team of a new catheter. Discussion took place that this happens often; Kathy Rimmer said that the District Nurses often have to do trial without the information required and these often fail and there is often no management plans in place. • Cardiology – Rachel Cummings raised Choose & Book referrals to Cardiology. It was noted that referrals should be made outside of Southport. Dr Bond questioned what is happening with these services; Dr Scholtz thought this would be discussed at the meeting tomorrow between the CCG and the Hospital Trust. • Dr Hughes also mentioned that he has experienced similar problems with referrals to haematology through Choose & Book that have been marked as 'defer to provider' where the referral has been cancelled. Dr Hughes asked if this is the same situation as for Cardiology. Dr Scholtz confirmed that the situation	SF

No	Item	Action
	regarding Cardiology is only for this speciality. • Connected Communities - Dr Campbell reminded the Group of the services available through Connected Communities. Dr Obuchowicz suggested have leaflets on what is offered.	SF
15/33.	**Date and Venue for next meeting:** Tuesday 19th May 2015 at 1:00pm to 3:00pm Kew Surgery	

NHS
Southport and Formby
Clinical Commissioning Group

Central Locality Meeting Minutes

Date: Tuesday 19th May 2015

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

Attendees		
Dr Ian Hughes	GP, Cumberland House	IH
Dr Halina Obuchowicz	GP, Kew Surgery	HO
Dr Louise Campbell (Chair)	GP, Trinity Practice	LC
Dr Kati Scholtz	CCG Board Member	KS
Sharon Forrester	Locality Development Manager, S&F CCG	SF
Jan Leonard	Chief Redesign & Commissioning Officer, S&F CCG	JL
Dr Shaun Meehan	GP, St Marks Medical Centre	SM
Roy Boardman	Business Manager, St Marks Medical Centre	RB
Dawn Bradley-Jones	Practice Manager, Trinity Practice	DBJ
Kate Wood	Practice Manager, Kew Surgery	KW
Alix Shore	Community Matron	AS
Kathy Rimmer	District Nurses, Curzon Road	KR
Sejal Patel	Pharmacist, S&F CCG	SP
In attendance:		
Judith Malkin	ADO, S&O Community & Continued Care	JM
Maureen Collins	Locality Manager, S&O Community & Continued Care	MC
Apologies		
Rachel Cummings	Practice Manager, Cumberland House	RC
Dr Mark Bond	GP, Curzon Road Surgery	MB
Dr Wendy Coulter	GP, Kew Surgery	WC
Minutes		
Clare Touhey	Administrator, S&F CCG	CT

Attendance Tracker

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Dr M Bond	Curzon Road Medical Practice	✓	A										
Dr A Farrell	Curzon Road Medical Practice	A	A										
Dr G Hedley	St Marks Medical Centre	A	A										
Dr S Meehan	St Marks Medical Centre	✓	✓										
Dr G Stubbens	St Marks Medical Centre	A	A										

Name	Practice / Organisation	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Dr I Hughes	Cumberland House	✓	✓										
Dr H Obuchowicz	Kew Surgery	✓	✓										
Dr W Coulter	Kew Surgery	✓	A										
Dr L Campbell	Trinity Practice	✓	✓										
Dr G Kumble	Trinity Practice	A	A										

✓ Present
A Apologies
L Late or left early

No	Item	Action
15/34.	**Welcome, Apologies & Introductions** Apologies were noted.	Central Locality - attendance sheet M
	Community Services The meeting commenced with a presentation regarding Community Services by Judith Malkin, ADO for Community & Continued Care and Maureen Collins, Locality Manager for Community & Continued Care. Ms Malkin has come to open up communication channels and is meeting with all localities. It is an opportunity to discuss community services and if anything is not working. There has not been a forum to discuss practical issues before now and Ms Malkin is hoping to utilise 5-10 minutes of a meeting to do this – some localities have chosen to do this on a quarterly basis. Ms Malkin went on to discuss a 'Neighbourhood Directory' that is being compiled with all contact details for district nurses, community matrons and some data for your area. If there is anything else that we would like included please let them know; this is all part of the Facing the Future Together (FtFT) programme to improve communications. Dr Louise Campbell discussed the questions that had been raised at the last locality meeting to be answered at the forthcoming meeting with Community Services: • Pressure around district nurses' workload. Ms Malkin commented that this is being looked at as part of the Facing the Future Together. They are looking at non-clinical contacts and need to understand what the DNs are doing that is taking the most time; they are also looking at skill mixes, admin tasks etc. • District Nurses' attendance at MDTs – Dawn Bradley Jones commented that they have been asked to provide dates for these. It was acknowledged that this is being addressed. • Treatment Rooms – this is being looked at; demand is high and more clinics are being held with extended hours on Tuesdays and Thursdays. • Dr Campbell questioned the Lymphoedema services available for non-cancer leg ulcers. At present St Catherine's provide this service. It is not in the spec at present but is being looked at	

No	Item	Action
	under FtFT; the aim is to redirect from the Treatment rooms and therefore reduce pressure there. Community IV services are also being introduced in a phased way. • Catheter / Continence Teams – Sharon Forrester has emailed to Judith Malkin and is awaiting a response. Services are still there but there are problems relating to IPN and clinics being reorganised. These are being resolved. • Dr Hughes discussed problems with communications: for example results of tests requested by colleagues come back to the GP and they do not know where/who has requested. It was noted that the usual practice now is to telephone the GP beforehand. Alix Shore suggested that the results be copied to the referrer as well as the GP – possibly electronically – AS / JM to follow up. • Catheter samples – Kathy Rimmer advised that these would only be done if requested by GP. Sharon Forrester suggested including who will action the results in clinical information for test. Alix Shore to follow this up with lab. Dr Meehan suggested using secure email for this rather than faxes as these are becoming obsolete. Alix Shore to follow up with Michael Lightfoot regarding emails. • Dr Hughes also discussed patients being discharged on Clexane with no communications from hospital. Maureen Collins commented that this has been followed up. Alix Shore asked Group if they would like District Nurses and Community Matrons to continue attending the meetings; it was agreed that it is beneficial. Judith Malkin asked for feedback as to frequency of them attending the Locality Meetings.	JM AS/JM AS AS SF
15/35.	**Minutes of previous Meeting/Action Tracker** An amendment was made to the previous minutes under 15/30 regarding an Independent Mental Health Practitioner being present for discussions regarding DNR status.	FINAL 201504 MINUTES Central Lo
15/36.	**Chair's Update** • Locality Action Plan –The Wider Constituent Group Meeting took place on 13 May and Dr Stuart Bennett gave a presentation regarding stroke prevention and AF. The Plan focuses on 3 areas to improve in primary care; majority want to go forward with stroke prevention and AF. Dr Bennett is looking at making plans – assessing the size of the problem, see where gaps are, running the Grasp tool on all practices for COPD and heart failure – all of which is ongoing. They would like to establish a working group; ideally to have someone from each locality – Sharon Forrester asked for volunteers now or to discuss with individual practices and feedback. Please feedback to SF. Karl McCluskey discussed this at the WCG meeting – there is a transformation fund but they are ideally looking at the work being cost neutral; or if can demonstrate savings for example with stoke prevention or mortality there could be more funding. • Governing Body Update –there is huge financial pressure on	ALL

No	Item	Action
	the CCG at present with a £9m deficit between South Sefton and Southport & Formby CCGs. We have to plan to counteract this and for every £1 put in we need £3 back. There are lots of schemes in place to make the investments work. One is the new Geriatric Scheme from June; each locality will have a Geriatric specialist. There is a Clinician's meeting next Thursday at 1pm at the Fylde Road surgery so please feedback any issues. Discussion took place over hospital expecting re-referrals when patients haven't even had an appointment given and how this is draining the system. Jan Leonard commented that this has been fed back via the recent Board to Board meeting between the CCG and S&O NHS Trust.	
15/37.	**Quality and Patient Safety** No issues reported.	
15/38.	**Medicines Management** Prescribing Quality Scheme has been approved. 6 monthly anti-microbial review is due.	
15/39.	**Any Other Business** • Dr Obuchowicz would like to discuss the Local Quality Contract proposal for £200 per patient for Frail & Elderly over 75s as practices with younger populations are losers on this scheme. Dr Obuchowicz would like compensating in other areas in which they have to provide other services for their patients and would like this fed back to the Board. Dr Scholtz suggested sending a letter; Dr Naidoo, The Family Surgery has done this on both of their behalf's. Jan Leonard explained that the scheme for Frail & Elderly is looking at prevention for over 75s so that monies can be invested in other community services and primary care. JL to follow up from Dr Naidoo's letter. • Community Paramedic Role – Sharon Forrester asked for any spare capacity within practices to accommodate this position. Dr Meehan commented that St Marks Medical Centre may be able to help. Billie Dodd to get in touch with Roy Boardman with more details of what role involves as it was felt this needs further clarification. • Alix Shore asked practices how they would like to be communicated with following the removal of many fax machines. Dr Meehan suggested Emis tasks and setting up generic district nurse task group. Dr Scholtz raised concerns that this may not be failsafe. Discussion took place over best way to set this up and it was agreed that Informatics should be contacted. • Remote access on iPads – Dawn Bradley-Jones is looking into remote access to Emis, currently they are unable to access via GPs iPad's and this is causing lots of problems for Trinity. It was suggested to contact Paul Shillcock for help with this.	JL BD AS DB-J
15/40.	**Date and Venue for next meeting:** The next meeting has been rescheduled to: - **Tuesday 7th July 2015 at 1:00pm to 3:00pm at Kew Surgery.**	