NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Wednesday 30th March 2016, 13:00 hrs to 15:10 hrs
Venue: Family Life Centre, Cedar Room, Ash Street, Southport, Merseyside, PR8 6JH

13:00 hrs Members of the public may highlight any particular areas of concern/interest and address questions to Board members. If you wish, you may present your question in writing beforehand to the Chair.

13:15 hrs Formal meeting of the Governing Body in Public commences. Members of the public may stay and observe this part of the meeting.

The Governing Body		
Dr Rob Caudwell	Chair and Clinical Director	RC
Helen Nichols	Vice Chair and Lay Member for Governance	HN
Dr Niall Leonard	Clinical Vice Chair and Clinical Director	NL
Paul Ashby	Practice Manager and Governing Body Member	PA
Matthew Ashton	Director of Public Health *(co-opted member)*	MA
Dr Doug Callow	GP Clinical Director and Governing Body Member	DC
Dr Martin Evans	GP Clinical Director and Governing Body Member	ME
Debbie Fagan	Chief Nurse & Head of Quality & Safety	DF
Dwayne Johnson	Director of Social Services & Health, Sefton MBC *(co-opted member)*	DJ
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Martin McDowell	Chief Finance Officer	MMcD
Dr Hilal Mulla	GP Clinical Director and Governing Body Member	HM
Colette Riley	Practice Manager and Governing Body Member	CR
Dr Kati Scholtz	GP Clinical Director and Governing Body Member	KS
Dr Jeff Simmonds	Secondary Care Doctor and Governing Body Member	JS
Fiona Taylor	Chief Officer	FLT
[Vacant]	Lay Member for Patient & Public Engagement	
In Attendance		
Jayne Byrne	PA To Chief Officer *(Minute taker)*	JBy
Tracy Jeffes	Chief Delivery & Integration Officer	TJ
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC

No	Item	Lead	Report	Receive/ Approve	Time
Governance					
GB16/35	Apologies for Absence	Chair	Verbal	R	3 mins
GB16/36	Declarations of Interest	Chair	Verbal	R	2 mins
GB16/37	Minutes of Previous Meeting	Chair	✔	A	5 mins
GB16/38	Action Points from Previous Meeting	Chair	✔	A	5 mins
GB16/39	Business Update	Chair	Verbal	R	5 mins
GB16/40	Chief Officer Report	FLT	✔	R	10 mins
GB16/41	GP Pressures and Supporting Practices	All	Verbal	R	5 mins
GB16/42	LCR NHS CCG Alliance – Revised Terms of Reference	FLT	✔	A	2 mins
GB16/43	Corporate Objectives	KMcC	✔	A	3 mins
GB16/44	Equality and Diversity Annual Report	FLT	✔	A	5 mins

No	Item	Lead	Report	Receive/ Approve	Time
Quality & Safety					
GB16/45	Personal Health Budgets	TF	✔	A	10 mins
GB16/46	Safeguarding Peer Review Action Plan	DF	✔	A	10 mins
GB16/47	Looked After Children Strategy	Safeguarding Team	✔	A	10 mins
Service Improvement/Strategic Delivery					
GB16/48	Dementia Friendly Communities and the CCG's Role	KT	✔	R	10 mins
GB16/49	Transforming Care for People with Learning Disabilities: Implementation of National Plan	GO'C	✔	R	10 mins
Finance and Quality Performance					
GB16/50	Integrated Performance Report	KMcC/ MMcD/DF	To Follow	R	15 mins
For Information					
GB16/51	Key Issues reports: a) Finance & Resource (F&R) Committee b) Quality Committee c) CIC: Realigned Hospital Based Care d) CIC: LCR NHS CCG Alliance e) Joint Commissioning Committee f) Audit Committee g) 4-monthly Locality Reports - North - A&B - Central - Formby	Chair	 R R R R R R R R R R	 R R R R R R R R R R	5 mins
GB16/52	F&R Committee Minutes - Nov 2015 - Jan 2016				5 mins
GB16/53	Quality Committee Minutes - Dec 2015 - Jan 2016				
GB16/54	Approvals Committee - no mtg since Sept 2015				
GB16/55	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				5 mins
GB16/56	Date of Next Meeting Wednesday 25th May 2016 at 13:00 hrs, Family Life Centre, Southport, PR8 6JH				-
Estimated meeting close					**15:15hrs**

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

NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public Minutes

The Governing Body		
Dr Rob Caudwell	Chair and Clinical Director	RC
Helen Nichols	Vice Chair and Lay Member for Governance	HN
Dr Niall Leonard	Clinical Vice Chair and Clinical Director	NL
Paul Ashby	Practice Manager and Governing Body Member	PA
Dr Doug Callow	GP Clinical Director and Governing Body Member	DC
Dr Martin Evans	GP Clinical Director and Governing Body Member	ME
Debbie Fagan	Chief Nurse	DF
Dwayne Johnson	Director of Social Services & Health, Sefton MBC *(co-opted member)*	DJ
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Margaret Jones	Interim Director of Public Health *(co-opted member)*	MJ
Martin McDowell	Chief Finance Officer	MMcD
Dr Hilal Mulla	GP Clinical Director and Governing Body Member	HM
Roger Pontefract	Lay Member for Patient & Public Engagement	RP
Colette Riley	Practice Manager and Governing Body Member	CR
Dr Kati Scholtz	GP Clinical Director and Governing Body Member	KS
Dr Jeff Simmonds	Secondary Care Doctor and Governing Body Member	JS
Fiona Taylor	Chief Officer	FLT
In Attendance		
Jayne Byrne	PA To Chief Officer *(Minute taker)*	JBy
Lyn Cooke	Head of Communication	LC
Tracy Jeffes	Chief Delivery & Integration Officer *(for 16/8 and 16/9)*	TJ
Jan Leonard	Chief Redesign & Commissioning Officer *(for 16/14)*	JL
Karl McCluskey	Chief Strategy & Outcomes Officer *(for 16/12, 16/13 and 16/15)*	KMcC
Brendan Prescott	Deputy Chief Nurse/Head of Quality & Safety *(deputising for DF)*	BP

'Care Act' ***presentation by Dwayne Johnson, Sefton Council*** 0000 CARE ACT - PRESENTATION JANL

No	Item	Action
GB16/1	**Apologies for Absence** Apologies for absence were received from Dr Martin Evans, Debbie Fagan, Margaret Jones, Maureen Kelly and Dr Hilal Mulla.	
GB16/2	**Declarations of Interest** Those members holding dual roles across both Southport & Formby CCG and South Sefton CCG declared their interest.	
GB16/3	**Minutes of Previous Meeting** The minutes of the previous meeting were approved as a true and accurate record.	
GB16/4	**Action Points from Previous Meeting** *GB15/163 Developing Personal Health Budgets* – policy to be presented to Governing Body meeting in March 2016, keep on tracker. *GB15/165 Integrated Performance Report – Practice Visits to be arranged* – events moved on, remove from tracker. *GB15/206 Remuneration Committee Terms of Reference* – additional sentence to be added in relation to broadening membership. Done, remove from tracker. *GB15/207 Organisational Development Plan* – detailed plan to be prepared for approval by the F&R Committee –, leave on tracker. *GB15/209 CCG Interim Strategic Estates Plan 2015-2020* – reference to 'Virtual Ward Model' should be changed to 'Care Closer to Home Model'. Done, remove from tracker.	

No	Item	Action
	GB15/212 Integrated Performance Report – Breast Services – JL to give SLT update to ensure no unintended consequences. FLT reported this was on the executive team's work plan for this quarter and a report will be brought back in March. Remove from tracker.	
GB16/5	**Business Update** *Winter Pressures* - A huge amount of work went into the planning of a smooth Christmas and New Year period and as a result Dr Caudwell was pleased to report quality had not been compromised with no major incidences reported. The NHS is still under an enormous amount of pressure and the advice to members of the public would be to look at their choices; get pharmaceutical care where possible. Conversations were underway in relation to clinical quality and how we spend the money we have in the right way. A number of practices had undergone CQC inspections, all with good outcomes. RC congratulated the practices; it was reassuring and a credit to those practices that they were doing so well.	
GB16/6	**Chief Officer Report** FLT gave highlights from her report. *National Diabetes Prevention Programme* - FLT thanked Dr Doug Callow for his contribution to the programme. *Farewells* - Roger Pontefract was thanked for all his hard work and contribution to the Governing Body as Lay Member for Patient and Public Engagement. RP responded he had enjoyed his time working for the CCG and wished everyone well in the future. Dr Janice Eldridge was retiring at the end of January as the CCG's Clinical Prescribing Lead and FLT thanked for her commitment and passion. National Patient Survey 2016 – the most up-to-date GP Surveys have been published and FLT was delighted to see such a good range across the 19 practices. RP added it was good to see the hard work acknowledged in this way. **Outcome: The Governing Body received the report.**	
GB16/7	**GP Pressures and Supporting Practices** Dr Caudwell reported an Extraordinary Local Medical Council (LMC) Conference had been arranged to look at the national Primary Care crisis, CQC inspections and their impact and unfunded work. He believed fairly radical motions would be passed and it would be interesting to see what came out of it. Dr Leonard confirmed he is to lead a meeting to discuss transforming primary care which he believes will be a great opportunity to do things differently. Another 5 experienced GPs are due to retire who would be difficult to replace and he wondered whether the way forward was to devise 'end of career roles' for GPs so their system knowledge wasn't be lost. He noted GPs were now taking themselves off the GMC register due to both personal issues and pressures on the system, which would not have happened a decade ago. In relation to Care Homes, a new system where first point of contact was with a community matron via a Skype interview was proving to be very successful. Practice Managers, Colette Riley and Paul Ashby, were experiencing a very busy period but were looking forward to getting involved in Dr Leonard's work.	
GB16/8	**Corporate Risk Register and Q3 GB Assurance Framework** The Governing Body was presented with the updated Corporate Risk Register (CRR) as at December 2015 and the Quarter 3 (end December) Governing Body Assurance Framework (GBAF). TJ made the Governing Body aware that these updates had not previously been scrutinised by the Quality Committee, due to unforeseen circumstances, however they had been reviewed by the Corporate Governance Group and the Senior Management Team.	

No	Item	Action
	Corporate Risk Register (CRR) and Q3 Governing Body Assurance Framework (GBAF) P21 - QA040 – TJ pointed out the last risk summary referred to a different risk. P19 - GBAF 7.2 – the summary highlights the risks as diminished but the assurance framework didn't reflect that. TJ assured the Governing Body that contracts had been signed with the new CSU and the next update of the CRR would show a diminished risk. TJ confirmed the next update would be presented to the Quality Committee in February and come back to Governing Body in due course. **Outcome: The Governing Body approved the Corporate Risk Register and Q3 GB Assurance Framework subject to amendments and further review by Quality Committee.**	TJ
GB16/9	**Improving the Quality of NHS Complaints Investigations (Parliamentary and Health Service Ombudsman (PHSO) Summary Report)** TJ gave highlights from the report. Lisa Gilbert, the CCG's Corporate Governance Manager, would be working with colleagues across the health economy to implement the recommendations made in the report. FLT had escalated the matter to NHS England as she believed much more could be done in relation to thought and compassion for patients and their families. She was always happy to meet with a patient's relatives as she felt a letter was sometimes too impersonal. Dr Caudwell noted Primary Care was hardly mentioned in the PHSO summary report. FLT believed that was due to those complaints being dealt with; she thought it was the more complex cases that were referred to the CCG, although she asked for Colette Riley and Paul Ashby to circulate the report to their Practice Manager peers for information. HN queried whether the work from this report would also be used for serious incidents, as there were also concerns about how they were being investigated. TJ confirmed Lisa Gilbert would be working with the Quality Team to ensure this happened. **Outcome: The Governing Body received the report.**	CR/PA
GB16/10	**LCR NHS CCG Alliance (formerly Merseyside CCG Network) Terms of Reference** FLT presented the Terms of Reference for the new LCR NHS CCG Alliance, which had evolved from a growing recognition of the need to ensure patients continued to receive high standards of health and social care despite severe Government budget cuts. **Outcome: The Governing Body approved the Terms of Reference.**	
GB16/11	**Draft Children's and Young People's Plan** Dwayne Johnson explained the draft plan was centred on improving outcomes for children, young people and families across the borough, regardless of background. Partners of the plan will work towards actions that promote early intervention and prevention. DJ was due to discuss the plan with Jan Leonard, Chief Redesign & Commissioning Officer, and Peter Wong, the managerial lead for Children & Maternity Services and he asked for any additional comments from the Governing Body to be sent to him by the beginning of March. His intention was to bring further updates back to the Governing Body. Roger Pontefract praised DJ for a very comprehensive draft plan however suggested the eight abbreviations in the section "At the start the journey so far" should either be explained or left out. RP remembered a healthy schools programme which had encouraged healthy habits in primary school children in a straightforward way and wondered if something similar should be incorporated. FLT reported her attendance at the local authority's Overview & Scrutiny Committee (Children & Safeguarding Services) (the OSC) the previous night for the formal introduction of the plan. The OSC wants to be assured its population is receiving a high standard of service in relation to child mental health, which coincides with a recent study by the NSPCC. **Outcome: The Governing Body noted the content of the report.**	DJ ALL

No	Item	Action
GB16/12	**Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21** KMcC gave highlights from his report and confirmed the requirement for the CCG to produce a Sustainability and Transformation Plan (STP) and an Operational Plan (OP) to be in line with the latest planning guidance. A GAP analysis is being undertaken to identify gaps between our programmes and the guidance. It was important to note the STP would be the only method of drawing down transformation monies in future. There was a meeting with NHS England on Friday 29th January to finalise where organisations should sit due to their complexity and the need to consider the best economic scale. The likely footprint would be based upon the Liverpool City Region, which would involve a number of CCGs working together. There was a need for the CCG to concentrate on various models of care whilst ensuring financial balance and, going forward, the CCG would be looking at integrating our QIPP targets into our commissioning intentions. KMcC pointed out that the timeline contained in the report was based on receiving further information including baselines, from NHS England which was yet to be received. Dr Caudwell highlighted an inaccuracy at the top of page 155 – there was no link between "deaths and levels of consultant cover". KMcC pointed out the reference had been lifted from the NHS England planning guidance. **Actions: The Governing Body:** **(i) received the summary for information; and** **(ii) gave delegated authority to SLT, to enable the required submission timetable to be met.**	
GB16/13	**Shaping Sefton Update** KMcC updated Governing Body members on the Shaping Sefton Transformation Plan, as part of the overall CCG Strategic Plan. The Governing Body was asked to note the progress under the respective strategic blueprints, recognising that more detailed performance was contained within the Integrated Performance Report. KMcC reported Tanya Mulvey had been recruited for 12 months and was currently meeting with Practice Managers to look at some of the issues, share good working practices, drive change and progress the self-care agenda. The job description for the Medical Director role, previously approved by the QIPP Committee, had been drafted. HN's understanding of the Medical Director and Band 7 roles were that they spent time with practices looking at variation of referrals in particular areas and see whether best practice could be spread across with a view to reducing referrals across the system. She asked for assurance that this was still the case. KMcC confirmed it was - this work will help us assess and form a different model on a more sustainable basis going forward. The CCG has been working with Southport & Ormskirk Hospital NHS Trust in relation to acute hospital and community activity and set that against primary care in order to align different parts of the system. In terms of intermediate care, some work was initiated to explore extended intermediate care work, although a decision was made not to support it at this time. HN queried what impact lack of the intermediate care beds would have in terms of winter pressures. KMcC responded the current level of care beds was consistent with comparative years, the Trust had introduced Bluebell Lodge to help through the step down function. Mental Health – a workshop was held with Mersey Care in December at which a shared set of principles was agreed. The CCG is hoping to develop a joint commissioning approach with Liverpool CCG through further discussion. **Outcome: The Governing Body received the report.**	

No	Item	Action
GB16/14	**Community Services Procurement Update** Jan Leonard reported the procurement programme was progressing well and in accordance with the timescales set out in the procurement plan. The CCG had received 8 expressions of interest, which were currently being evaluated with invites to tender being issued in early April. Sefton Council had asked for documentation relating to the procurement and cost to be shared with them. FLT would confirm back to the Council that all public documentation other than commercial documents could be shared and a breakdown of cost would be provided. **Outcome: The Governing Body received the update.**	FLT
GB16/15	**Integrated Performance Report** *A&E 4 Hours Target* – the CCG's performance had been consistent with the rest of the Cheshire & Merseyside landscape and represented continuing challenges around A&E, both locally and nationally. In line with that there were corresponding challenges in relation to ambulance targets. *Cancer Performance* – performing well in nearly all cancer categories, the two-week wait for breast symptom patients against 93% target related to 8 patients who elected not to be seen in that timeframe. FLT asked clinical colleagues if there was anything we could do if patients decided not to go for treatment. HN queried why the CCG was scoring red on breast when other CCGs were green; it was agreed to discuss this further in an SLT meeting. *62-Day Waiting Time* – the diagnostic service failed to meet target and following concerns raised at Bridgewater related to hearing there is a full remedial plan in place and some detailed monitoring of audiology performance underway. Additional support for Southport & Ormskirk Hospital NHS Trust has been provided and JL was assured they would catch up by the end of the year. *Referral to Treatment* – the CCG was fully compliant with the 18 weeks' target. *Improving Access to Psychological Therapies* (IAPT) – November showed a slight (0.86%) improvement in October's performance. October. *Stroke Performance* – due to emergency pressures and prior to the addition of stroke beds in September, this figure struggled against the target. KMcC highlighted the latest stroke performance information which demonstrated significant improvement and reflected the work the team had done in reviewing and improving practices. *Delayed Transfers of Care (DTOC)* – this was included as part of the new planning guidance. The CCG was fortunate to be in a good starting position to address DTOC performance and it would be required to monitor it as part of the integration plan with Sefton Council. *Quality* – The Trust remained below 23 CDiff infections for the year, 2 were successful in being over-turned on appeal. PROMS on knee replacements – some work being done on MCAS to develop a pathway, where effectively two exist at the moment. It was noted there had been some really good outcomes at Southport & Ormskirk; the public should be encouraged to get explore these issues as there would be some difficult discussions to be had in the future. ***Finance*** – MMcD reported he could not guarantee the CCG would achieve its target and could potentially be on target for £1.8m deficit after applying penalties for non-delivery of contract. He and FLT had recently attended an NHS England event for financially-challenged CCGs. NL believed the CCG was starting to see the impact of people getting older and long term conditions and he was trying to pull an article together which establishes the English 'norm' and the Southport 'difference'. RP, who also chaired the Finance & Resource Committee, confirmed the Committee was taking whatever actions were required and starting to look ahead to next year. He had observed a very positive response when it had been discussed at the Wider Group meeting in January. It was important to take some urgent action on items discussed, as the CCG would have to consider public engagement, etc.	FLT

No	Item	Action
	Dwayne Johnson had discussed whether Southport & Formby CCG and South Sefton CCG, together with Sefton Council, should commission work to evidence the benefit of working together and the current context of resource constraints. The difficulties the CCG was experiencing would be compounded by Council cuts. Strategically, the CCG was heading in the right direction; reducing people into care, reducing people going into hospital, best Delayed Transfers of Care (DTOC) rate in the north west, etc. Meeting to be arranged with Leadership Team and Sefton Council. Third Sector Contracts – FLT asked for an update to be brought back to the Governing Body.	FLT MMcD
GB16/16	**Key Issues Logs from Committees of the Governing Body:** a) *Finance & Resource Committee* – the committee has been focussing on the financial position and need to take urgent action. b) *Quality Committee* – the Committee has been focussing on safeguarding and serious incident reporting at the Trust, with some improvement seen. c) *CIC: Realigned Hospital Based Care* – there was a growing need to ensure the transformation programmes for both Knowsley and Sefton were linked most effectively with Healthy Liverpool. d) *CIC: LCR NHS CCG Alliance* – no comment. e) *Joint Commissioning Committee* – Care Homes - conversation to be held with the Care Home sector to be mindful of reducing monies. Dr Scholtz had had various discussions in relation to care homes and believed a transformation plan could be developed and presented to the wider constituency for review. KMcC and NL to review. **Outcome: The Governing Body received the Key Issues Logs.**	KMcC/ NL
GB16/17	**Finance & Resource Committee Minutes** **Outcome: The Governing Body received the Finance & Resource Committee Minutes.**	
GB16/18	**Quality Committee Minutes** **Outcome: The Governing Body received the Quality Committee minutes.**	
GB16/19	**Audit Committee Minutes** **Outcome: The Governing Body received the Audit Committee minutes.**	
GB16/20	**Approvals Committee** – none presented	
GB16/21	**Any Other Business** *Absence of locality minutes* – as per FLT's Chief Officer's report, locality minutes would no longer be included in the meeting pack, instead Locality Managers would prepare a précis on a 4-monthly basis.	
GB16/22	**Date of Next Meeting** Wednesday 30th March 2016 at 1300 hrs, Family Life Centre, Southport, PR8 6JH	

Governing Body Meeting in Public
Actions from meeting held 27th January 2016

No	Item	Action
GB15/163	**Developing Personal Health Budgets** PHB Policy & Practice Guidance to be presented to Governing Body in March 2016.	TF
GB15/207	**Organisational Development Plan** A detailed development plan to be prepared for approval by the Finance & Resource Committee.	TJ
GB16/9	**Improving the Quality of NHS Complaints Investigations (Parliamentary and Health Service Ombudsman (PHSO) Summary Report)** Dr Caudwell noted Primary Care was hardly mentioned in the PHSO summary report. FLT believed that was due to those complaints being dealt with; she thought it was the more complex cases that were referred to the CCG, although she asked for Colette Riley and Paul Ashby to circulate the report to their Practice Manager peers for information. HN queried whether the work from this report would also be used for serious incidents, as there were also concerns about how they were being investigated. TJ confirmed Lisa Gilbert would be working with the Quality Team to ensure this happened.	CR/PA LG
GB16/11	**Draft Children's and Young People's Plan** DJ was due to discuss the plan with Jan Leonard, Chief Redesign & Commissioning Officer, and Peter Wong, the managerial lead for Children & Maternity Services and he asked for any additional comments from the Governing Body to be sent to him by the beginning of March. His intention was to bring further updates back to the Governing Body.	DJ
GB16/12	**Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21** The Governing Body gave delegated authority to SLT, to enable the required submission timetable to be met.	SLT
GB16/14	**Community Services Procurement Update** Sefton Council had asked for documentation relating to the procurement and cost to be shared with them. FLT would confirm back to the Council that all public documentation other than commercial documents could be shared and a breakdown of cost would be provided.	FLT
GB16/15	**Integrated Performance Report** *Cancer Performance* – HN queried why the CCG was scoring red on breast when other CCGs were green**; it was agreed to discuss this further in an SLT meeting.** Dwayne Johnson had discussed whether Southport & Formby CCG and South Sefton CCG, together with Sefton Council, should commission work to evidence the benefit of working together and the current context of resource constraints. **Meeting to be arranged with Leadership Team and Sefton Council.** *Third Sector Contracts* – **FLT asked for an update to be brought back to the Governing Body.**	FLT FLT MMcD
GB16/16	**Key Issues Logs from Committees of the Governing Body:** *Joint Commissioning Committee – Care Homes* - conversation to be held with the Care Home sector to be mindful of reducing monies. Dr Scholtz had had various discussions in relation to care homes and believed a transformation plan could be developed and presented to the wider constituency for review. KMcC and NL to review.	KMcC/ NL

NHS
Southport and Formby
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MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/40	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: March 2016	
Title: Chief Officer Report	

Summary/Key Issues:

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

Recommendation

The Governing Body is asked to formally receive this report and approve delegated authority to the Chief Officer to sign off the BCF on its behalf.

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

16/40 CO Report

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

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

Report to Governing Body
March 2016

1. Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21 Update

The CCG submitted the second iteration of the one year operational plan on 18th March 2016. This date was not part of the original timetable and has been added by NHSE this month to enhance their level of assurance. The next iteration is due for submission on 11th April.

The plans have been built up by point of delivery (Elective, Out-patients, Non-electives, A&E attendances) and by provider. The baseline used at the outset was the month 6 baseline, provided by NHSE. We have up-dated the baseline for CCG planning purposes based on month 9 forecast outrun, with adjustments for seasonality. Plans have then been augmented to take account of demographic changes. Thereafter plans have incorporated adjustments based on existing QIPP and transformation schemes.

These plans will now need to be tested through Senior Leadership Team and the Governing Body Development sessions to inform the next iteration.

2. Sustainability & Transformation Plan (STP)

In terms of STP, the agreed footprint remains Cheshire and Merseyside, with the following Local Delivery Systems:

- North Mersey;
- Mid Mersey;
- Wirral & West Cheshire;
- Eastern Cheshire;
- Central & South Cheshire.

South Sefton CCG and Southport & Formby CCG remain part of the North Mersey LDS with Liverpool and Knowsley CCGs.

The CCG is now working within the LDS footprints to build up the respective plans in contribution to the STP deadline of June 2016.

3. Shaping Sefton

In February 2015 we launched the Shaping Sefton Transformation programme. Focused on the CCGs three strategic aims

- Care of frail/vulnerable person
- Transformation of the Unplanned care system
- Transformation of Primary Care

The work programmes have been built around our settings of care

- Prevention
- In Hospital
- Out of hospital

These are aligned to the three components of Triple Aim

- Better Health
- Better Care
- Better Value

We are now working within the Comms team to articulate this vision and outcomes of the programmes into our annual report and making it available for our next Big Chats. We will continue to work closely with our colleagues Liverpool CCG on shaping the 'in hospital model of care', building on the recent discussions of the governing body, engaging with the CCG membership, clinicians and public.

There is also work going on with the new Director of Public Health Matthew Ashton to build on the Health & Well Being Strategy and consolidate the CCG and Local Authority thinking across the Health & Well Being/Prevention agenda. A programme manager will be appointed on a fixed term basis to lead this work.

4. Better Care Fund Policy Framework 2016/17

The Policy Framework was published on 8 January 2016. It sets out the agreed way in which the Better Care Fund will be implemented in the 2016/17 financial year. The underlying principles are to remain in that:

- a pooled fund is required,
- Health and Wellbeing Boards are expected to agree plans,
- plans will be approved by NHS England in consultation with Department of Health and in addition the Department of Communities and Local Government.

The Framework covers:

- the legal and financial basis of the fund
- conditions of access to the fund
- national performance metrics
- the assurance and approval process

The six National Conditions remain with addition of two

- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
- Agreement on local action plan to reduce delayed transfers of care.

These two conditions replace the performance fund element, where areas were required to commit to a reduction in non-electives and "hold funds back on the basis of making that reduction" (Payment for Performance). However, there is an option to retain this arrangement, with agreement.

The process for developing plans will be simplified and plans have been aligned to the timetable for CCG operational plans. We are currently working through our BCF plans with Sefton MBC, supported by Sharon Lomax- Integrated Health and Social Care Manager. **The governing body is asked to give delegated authority to the Chief Officer to sign off the BCF on its behalf.**

5. Quality

4.1 Nurse Revalidation

The Governing Body have previously received updates on the preparation for revalidation. Nurse revalidation comes into effect from 1st April 2016. The requirements for revalidation for each nurse registered with the Nursing & Midwifery Council are as follows:

- 450 practice hours or 900 if renewing as both a nurse and a midwife;
- 35 hours of CPD including 20 hours of participatory learning;
- Five pieces of practice-related feedback;
- Five written reflective accounts;
- Reflective discussion;
- Health and character declaration;
- Professional indemnity;
- Confirmation.

Internally Within the CCG - The Chief Nurse and Deputy Chief Nurse are aware of all registered nurses currently working within the organisation and HR has notified the Chief Nurse of all nurses working within the CCG who are due for revalidation within the next couple of months. SFCCG, SSCCG and LCCG have been working collaboratively to deliver internal awareness raising sessions and these have now developed into reflective practice opportunities for the registered nurses. Registered Nurses who are line-managed by another NMC registrant can undertake both their reflective discussion and confirmation sign-off at the same time. Registered Nurses who are not line-managed by a NMC registrant will have to seek sign-off of their reflective discussion from another NMC Registrant before confirmation can take place by their line-manager.

Practice Nurses Working Within Constituent Practices – The practice nurse facilitators have developed and delivered a reflective writing workshop session for constituent practice nurses as part of the protected learning time event in December 2015. The aim of the session was to prepare nurses on completing reflective accounts as part of the revalidation process. A revalidation page has been developed for practice nurses on the CCG web site to provide updates and links to the NMC website for revalidation guidance. Regular updates have been included in CCG bulletins over the last 9 months. The practice nurse facilitators have also contacted individual practices to offer support to both practice nurses and practice managers on revalidation.
Commissioning Assurance – CCG commissioners have jointly agreed key performance indicators to be negotiated into the 16/17 quality schedule in relevant provider contracts.

4.2 Student Nursing Times Awards 2016: Student Placement of the Year – Community Category

Southport & Formby CCG and South Sefton CCG have been shortlisted in the Student Nursing Times Awards 2016. The CCGs have made it into the final round of the 'Student Placement of the Year – Community' category. The winner of this national award will be announced at a ceremony in London on 28th April 2016.

4.3 Article for Publication – Student Placements in the CCG

The Quality Team have recently received confirmation that the article that was written regarding Student Placements within the CCG has been accepted for publication in The Nursing Times. The publication date is awaited. The article was written as a collaborative submission with input and

review from NHS Southport & Formby CCG, NHS South Sefton CCG, Edge Hill University, North West Placement Development Network and NHS England Nursing Directorate (national team).

4.4 Health Care Assistant Apprentice Graduation – Hugh Baird College

The CCG Practice Nurse Facilitators were involved in the development and delivery of the Apprentice Programme as well as providing support to both GP Practices and trainees. Evaluation of the course is currently underway and is being undertaken on behalf of the CCG by Edge Hill University. The first cohort graduated in March 2016 and an award ceremony took place – awards were presented by the CCG Deputy Chief Nurse.

4.5 NHS England Cheshire & Merseyside (C&M) Health Care Associated Infection (HCAI) Summit

In February 2016, NHS England C&M held the second HCAI Summit. The Deputy Chief Nurse delivered a joint presentation with the Infection Prevention Control Nurse Lead from Aintree University Hospitals NHS Foundation Trust on the development and implementation of the local clinically-led C.difficile appeals process. This highlighted collaboration and ownership of the process by local providers and commissioners and will form the basis for the next HCAI summit to promote reliability and consistency of the process across the wider health economy. The CCG received thanks from the NHSE C&M Director of Nursing & Quality for their involvement in the day.

4.6 Quality Walkarounds

Southport & Ormskirk Hospitals NHS Trust (Accident & Emergency Department / GP Assessment Unit) - The CCG Team, in partnership with NHS West Lancashire CCG, have recently undertaken a Quality Walkaround through the A&E Department and GP Assessment Unit at the Trust as part of the assurance process due to recent pressures. The CCGs were accompanied by the Trust Director of Nursing who also facilitated the opportunity for a discussion with staff and patients during the visit.

Southport & Ormskirk Hospitals NHS Trust (Stroke Unit) – The CCG Team, in partnership with NHS West Lancashire CCG, are awaiting a date to be finalised for a Quality Walkaround through the Stroke Unit following the confirmation of ring-fenced beds from the Trust.

Mersey Care NHS Trust – The CCG Team have recently met with the Trust Director of Nursing and the relevant provider teams to gain an understanding of the patient pathway from A&E to the specialist suite at Clock View due to some longer than expected waiting times. A member of the Quality Team has also 'shadowed' the Mersey Care Team to observe the systems and processes they have in place when undertaking internal quality assurance visits and plans are in place for a future visit to take place. The CCG Quality Team has offered a reciprocal arrangement to the Trust to see how the CCG Quality Team operates as part of a 'commissioner / provider knowledge exchange' and to further support joint working and learning opportunities across the local system.

4.7 Single Item Quality Surveillance Group –Southport & Ormskirk Hospitals NHS Trust

A follow-up Single Item Quality Surveillance Group Meeting for Southport & Ormskirk Hospitals NHS Trust was Chaired by NHS England (Cheshire & Merseyside) on 8th March 2016. The Trust evidenced progress against the key lines of enquiry which were identified at the previous meeting. A date has not been set for a future meeting as the Trust have an announced CQC visit in April 2016 and all key stakeholders will be invited to a meeting to be informed of the outcome of the planned inspection.

4.8 Care Quality Commission (CQC) Planned Inspections of Local NHS Providers

The CCG have announced that they will be undertaking planned inspections of Southport & Ormskirk Hospitals NHS Trust, Liverpool Heart & Chest Hospital NHS Foundation Trust and The Walton Centre NHS Foundation Trust in April 2016. The CQC have requested that the CCG support any promotion of the visits with the public and also inform them of any engagement events we are holding that they can utilise. As per usual practice, the CCG will be liaising with the CQC prior to the visits to share any relevant information.
Liverpool Community Health NHS Trust has had a recent inspection visit from the CQC. The Governing Body will be informed of the outcome of the CQC inspection visits once known.

4.9 Care Home Closures

The CQC undertook an inspection of the Ferns Nursing Home in Southport in February 2016 and the CCG were notified that a letter of intent had been issued to de-register the care home. The CCG worked in partnership with Southport & Ormskirk Hospitals NHS Trust in order to mitigate any clinical risk to patients at that time. On consideration of the actions from the CQC, the owners decided to close the home. An agreement was reached that the nursing home would close within 7 calendar days but the most high risk and complex patients were moved within a 24 hour period. The CCG supported Sefton Council's closure plan with the support of the Head of Vulnerable People, Medicines Management, Primary Care and CSU CHC Team. All 31 residents were safely transferred to an alternative placement within the stipulated timescales and the home closed on 10th March 2016.

Since October 2015 there have been a loss of 93 nursing home beds across the borough of Sefton due to nursing home closures - 2 were as a result of CQC inspection processes and 1 home closed on a voluntary basis. There are still vacant beds available to provide care in Sefton.

4.10 Youth Offending Team Board

The Deputy Chief Nurse represents the CCG at the Youth Offending Team Board and at the March 2016 meeting presented a paper highlighting the current commissioning arrangements and health activity. Verbal feedback indicated 'reasonable assurance' and further work has been agreed to take place outside of the Board on lower level Mental Health input for those children and young people who wouldn't meet the criteria for Mental Health Services.

4.11 Individual Patient Activity (IPA) Programme Board

Midlands & Lancashire Commissioning Support Unit (MLCSU) are now delivering the commissioning support function to the CCG for individual packages of care, including Continuing Health Care (CHC), excluding non-CHC Learning Disability packages of care which are commissioned via a joint arrangement with the Local Authority. The CCG still has in place the CHC Steering Group (Chaired by a SFCCG Lay Member) but an IPA Programme Board has now been established between SFCCG, SSCCG, LCCG and M&LCSU. The purpose of the Programme Board will be to support the development and delivery of our strategic vision and provide relevant assurance. It is envisaged that the CHC Steering Group will shortly be disbanded with the work it scrutinised forming part of the remit of the IPA Board. The IPA Programme Board has now met on 2 occasions and members are keen to have Local Authority colleagues in attendance once the Board is further established.

4.12 Safeguarding

Joint Targeted Area Inspections

The Quality Committee received an update from the CCG Safeguarding Service in February 2016 regarding the new Joint Targeted Area Inspection (JTAI) which has been launched from 1st February 2016 – Inspectors will include those from Ofsted, Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and her Majesty's Inspectorate of Probation (HMIP). The joint inspection will examine how the Local Authority, Police, Health, Probation and the Youth Offending Service work together to identify, support and protect vulnerable children and young people. For inspections that take place between February 2016 and August 2016, the 'deep-dive' will focus on Child Sexual Exploitation (CSE) and missing from home, education and care.

The CCG Safeguarding Service have sent a briefing to the relevant commissioned provider services outlining the expectations and documents that will be required and prepared once an inspection is announced. The CCG / Safeguarding Service were in attendance at a recent meeting called by the Local Authority in order to understand and scope out the expectations of the partnership and establish communication pathways for collating and sharing requested documentation.

Section 11 Action Plan Update

The CCG is required to complete a Section 11 Audit which is returned to the Local Safeguarding Children Board (LSCB). This self-assessment undertaken by the CCG Safeguarding Service identified a high level of compliance across the majority of standards as well as some areas that could be further strengthened which include ease of availability of the CCG Safeguarding Policy to staff and the inclusion of safeguarding children signposting in induction processes . An action plan has been developed and an updated version (v2. February 2016) presented to the Quality Committee in February 2016. The revised CCG Safeguarding Policy has been uploaded onto the CCG website and includes links to the Local Safeguarding Children Board for multi-agency safeguarding children policies. With regard to the CCG induction process, the CCG Safeguarding Service is working closely with the CCG HR Team from the Commissioning Support Unit and the CCG Chief Delivery & Integration Officer is now also supporting this process.

NHS England CCG Quality Assurance Process

NHS England has written to CCGs outlining their planned assurance process for Safeguarding. The CCG are required to complete an assurance tool demonstrating the meeting of statutory requirements to safeguard children, young people and adults at risk. The completed assurance tool will be completed by the CCG Safeguarding Service and reviewed by the Chief Nurse prior to submission in April 2016. The CCG Safeguarding Service will be providing an exception report to the Quality Committee as part of the CCG internal assurance processes.

CCG Safeguarding Peer Review Action Plan

The CCG Safeguarding Peer Review Action Plan was presented to the Quality Committee in February 2016 and has supported the recommendation for closure by the Governing Body. This will be presented as a separate agenda item at the Governing Body.

Child Sexual Exploitation (CSE)

The Governing Body have previously received a CSE update from the CCG Safeguarding Service in 2015. The CCG Safeguarding Service continues their leadership role with regard to this agenda at a local and regional level. Recent CCG activity in relation to CSE includes:

- **Local Safeguarding Children Board (LSCB) CSE Summit** – this Summit for LSCB Board Members was held on 16th March 2016. The Chief Nurse, Head of Safeguarding Children / Designated Nurse and the Named GP were in attendance as members of the LSCB representing the CCG;

- **Local Authority Stakeholder Briefing** – The CCG attended a recent CSE Briefing Session facilitated by the Local Authority in February 2016;

- **Provider Contracts 16/17** - The CCG Contracts Team have worked with the CCG Safeguarding Service to ensure that expectations around CSE are included in relevant provider contracts for 2016/17. Specific reference is being made regarding the requirement for the provider to take into account and adopt the Pan Cheshire/ Merseyside Child Sexual Exploitation Multi-Agency Strategy 2015 -2017 and Pan Cheshire/ Merseyside Child Sexual Exploitation Operating Procedure 2015-17. Relevant providers were performance managed on a range of Key Performance Indicators (KPIs) in relation to CSE in 2015/16 contracts and KPIs for 16/17 are currently being determined;

- **National CSE Awareness Day** – This took place on 18th March 2016 and information was circulated within the CCG and to membership practices by the Communication & Engagement Team;

- **Joint Targeted Area Inspection (JTAI)** – The CCG Quality Team and CCG Safeguarding Service have ensured that relevant information in relation to CSE is readily available as part of the CCG preparation for the JTAI.

NHS England PREVENT Masterclasses for CCG Executive Safeguarding Leads & Directors of Nursing

This masterclass was held on 16th February 2016. This 'Senior Development Session' covered the following areas – Statutory duty and what it means in practice; Policy and Procedure; Information Governance; Data Collection; Priority areas; Role of the Regional Prevent Co-ordinators; Role of the National Prevent Sub-Group. The CCG were represented the CCG Head of Vulnerable People. The CCG's current arrangements for Prevent are in-line with the statutory requirements.

4.13 Looked After Children (LAC)

Looked After Children Health Assessments and Reviews - The issue of health assessments and health reviews for looked after children (LAC) were placed on the CCG Corporate Risk Register in 2015. On 31st March 2016, the CCG Chief Nurse is chairing a follow-up meeting to the lessons learnt event undertaken in 2015 to review progress to date. From a health perspective, work has been undertaken in the interim supported by the CCG Designated Nurse for Looked After Children, to improve local system and processes. Current provider performance in relation to health assessments for LAC has been presented and discussed at the March 2016 meeting of the Quality Committee as part of the CCG Safeguarding Service Assurance Report.

CCG Looked After Children Strategy – The CCG Looked After Children Strategy has been developed by the CCG Safeguarding Service and reflects national guidance. This has recently been presented to the Quality Committee and is a separate agenda item at today's meeting.

Governing Body Development Session – the date is currently being finalised for the delivery of Board level training by the CCG Safeguarding Service at a future Governing Body Development Session.

4.14 Local Government Association (LGA) Adults Peer Challenge Training

Peer Challenge is an important component of Sector Led Improvement in Adult Social Care. The LGA wanted to widen the number of 'Health Peers' with CCG experience and the CCG Chief Nurse, Deputy Chief Nurse and Head of Vulnerable People successfully completed training to support the LGA Adult Safeguarding Peer Challenge Programme in March 2016. The time commitment will be no more than one Peer Review per year for each of the trained individuals and this is dependent on being suitably 'matched' with the requesting area. This will develop further the experience the Quality Team has with regard to peer review and builds upon the experience of the team in supporting a mock CQC-style Chief Inspector of Hospitals inspection as previously reported to the Governing Body.

6. Mental Health Taskforce Report

In February the long awaited Mental Health Taskforce Report was published. The independent Taskforce which was established in March 2015 was chaired by Paul Farmer of Mind and aimed to pull together a long term strategic approach to improving mental health outcomes across the NHS.

The Taskforce brought together a range of experts from arm's length bodies, the voluntary sector, mental health providers, carers, experts by experience. The report set out the start of a ten year journey for that transformation a set of recommendations for the six NHS arm's length bodies to achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people. The main ambition is to have a decent place to live, a job or good quality relationships in their local communities.

There is a particular focus on tackling inequalities. Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination. For too many, especially black, Asian and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital. To truly address this, we have to tackle inequalities at local and national level

There are 57 recommendations and while recognising that the recommendations set out in the report will be tough to implement, the report is an important challenge to the whole system, and certainly one that the CGG will take seriously. It is an opportunity to make a real difference to mental health services, address the inequalities that persist and provide the best possible care for people with mental health issues, within the available resources.

Some key messages include

- 1 in 10 children aged 5-16 years have a diagnosable mental health problem
- Nine out of ten adults with mental health problems are supported in primary care
- £34 billion each year spent on mental health
- Just 43% of people with mental health problems are in employment
- £1 billion additional investment needed
- Right care, right time, right quality – 7 days a week

One of the recommendations specifically focuses on CCGs. It suggests that the Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for Children and Adolescent Mental Health Services, from 2017/18 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall allocation increase. For children and young people, this should be broken down initially into spend in the community, on emergency, urgent and routine treatment, and for inpatient care.

https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

7. Review of Women's and Neonatal Services at Liverpool Women's Hospital NHS FT

On the 4th March 2016 a review to identify how health services for women and premature babies in Liverpool can continue to flourish for future generations was announced.

The review, which is part of the Healthy Liverpool programme and very much aligned to the Shaping Sefton programme, will be led by NHS Liverpool Clinical Commissioning Group (CCG) as co-ordinating commissioner, in partnership with Liverpool Women's NHS Foundation Trust.

The move comes following a piece of work undertaken by doctors, nurses and midwives at Liverpool Women's Hospital to highlight how these services could be made better for future generations of women, babies and their families. The way that services for women and babies are currently organised in the city was put in place more than 20 years ago. The health needs of the population have changed during this time, and are continuing to change, so it's important that we look at how services might be delivered differently for the benefit of patients.

First and foremost this review is about making sure local people have access to the very best care, but this process will also give us the opportunity to think about solutions which will protect services by ensuring that they are financially sustainable. This review will consider all options available to ensure that specialist women's and babies' services continue to flourish in this city for future generations.

The review results will inform a further conversation with the public early in summer 2016. This will be followed by a formal public consultation around any service changes later this year, ahead of a final decision being reached in 2017.
The governing body will continue to be updated and the CCG clinical lead for women's and children will be involved in this work as well as the work of the Vanguard.

8. Liverpool City Region (LCR) NHS CCG Alliance (formerly Merseyside CCG Network)

As work has progressed on the Sustainability & Transformation Plan the terms of reference for the LCR NHS CCG Alliance have been reviewed and will be presented back to the Governing body for approval.

9. NHS Diabetes Prevention Programme (NHS DPP)

The Healthier You: NHS Diabetes Prevention Programme (NHS DPP) will identify those at high risk of developing type 2 diabetes. It is estimated that around 22,000 people with diabetes die early every year. Type 2 diabetes is a leading cause of preventable sight loss in people of working age and is a major contributor to kidney failure, heart attack, and stroke. As well as the human cost, Type 2 diabetes treatment currently accounts for just under nine per cent of the annual NHS budget. This is estimated at around £8.8 billion a year.

Healthier You: The NHS Diabetes Prevention Programme will start this year with a first wave of 27 areas covering 26 million people, half of the population, and making up to 20,000 places available. This will roll out to the whole country by 2020 with an expected 100,000 referrals available each year after.

Those referred will get tailored, personalised help to reduce their risk of Type 2 diabetes including education on healthy eating and lifestyle, help to lose weight and bespoke physical exercise programmes, all of which together have been proven to reduce the risk of developing the disease.

There are currently 2.6 million people with Type 2 diabetes in England with around 200,000 new diagnoses every year. While Type 1 diabetes cannot be prevented and is not linked to lifestyle, Type 2 diabetes is largely preventable through lifestyle changes. One in six of all people in hospital have diabetes – while diabetes is often not the reason for admission, they often need a longer stay in hospital, are more likely to be re admitted and their risk of dying is higher.

Seven demonstrator sites have been testing innovative approaches to programme delivery for the last year and this learning has shaped the final programme to get the best results for patients.

Through a phased approach the 27 areas will open their doors to patients in the next few months and throughout 2016. I am pleased to report that Sefton is one of these 27 areas following on from these seven demonstrator sites. The NHS DPP is a joint commitment from NHS England, Public Health England and Diabetes UK. The programme launch coincides with PHE's new national campaign, One You, which encourages people in midlife to take control of their health and make better lifestyle choices – helping them to prevent ill health and help them live well for longer.

I want to offer my thanks to Sharon Forrester-Programme Lead and the two CCG clinical leads, Dr Doug Callow and Dr Nigel Taylor who have worked with Dr Davina Hanlon in the Councils Public Health team to submit a successful bid. The governing Body can look forward to progress updates.
https://www.england.nhs.uk/ourwork/qual-clin-lead/diabetes-prevention

10. Governing Body changes

As a result of an open recruitment process the position for the replacement of Roger Pontefract- Lay Member Engagement & Patient Experience has been offered and we are awaiting confirmation through the usual Human Resources recruitment processes.

11. Macmillan Health and wellbeing event

Southport Macmillan Cancer Information and Support Centre, a joint partnership set up by Macmillan and NHS Southport and Formby Clinical Commissioning Group (CCG) launched its new Cancer Recovery Programme at the sixth successful 'Health and Wellbeing Event' on March 17 at Southport Theatre and Convention Centre.

Almost 200 people attended the event and benefitted from the chance to chat to nurse specialists and people from key organisations at the various market stalls. Visitors also listened to talks, took part in activity sessions, had hand massages and watched a healthy food demonstration. Guests were also told about different support groups, such as the new Macmillan gardening group which starts in April.

The regular event, run in partnership with Southport & Ormskirk Hospital NHS Trust, aims to support people in adjusting to life with and beyond cancer by providing information on the wide range of services which are available locally as well as healthy living activities.

Feedback on the day was excellent with comments such as: "All fantastic and uplifting for mind, body and soul" and "Thank you for having these magnificent events that can really change people's lives."

12. Recommendation

The Governing Body is asked to formally receive this report and approve delegated authority to the Chief Officer to sign off the BCF on its behalf.

Fiona Taylor
Chief Officer
March 2016

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/42	**Author of the Paper:** Fiona Taylor Chief Officer Email: fiona.taylor@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: March 2016	

Title: LCR NHS CCG Alliance – Revised Terms of Reference

Summary/Key Issues:

As work has progressed on the Sustainability & Transformation Plan the terms of reference for the LCR NHS CCG Alliance have been reviewed and are being presented back to the Governing body for approval.

Recommendation

The Governing Body is asked to approve the revised terms of reference.

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.
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				
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)*	
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

To be tabled at the meeting on Wednesday 30th March 2016

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/43	**Author of the Paper:** Karl McCluskey Chief Strategy and Outcomes Officer Email: karl.mccluskey@southportandformbyccg.nhs.uk Tel: 0151 247 7251
Report date: March 2016	
Title: Corporate Objectives 2015/16	

Summary/Key Issues:

The CCG has revisited its current Corporate Objectives and developed a proposal for 2016/17.

The proposed Corporate Objectives will be discussed at the CCG Senior Leadership Team and Operational Team meeting in April 2016.

Recommendation

The Governing Body is asked to approve this report.

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.
x	To develop the integration agenda across health and social care.
x	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		
Clinical Engagement	x			
Equality Impact Assessment		x		
Legal Advice Sought		x		
Resource Implications Considered	x			
Locality Engagement	x			
Presented to other Committees		x		

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
March 2016

1. Introduction and Background

The CCG has revisited its current Corporate Objectives and developed a proposal for 2016/17.

The proposed Corporate Objectives were discussed at the CCG Senior Leadership Team and Operational Team meetings in March / April 2016.

2. Proposed Corporate Objectives 2016/17

1 To focus on the identification of QIPP (Quality, Improvement, Productivity & Prevention) schemes and the implementation and delivery of these to achieve the CCG QIPP target.

2 To progress Shaping Sefton as the strategic plan for the CCG, in line with the NHSE planning requirements set out in the "Forward View", underpinned by transformation through the agreed strategic blueprints and programmes.

3 To ensure that the CCG maintains and manages performance & quality across the mandated constitutional measures.

4 To support Primary Care Development through the development of an enhanced model of care and supporting estates strategy, underpinned by a complimentary primary care quality contract.

5 To advance integration of in-hospital and community services in support of the CCG locality model of care.

6 To advance the integration of Health and Social Care through collaborative working with Sefton Metropolitan Borough Council, supported by the Health and Wellbeing Board.

3. Recommendations

The Governing Body is asked to approve the proposed Corporate Objectives for 2016/17.

Karl McCluskey
March 2016

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/44	**Author of the Paper:** Andrew Woods Senior Governance Manager Equality & Inclusion Email: andy.woods@southseftonccg.nhs.uk Tel: 0151 247 7000
Report date: March 2016	

Title: Equality and Diversity Annual Report 2015/16

Summary/Key Issues:

This report introduces Southport & Formby CCG's Equality and Diversity (E&D) Annual Report (Appendix A) and the Governing Body is asked to pay particular attention to:

- The CCGs approach to and grading feedback in relation to, the Equality Delivery System2 (EDS2), (Appendix A section two);
- Draft CCG's refreshed 3 year Equality Objectives Plan (Appendix A, section three);
- The NHSE EDS2 Summary Report (Appendix B).

Recommendation

Receive	x
Approve	x
Ratify	

The Governing Body is asked to:

a) receive the Equality & Diversity Annual report (Appendix A);
b) receive the CCG approach to Equality Delivery Systems 2 assessment (Appendix A section two);
c) approve the 3-year Equality Objectives Plan in light of the EDS2 assessment (Appendix A, section three); and
d) receive the NHS England EDS summary Report (Appendix B).

Links to Corporate Objectives *(x those that apply)*	
	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.
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			Extensive engagement with national regional and local organisations who represent the views of people who share protected characteristics informed the Annual Report, Equality Objectives and Equality Delivery Systems 2 assessment
Clinical Engagement		x		
Equality Impact Assessment	x			The Annual Reports Equality Objectives Plan has been developed by the Equality Delivery Systems 2 assessment
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement	x			Extensive engagement with local organisations who represent the views of people who share protected characteristics informed the Annual Report, Equality Objectives and Equality Delivery Systems 2 assessment
Presented to other Committees	x			Presented to EPEG committee in February 2016

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 Governing Body
March 2016

1. Executive Summary

This report introduces the NHS Southport & Formby CCG's Equality and Diversity (E&D) Annual Report (Appendix A) and the Governing Body is asked to pay particular attention to:

- The CCGs approach to and grading feedback in relation to, the Equality Delivery System2 (EDS2), (Appendix A section two);
- Draft CCG's refreshed 3 year Equality Objectives Plan (Appendix A, section three);
- The NHSE EDS2 Summary Report (Appendix B).

2. Introduction and Background

The CCG is required to pay due regard to the Public Sector Equality Duty (PSED) and Specific Duties to set Equality Objectives and publish equality information as set out in the Equality Act 2010. Failure to comply has legal, financial and reputational risks. Furthermore all CCGs are required to undertake the Equality Delivery Systems 2 (EDS 2) toolkit as part of the NHS England assurance process.

3. Key Issues

3.1 Annual report and Legal Background

The CCG has produced an annual Equality & Diversity Report which sets out how the CCG has been demonstrating 'due regard' to their Public Sector Equality Duty's three aims to eliminate discrimination, advance equality of opportunity and foster good community relations and will provide evidence for meeting the specific equality duty, which requires all public sector organisations to publish their equality information annually and set Equality Objectives.

3.2 Equality Delivery System

The CCG adopted the Equality Delivery System (EDS2) toolkit as its performance toolkit to support the NHS England Assurance process. The CCGs grades can be viewed in *Appendix A section two.* The CCG's NHS England EDS2 Summary Report can be viewed in Appendix B.

3.3 Equality Objective Plan

All Public authorities are required to meet their specific duties under the Equality Act 2010 to set Equality objectives every 4 years. As a result of the EDS 2 process an Equality Objective Plan has been developed to improve access and outcomes across protected characteristics over the next three years.

4. Conclusions

4.1 By receiving the Annual Report and ratifying the Equality Objective plan the CCG will continue to pay due regard to the exacting Public Sector Equality Duty and strive to continue to address barriers people with protected characteristics face.

4.2 The CCGs are now required to complete and maintain an NHS England EDS2 Summary Report (Appendix B), which will be available on our websites and the link shared with NHS England for the national EDS2 dashboard.

4.3 The CCGs Annual report and Equality objectives plan will be published on the CCG website where it can be accessed by external stakeholders, patients and communities.

4.4 The Governing Body will continue to receive an annual update report and other key reports will be presented to other relevant CCG committees.

5. Recommendations

The Governing Body is asked to:

a) Receive the Equality and Diversity Annual report (Appendix A);
b) Receive the CCG approach to Equality Delivery Systems 2 assessment (Appendix A section two);
c) Approve the 3 year Equality Objectives Plan in light of the EDS2 assessment (Appendix A, section three);
d) Receive the NHS England EDS summary Report (Appendix B).

Appendices

Appendix A - Equality & Diversity Annual Report
Appendix B - NHSE EDS2 Summary Report

Andrew Woods
March 2016

APPENDIX A

NHS
Southport and Formby
Clinical Commissioning Group

EQUALITY & DIVERSITY ANNUAL REPORT

NHS
Southport and Formby
Clinical Commissioning Group

Contents

Foreword

There is clear evidence that people's health, their access to health services and experiences of health services are affected by their age, gender, race, sex, sexual orientation, religion/belief, transgender, marital/civil partnership status and pregnancy/maternity status. NHS Southport & Formby Clinical Commissioning Group (CCG) strive to commission services that meet the needs of our communities; improving access and outcomes for residents and communities in the area.

Southport & Formby CCG believes that equality & diversity should be embedded into all our commissioning activity as well as addressing health inequalities.

1.0 Introduction

This document is the CCG's annual Equality & Diversity Report which sets out how the CCG has been paying 'due regard' to the Equality Act 2010's, Public Sector Equality Duty's (PSED) three objectives to:-

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
2. Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
3. Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Protected characteristics include the age Race, sex, gender reassignment status, disability, religion or belief, sexual orientation, marriage and civil partnership status

This document outlines the CCG's approach to embedding Equality & Diversity within the organisations via the EDS 2 toolkit, setting Equality objectives, monitoring the equality performance of our key NHS providers, ensuring our workforce are supported and engaged and we have robust processes in place to consider our Public Sector Equality Duty (PSED) when we are making commissioning decisions. The report also outlines our strategy and plans to ensure we have strong engagement with people who share protected characteristics.

1.1 What is 'due regard'?

"Due regard" means that the CCGs have given *advanced* consideration to issues of equality and discrimination before making any commissioning decision or policy that may affect or impact on people who share protected characteristics. It is vitally important Equality is an integral part of what we as a CCG do.

The CCG has considered their PSED by undertaking Equality Assessments on Policy and Service changes, by undertaking their Equality Delivery Systems 2 toolkit over 2015 and by ensuring communities who share protected characteristics have a voice in how services are delivered. The CCG prides itself of our involvement of local organisations within the Community and Voluntary Sector who have expertise or who represent the issues of communities and people who share protected characteristics.

1.2 What is discrimination?

Discrimination can be direct or indirect.

Direct discrimination is when one person receives less favourable treatment than another person because of a protected characteristic. For example, if a clinic refuses to offer fertility services to a lesbian couple because they are not heterosexual, this constitutes direct discrimination on grounds of sexual orientation.

Indirect discrimination is when there is a condition, rule, policy or practice that applies to everyone, but which particularly disadvantages people who share a protected characteristic. For example, a social care provider that runs a day centre decides to apply a 'no hats or other headgear' rule to its service users. If this rule is applied to every service user, then Sikhs, Jews, Muslims and Rastafarians, who may cover their heads as part of their religion, will not be allowed to use the drop-in centre. Unless the social care provider can objectively justify using the rule, this is indirect discrimination.

The Equality and Human Rights Commission has developed guidance for users of health and social care.

For more information please visit http://www.nhs.uk/NHSEngland/thenhs/equality-and-diversity/Pages/equality-and-diversity-in-the-NHS.aspx

1.3 What the Equality Act 2010 means for you

The Equality Act 2010 gives the NHS opportunities to work towards eliminating discrimination and reducing inequalities in care. The NHS already has clear values and principles about equality and fairness, as set out in the NHS Constitution, and the laws under the Equality Act 2010 reinforce many of these.

Most of us need to visit a doctor or may need hospital treatment on occasion. Others may rely on the NHS and social care services for help with long-term health conditions or disabilities. Whenever you need healthcare, medical treatment or social care, you have the right to be treated fairly and not to be discriminated against, regardless of your 'protected characteristics' (you can see a list of protected characteristics below). Laws under the Equality Act set out that every patient should be treated as an individual and with respect and dignity.

The laws mean that all NHS organisations will be required to make sure health and social care services are fair and meet the needs of everyone, whatever their background or circumstances.

1.4 Protected characteristics

The Equality Act 2010 offers protection to nine characteristics. These are:

- Age;
- Race;
- Sex;
- Gender reassignment status;
- Disability;
- Religion or belief;
- Sexual orientation;
- Marriage and civil partnership status;
- Pregnancy and maternity.

For the first time the law also protects people who are at risk of discrimination by association or perception. This could include, for example, a carer who looks after a disabled person.

This Equality and Diversity report sets out our ambitions for equality and diversity between 2015 and 2018, both in relation to staff and in delivering services to the public.

2.0 Equality Delivery Systems (EDS2)

We have adopted the Equality Delivery System (EDS2) as our performance toolkit to support us in demonstrating our compliance with the Public Sector Equality Duty. The Equality Delivery System (EDS) is a tool-kit that can the CCG improve the services we provide for our local communities, consider health inequalities in our locality and provide better working environments, free of discrimination, for those who work with us in the NHS.

The EDS 2 has four goals key goals (with 18 specific outcomes) achieving **better outcomes**, **improving patient access and experience, developing a representative and supported workforce and finally, demonstration of inclusive leadership**. Each of these goals can be assessed and a grading applied to illustrate progress in achieving the outcomes and the involvement of the communities and organisations who represent the views of people with protected characteristics is important. The grading's applied as follows:

Undeveloped if there is no evidence one way or another for any protected group of how people fare or Undeveloped if evidence shows that the majority of people in only two or less protected groups fare well

Developing if evidence shows that the majority of people in three to five protected groups fare well

Achieving if evidence shows that the majority of people in six to eight protected groups fare well

Excelling if evidence shows that the majority of people in all nine protected groups fare well

2.1 The local approach to EDS 2

During 2015/16, the CCG's adopted an innovative approach to delivering the EDS 2 Toolkit; engaging with national, regional and local organisations who represent the views of people and communities who share protected characteristics. We undertook one-to-one meetings, workshops, interviews, briefings and research with partner organisations and stakeholders including to name but a few: Healthwatch, The Race Equality Foundation, Deaf Health Champions (Sick of It Report), In Trust Merseyside, Alzheimer's Society, Age Concern, Sefton Equalities Partnership and other key networks across Sefton CVS. The aim of the engagement was to ensure the CCG's understand the 'barriers' communities across protected characteristics face to enable the CCG to improve access and outcomes.

The CCG recognises that patients and staff who share certain protected characteristics are less likely to complain, complete NHS surveys or access community networks to provide their feedback and this level of engagement with stakeholders will ensure that entrenched barriers communities face in relation to accessing healthcare services are understood and mitigated as part of the CCG strategic and operational programmes. Meeting and understanding the needs of people is essential to remove disadvantage and advance equality of opportunity, so we will continue to endeavour to address these issues through mainstream plans, changing service specifications, the way we monitor our NHS providers, business plans and strategies, procurement activity, contract monitoring and discussions with key partners including NHS England, the Local Authority and community, voluntary and faith sectors.

The EDS2 findings identified a range of actions for CCGs' Equality Objective Plan and fair EDS 2 grading. This process also informed the preparation of the CCG's *EDS2 Summary Submission* to NHS England for 2015/16, which explains some of our processes.

Currently Grading for the vast majority of patient and public related services (Goals 1, 2& 4) for the CCG is assessed as **Developing**. Once these key issues are being addressed and or mitigated via mainstream business plans then the CCG can progress form ***developing*** status to ***achieving*** status across the relevant outcomes and goals.

The EDS2 assessment for the CCGs can be viewed in **Appendix 1** below and each goal is presented alongside the national EDS 2 grading achieved by the CCGs.

3.0 NHS Southport & Formby CCGs Equality Objective Plan 2015/18 (Appendix Two)

As a direct result of EDS 2 the CCG has developed a specific long term Equality Objectives Action Plan, which will enable the CCG to address barriers through mainstream plans including- changes to specifications, business plans and strategies, improving procurement activity and processes, changing quality contract monitoring and enabling improved information and intelligence exchange with key partners including NHS England, the Local Authority and Community Voluntary and Faith Sector.

Some of the key issues are:

- Translation and interpretation across health services remains varied and standards need to be raised via work through the Quality Contract Schedule for Secondary Care Providers and establishing a base line of standards and usage in Primary Care;
- The duty carry out reasonable adjustments (Equality Act 2010) to support better access and outcomes for disabled people and frail elderly is often misunderstood, and needs to addressed via contract monitoring and collaborative work between providers;
- Understanding Transgender issues across health services is a key priority and needs to be progressed further within the CCG, the services they commission and Primary Care.

The CCG's current equality objectives are:

- To make fair and transparent commissioning decisions;
- To improve access and outcomes for patients and communities who experience disadvantage;
- To improve the equality performance of our providers through robust procurement and monitoring practice;
- To empower and engage our workforce.

The Objective plan has mapped the Objectives, EDS 2 outcomes and Public Sector Equality Duties to each action area.

4.0 Monitoring the Equality & Diversity performance of our key NHS providers

During the year we collaborated with neighbouring CCGs to ensure that contracts with key local NHS providers include requirements to achieve and improve equality and diversity standards, including through the Equality Delivery System.

Providers over 2015/16 were expected to:

- Agree a Smart Equality Objectives Plan;
- Complete an EDS assessment;
- Provide evidence of compliance with Equality Act 2010 specific duties(including the Workforce Race Equality Standard);
- Only take decisions about service redesign after an equality analysis or equality impact assessment has been carried out to demonstrate due regard of the PSED;
- Provide data on the use of translation and interpretation services.

5.0 Equality & Diversity and the Workforce

The CCG is committed to developing a representative and supported workforce and we specifically consider equality and diversity for our staff. We are aim to ensure that we have fair and equitable employment and recruitment practices as well as holding up to date information about the CCGs' workforce. It should be noted that as the CCGs have a small workforce and as such we are not required under the Specific Equality Duty to publish our workforce data. Over the next year our Workforce Equality plan in **Appendix 4** below will ensure we are cognisant of Equality Duties and our Workforce Race Equality Standard and that our relevant committees scrutinise the data available to them and ensure we value diversity and advance equality of opportunity for our staff.

5.1 Workforce and EDS 2

A key part of our EDS 2 (Goal 3) assessment focusses on our workforce and for the majority of our outcomes we are graded as achieving and developing status. These grades can be viewed in **Appendix 1**. By rolling out our Equality Workforce Plan over the next year we intend to progress to ***achieving*** across all our EDS 2 workforce outcomes.

5.2 Staff Training

Staff working within the CCGs undertakes annual equality and diversity training. The training is designed not only as an introduction to diversity and cultural awareness, but also as a practical guide to making our organisational culture an inclusive one. It combines a focus on personal and organisational beliefs, values and behaviours and the impact they have in our interactions at workplace, internally and externally. Furthermore programme leads within the CCG who are responsible for transforming health services have received training and one to one coaching on undertaking Equality Assessment reports.

6.0 Governance and accountability

The corporate team manged by the Chief Corporate Delivery and Integration Officer will be directly responsible to the Senior Management Team and Governing Body of the clinical commissioning group for providing the necessary information on progress and compliance to the PSED as part of their update on equality and diversity, which is planned into the Governing Body reporting and meeting cycle.

Over the last two years update reports on our compliance and issues associated with meeting our statutory duties have taken place in our EPEG Committee, Sefton Corporate Governance Group and Human Resources committee.

7.0 Conclusion

The CCG will continue to strive to ensure that the services the CCG commission are accessible to all. During the last twelve months we have made good progress around equality & diversity developing new and building on existing relationships with groups and individuals who share and represent the interests of protected characteristics. This year's EDS exercise has allowed us to fully improve our understanding of what barriers certain communities face and tackle them through mainstream processes and plans. We have developed a refreshed and long term Equality Objective Plan 2015-18 that focuses' on the internal processes we need to improve and the actions we need to undertake to tackle barriers and disadvantages certain communities face. The CCG has developed Workforce Equality & diversity Plan which aims to build on the solid foundations that are already in place. The CCG will continue to engage with the population and staff as a whole and continue to develop strong links with members of the population and groups who represent the interests of people who share protected characteristics and ensure that their views are built into the services we commission or the policies we develop.

NHS Southport & Formby CCG is committed to reducing health inequalities, promoting equality and valuing diversity as an important part of everything we do. This document clearly describes the headline activity that has taken place and more importantly it sets out the work and approaches that need to be undertaken to advance equality of opportunity.

We will continue to monitor our progress against the action plan and report annually and openly on the development of this work.

NHS
Southport and Formby
Clinical Commissioning Group

APPENDIX 1 - SOUTHPORT & FORMBY CCG EDS 2 GRADES AND OUTCOMES

NHS Southport & Formby CCG EDS2: The Goals and Outcomes			Grade Status
Goal	**No**	**Description of outcome**	
Better health outcomes	**1.1**	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Developing
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Developing
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Developing
	1.4	When people use NHS services their safety is prioritised, and they are free from mistakes, mistreatment and abuse	Developing
	1.5	Local health campaigns reach communities	Developing
Improved patient access and experience	**2.1**	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Developing
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Developing
	2.3	People report positive experiences of the NHS	Developing
	2.4	People's complaints about services are handled respectfully and efficiently	Developing
A representative and supported workforce	**3.1**	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Developing
	3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving
	3.3	Training and development opportunities are taken up and positively evaluated by all staff	Developing
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Developing
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Developing
	3.6	Staff report positive experiences of their membership of the workforce	Developing
Inclusive leadership	**4.1**	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Developing
	4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Developing
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Developing

APPENDIX 2 - NHS Southport & Formby CCG Equality Objective Plan 2015-18

The CCGs current equality objectives are:

1. To make fair and transparent commissioning decisions;
2. To improve access and outcomes for patients and communities who experience disadvantage;
3. To improve the equality performance of our providers through robust procurement and monitoring practice;
4. To empower and engage our workforce.

The Objective plan has mapped the Objectives, EDS 2 outcomes and Public Sector equality Duties to each action area.

Protected Characteristic	Key Issue and Barrier Identified	Action and responsible Officer	EDS Outcome PSED CCG Equality Objective
Race	Language and cultural barriers	Consider implementation of the new NHSE Translation and interpretation Framework for primary care when they are launched in 2015. Chief Corporate Delivery and Integration Officer awaiting launch address issues of Equality Impact to the CCGs' Primary Care Teams - March 2018 The CCGs to address this issue in line with plans on delegated commissioning responsibility in primary care (on going) Develop base line usage of T&I services in Primary Care-CCG E&D lead – July 2016 (in progress) Ensure Key secondary care providers continue to report on T&I usage via the Quality Contract Schedule -2016/17 on going – Chief Nurse (in progress) Explore CCG support of sustain and continue to develop a Bilingual Volunteer project– March 2017	1.1, 1.2,1.3, 1.4, 1.5, 2.1, 2.2, 2.3, 2.4, Eliminate Discrimination Advance Equality Of Opportunity Equality Objectives 1,2,3
Race	Lack of understand on which services to access and inappropriate A&E attendance	Work collaboratively with relevant Community groups and health services to develop local communications to support appropriate access including registration with GPs- CCGE& lead and primary care Locality lead – March 2017 Ensure Specification for CCG BME related project reflects actions within Equality objective Plan- Chief Corporate Delivery and Integration Officer (October 2016)	2.1, 1.1 Advance Equality of Opportunity Equality Objective-1,2
Race	Lack of Cultural understanding within commissioning and primary and	Promote BME organisations offer and promote Cultural competency training across CCGs, primary and secondary care (CCG E&D Lead &head of communications)- December 2016	1.1, 1.5, 2.1Advance Equality Of Opportunity and Foster Good Community relations

	secondary care services		Equality Objective-1, 2,3
Disability / age older citizens and young people)	Lack of understanding of mental health resulting in negative attitudes	Address issues of attitudes to people with mental ill health to lead mental health commissioner and Chief Nurse – CCG E&D December 2016 monitor progress of changes made to mental health services on issues associated with extensive EDS engagement- Mental Health lead Commissioners - March 2016 – on going	2.1,1.2, 1.3, 1.4 Eliminate Discrimination, Advance Equality Of Opportunity Equality Objective-1,2,3
Disability / age / frail elderly	Lack of understanding of reasonable adjustments by health professionals across Health services Implement Accessible information Standard Duty to make Reasonable Adjustments	Implement Accessible information Standard is embedded across the CCG –Head of Communications & CCG E&D lead July 2016 – on going (In progress) Develop local CCG Translation and Interpretation policy — CCG E&D lead March 2016 (In progress) Develop comprehensive reasonable adjustment Guidance to support improvement in standards – CCG E&D lead – April 2016 – on (In progress) Ensure Accessible Information Standard and the need to make Reasonable Adjustments is monitored with the providers via the Quality Contract Schedule – CCG E&D lead & Chief Nurse - March 2016 and on-going (In progress) Develop communication brief on the standard to primary care Develop and Distribute Reasonable Adjustment Guidance – E&D lead & head of Communications January 2016 (completed) Produce brief Consider Reasonable Adjustments CQUIN proposal and address in Quality schedule March 2016 (completed)	1.1,1.2,1.3,2.1 Advance equality of opportunity Equality Objective-1,2,3
Age- young people and working age older citizens	Further explore potential for vulnerable Young people to face disadvantages	Issue will be addressed in Quality Surveillance thematic work stream for mental health and Crisis care - Chief Nurse December 2015 - ongoing (In progress) Ensure CaMHs service contract is monitored and patient experience is captured across all protected characteristics –Lead CAMH Commissioner & Quality Team March 2017	1.1, 1.2, 1.4, 1.3 Advance equality of Opportunity Equality Objective-2,3
Age- older citizens	Waiting times and timescales of referrals and appointments for frail elderly and Older citizens living alone	Address concerns raised by age organisations of flexibility and times around appointments to providers and relevant forums –Chief Corporate Delivery and Integration Officer March 2017 (In progress) Implements and monitors Accessible information Standard into provider contracts –E&D Lead & Head of Communications July 2016 (In progress)	1.1,1/2,1.3, 1.4, 2.1, 2.3, Advance Equality Of Opportunity Equality Objective-2,3

		Address concerns raised in EDS 2 engagement on older people and mental health Chief Corporate Delivery and Integration Officer March 2017 (In progress)	
Age	access to primary care for vulnerable young people lack of understanding Re children and young people	work underway via review of children's Mental Health Services - Lead CAMH Commissioner & Quality Team -July 2016 on going ensure all work re reasonable Adjustments is implemented – Chief Corporate Delivery and Integration Officer as above (In progress) ensure serious incidents policy and activity consider PSED and needs associated with protected characteristics –Chief Nurse & Quality Team March 2017 Forward concerns on lack of understanding of legal highs to Local Authority — Chief Corporate Delivery and Integration Officer December 2016	2.1, 1.4 Advance Equality Of Opportunity and Foster Good Community relations Equality Objective-1,2,3
Transgender	Lack of understanding of trans issues, variation in service standards	explore options to improve knowledge and understanding of Transgender across health Services (issues raised are stored in EDS Engagement Excel spreadsheet) –Chief Nurse and Quality Team E&D lead-March 2017 options to include:- • add to portfolio of Clinical Support Officer to determine needs • work on cheshire wide footprint on Transgender support officer • raise issue at Quality Surveillance Group	1.1, 1.2, 1.3, 1.4, 2.1, 2.2, 2.3 Eliminate discrimination, advance equality of opportunity Equality Objective-1,2,3,4
Sexual Orientation	Poorer patient experience and lack of understanding of needs across health services	Ensure clear communications are available across health services, specifically to support LGBT friendly services – March 2017 Head of Communications Ensure LGB information is acknowledged in specification and Commissioning –E&D lead and Chief Strategy and Outcomes Officer 7 Chief Redesign and Commissioning Officer March 2016 – on going	1.1, 1.2, 1.4 Eliminate Discrimination Advance equality of opportunity and Foster good Community relations Equality Objective-1,2,3,4
Pregnancy & Maternity	Barriers will be identified via the maternity services review Pre and post Equality assessment process	Barriers will identified via the maternity services review Pre and Post Equality assessment process –in line with Improving Me timescales – Coordinating CCG lead (Halton CCG) Chief Corporate Delivery and Integration Officer	1.1,2.1,1.21.3, Eliminate Discrimination Advance equality of opportunity and Foster good Community relations Equality Objective-1,2,3,4
All		Ensure actions identified in EDS 2 feedback form are addressed including system and process changes to complaints resolution –March 2017 Chief Corporate Delivery and Integration Officer	All EDS 2 PSED Equality Objective-1,2,3,4
All	Human resources and workforce	CSU Ensure HR Business Partner implement equality plan into HR committee HR –March 2017- Chief Corporate Delivery and Integration Officer	3.1,3.2,3.3,3.4,3.5,3.6 Eliminate Discrimination Advance equality of

			opportunity and Foster good Community relations Equality Objective 4
All Protected Groups (specifically for language and reasonable adjustments)	Access needs of Patients and public need to be addressed consistently in contract specifications	To ensure all specifications instruct all CCG commissioned providers to apportion accessibility funding to meet the needs of communities and patients. - Chief Corporate Delivery and Integration Officer & Chief Redesign and Commissioning Officer (March 2016)	1.1, 1.5, 2.1, 1.4, 2.2, 2.3, Advance equality of opportunity Equality Objectives 1,2,3
All		Ensure EDS 2 approach and plans are embedded in to the refreshed Communications and Engagement Strategy – E&D lead and head of Communications - October 2016 Ensure EDS engagement concerns for all protected Groups are communicated and addressed via relevant commissioners and approaches - Chief Redesign and Commissioning Officer -March 2018 Ensure that Governing Body and programme leads receive the appropriate level of E&D training - March 2017 Develop guidance to support the CCG to pay due regard to difficult commissioning decisions- Chief Corporate Delivery and Integration Officer June 2016 CCG E&D lead (In Progress) Continue to monitor and improve equality performance of providers- Chief Nurse – on going (In progress) Ensure Governance and decision making committee templates are reviewed to meet Equality Act 2010 requirements Chief Corporate Delivery and Integration Officer October 2016 (In Progress)	Equality Objectives 1,2,3,4, All PSED 4.2 Equality Objectives 1,2,3,4

APPENDIX 3 - Key NHS Provider EDS 2 grades

Goal	No	Southport and	Aintree	Liverpool	Alder Hey	Mersey	Liverpool
Better health outcomes	1.1	Developing	Developing	Achieving	Developing	Achieving	Developing
	1.2	Achieving	Developing	Achieving	Developing	Achieving	Developing
	1.3	Achieving	Developing	Achieving	Developing	Achieving	Developing
	1.4	Achieving	Developing	Achieving	Developing	Achieving	Developing
	1.5	Achieving	Developing	Achieving	Developing	Achieving	Developing
Improved patient access and experience	2.1	Developing	Developing	Achieving	Developing	Achieving	Developing
	2.2	Achieving	Developing	Excelling	Developing	Achieving	Developing
	2.3	Achieving	Developing	Achieving	Developing	Achieving	Achieving
	2.4	Achieving	Developing	Achieving	Developing	Achieving	Achieving
A representative and supported workforce	3.1	Achieving	Developing	Achieving	Developing	Achieving	Developing
	3.2	Achieving	Developing	Achieving	Developing	Achieving	Achieving
	3.3	Achieving	Developing	Achieving	Developing	Achieving	Developing
	3.4	Achieving	Developing	Achieving	Developing	Achieving	Developing
	3.5	Developing	Developing	Developing	Developing	Achieving	Developing
	3.6	Developing	Developing	Developing	Developing	Achieving	Developing
Inclusive leadership	4.1	Achieving	Developing	Achieving	Developing	Achieving	Developing
	4.2	Developing	Developing	Achieving	Developing	Achieving	Developing
	4.3	Developing	Developing	Developing	Developing	Achieving	Developing

APPENDIX 4 Workforce E&D plan

Task	Activity	Outcome	EDS comparator
Policy Proofing	1. Prioritise policies 2. Identify policy against essential list[1] 3. Identify guidance with policy[2] and test for indirect discrimination & advancing opportunity	1. Proportional input. 2. Cover fundamental elements of Equality Act 2010 3. Impact assess process against PSED – identifying any remedial actions	3.1 3.2 3.4
Monitoring	Identify policies and performances for monitoring – check against key tasks: • Recruitment • Selection • Review & performance • Disciplinary	1. Establish monitoring system 2. Identify indirect discrimination 3. Consider positive action or corrective action	3.1 3.2 3.3 3.4 4.3
Training	Identify current training programmes linked to E&D	Proof suitability and identify gaps in provision. Check profile of attendees against worker profile	3.3 4.3
Annual review **Publish equality Objectives**	Establish best measure for review programme Develop and review action plan in HR committee	Performance of polices monitored against PSED	3.3 3.4 3.5 4.3
Staff profile and surveys	Establish staff profile and include questions on E&D	Understanding staff relationship with organisational culture to eliminate any institutional discrimination	3.4 3.6 4.3

[1] See annex 2 and worksheet 1

[2] policy may be a statement of intention but the process of enacting the policy, i.e. guidance notes , also needs to be proofed

Positive Action	1. Monitor performance against policies to establish base line. 2. Identify trends 3. Establish conditions for positive action	Understanding travel of workers by protected characteristic through organisation's functions. Challenge barriers if data/evidence identifies them Advance equality of opportunity.	3.2 3.5 3.1 3.3 3.5 4.1 4.3
WRES	Complete the WRES template and ensure it is in the public domain	Advance Equality of opportunity and Foster good Community Relations Satisfy NHS England assurance processes	3.1 to 3.6

APPENDIX B

Equality Delivery System 2 for the NHS

EDS 2 Summary Report NHS Southport and Formby CCG

Additional Summary Report

NHS Organisation name: NHS Southport and Formby Clinical Commissioning Group

Organisation's Board lead for EDS 2: Tracy Jeffes

Organisation's EDS 2 Lead: tracy.jeffes@southseftonccg.nhs.uk

Level of Stakeholder Involvement in EDS 2 Assessments and Grading and Subsequent Actions

NHS Southport and Formby Clinical Commissioning Group is committed to carrying out meaningful engagement and communications with the local population, giving people: our patients, public and stakeholders, the opportunity to be involved in and to influence healthcare in their local area, ensuring that their voices are heard and that their thoughts and experiences are taken into consideration, specifically for our commissioning priorities and blueprints, which are intended to transform health services to meet the needs and demands of our diverse population.

To support this process, the CCG has undertaken an innovative and sustainable approach to EDS 2 and has worked closely with a number of stakeholders who represent the interests of people sharing protected characteristics at a national, regional and local level. This aims to ensure that the CCG can identify barriers that impact on access and unequal outcomes. Examples of key stakeholders have included the Race Equality Foundation, Deaf Health Champions, 'In Trust' Merseyside, Age Concern, Sefton CVS (including Sefton Equalities Partnership) and Healthwatch Sefton, to name but a few. Stakeholders have been engaged via a variety of different methods, including workshops, one to one meetings, attendance at voluntary group meetings, and via desktop research on a variety of reports. The CCG recognises that patients and staff who share protected characteristics are less likely to complain, to complete NHS surveys or access community networks to provide their feedback. This level of engagement with stakeholders will ensure that entrenched barriers faced by communities with regard to accessing healthcare services are understood and mitigated as part of the CCGs strategic and operational programmes. These include mainstream plans, changes to service specifications, business plans and strategies, procurement activity, contract monitoring and discussions with key partners, including NHS England, the Local Authority and community, voluntary and faith sectors.

The CCG has also, in the summary report below, reflected the good work that it is undertaking with regard to commissioning services that will meet needs across all communities.

The CCG will amend its Equality Objective Plan to reflect the EDS 2 for 2015/16, and has clear plans to move from '*developing*' to '*achieving*' status for a number of outcomes over the next year.

We will continue to strengthen relationships with a range of national, regional and local partners and work with them in various ways.

We will communicate and engage with local people, including patients and their carers, to involve them in our plans and decisions and listen to their views and suggestions.

We will be open and transparent. Our Governing Body Meetings and our Annual General Meeting are held in public, and meeting papers are available on our website.

Organisation's Equality and Diversity Objectives (2013-17)

1. To make fair and transparent commissioning decisions;

2. To improve access and outcomes for patients and communities that experience disadvantage;

3. To improve the equality performance of our providers through robust procurement and monitoring practice;

4. To empower and engage our workforce.

Headline good practice examples of EDS 2 outcomes

The CCG has undertaken an innovative and sustainable approach to community engagement, and has improved its understanding of the health needs that particular groups face with regard to accessing services and experiencing unequal outcomes. The engagement and research took place over a ten month period across a number of national, regional and local organisations that represent the views of communities sharing protected characteristics. This enabled the CCG to:

- Understand entrenched 'barriers' that exist on a national and local footprint;

- Address these barriers through mainstream plans, including:

    - changes to specifications, business plans and strategies;

    - improving procurement activity and processes;

    - changing quality contract monitoring;

    - support improved information and intelligence exchange with key partners, including NHS England, the Local Authority and the Community Voluntary and Faith Sector.

- Involve local stakeholders in a continuous model of engagement and drive up improvements in access and outcomes;

- Ensure that local and regional stakeholders are informed of the actions that the CCG will undertake to improve access and outcomes, and are provided with the evidence that people with protected characteristics fare as well as people overall.

- Understand and improve access and outcomes across all protected groups. Furthermore, the EDS 2 recommendations have clearly identified some key gaps and issues that need to be addressed across all protected characteristics areas. This work has been captured on a master Excel Template and a subsequent Action Plan. Some of the broad issues have been highlighted below.

- Translation and interpretation across health services remains varied and standards need to be raised.

- The duty to carry out reasonable adjustments (Equality Act 2010) to support better access and outcomes for disabled people and the frail elderly is often misunderstood and needs to addressed via contract monitoring and collaborative work between providers.

- Understanding Transgender issues across health services is a key priority and needs to be progressed further at the Merseyside Quality Surveillance Group.

Currently, grading for patient and public related services (Goals 1, 2 and 4) for the CCG is assessed as *developing*. Once these key issues are being addressed and/or mitigated via mainstream business plans, the CCG can progress from *developing* status to *achieving* status across the relevant outcomes and goals.

Better Health Outcomes

Outcome 1.1: Services are commissioned, procured, designed and delivered to meet the health needs of local communities – Developing

We are a membership organisation, made up of nineteen general practices within the North Sefton area, led by a Governing Body. This is a mixture of GP's, a hospital doctor, nurses and non-medical people who represent the local community. The Governing Body and its Committees make strategic decisions and oversee the smooth running of the CCG and its compliance with its duties and NHS Policy.

We listen to local people, and use clinical knowledge and close working relationships with various partners to improve services and ensure that they benefit our population as much as possible. To support us in setting priorities and to work closely with our partners to improve the way we meet the diverse needs, we use a range of strategy documents tools and processes including:

- Joint strategic needs assessment (JSNA);
- Continuous engagement with our population and patients, including those with protected characteristics and those who face stigma and or disadvantages;
- Sefton Blueprints and Vision;
- Monitoring the performance of our providers with regard to quality which includes patient experience data and equality related performance and KPI's;
- Setting incentives and targets for our secondary care and primary providers in order to meet needs and address the challenges that our population faces;
- Ensure that our work is underpinned through the process, using tools including equality impact assessments and engagement assessments;
- Implementation of our EDS 2 2015/16 Assessment, ensuring that we mainstream the recommendations;
- Considering our duty to address Health inequalities;
- Setting and updating our Equality Objectives.

We want to transform services outlined in our Blueprints to better meet the physical, mental and emotional health needs of our population. The services we commission should be designed around patients and the potential benefits that they will receive. GP clinical leads on our Governing Body take responsibility for specific commissioning priorities, as set in our Programmes and Priorities.

Southport and Formby CCG has certain legal duties under the NHS Act 2006 (as amended by the Health and Social Care Act 2012) including:

1. **Duty to improve the quality of services**

   The CCG buys services from providers of hospital, mental health services, community services, voluntary groups and charities. We may do this on our own or in partnership with other organisations, including neighbouring CCGs. We monitor how well these services are run and whether or not patients are happy with them. We also design new services that are better for people, and are better value for money.

   We now also manage GP practice contracts and can design incentive schemes and/or services to encourage improved performance. We are able to establish new practices and approve mergers between those already in existence.

   We hope that delegated commissioning will help pull together local health and care systems. It should help improve general practice, so that patients benefit more from the treatment received and have a better, safer, experience.

   These new powers will help us to tackle health inequalities to make it easier for everyone to get the care they need. We particularly want to improve care outside of hospital for people with mental health problems and learning disabilities, or those who live in the more deprived areas of Southport and Formby.

   There are various ways that the CCG monitors quality. The CCG is a member of Clinical Quality and Performance Groups (CQPG's) for all local providers, where current performance, issues and risks are discussed.

   Internally, the CCG has a Quality Committee to assess our performance. This looks at all the ways in which we measure quality, including current key performance indicators, and our performance on safeguarding adults and children and infection control, amongst other areas.

   The role of the Quality Committee is to lead the continuous improvement of service quality. During the year, all members have all been involved as members of the Clinical Quality Performance Groups of the providers from which we commission services.

   The CCG is also an active member of the local Quality Surveillance Group, which is led by NHS England and involves Healthwatch, the Care Quality Commission, the regulatory body 'Monitor', the NHS Trust Development Authority and other CCGs.

   The CCG has a number of communities of practice/clinical reference groups, where clinical staff from hospitals, public health and community care, with a specific shared interest such as cancer or mental health, can explore ways to improve related services.

2. **Duty to ensure public involvement and consultation**

   We want local people to feel heard, listened to and cared for. Southport and Formby GP's - the members of the CCG - are particularly well placed to understand local needs and priorities.

   The CCG's vision, values and strategy were developed in consultation with patients and the public. We aim to continually engage with, and involve them in, our work so that the local population can help to shape the commissioning agenda and the services that we commission.

   During the year, we continued to engage with the public regarding our transformation programme via stakeholder events including 'Big and Little Chats'

Underpinning our programme and operational commitments, we ensure that we have the right processes in place, such as our Engagement and Equality Planning Process and risk assessment tools, to ensure that services are transformed in conjunction with people who share protected characteristics, thereby meeting our statutory requirements.

We work closely with our main providers to ensure that equality and inclusion performance is monitored and improved. This involves EDS 2 compliance, compliance with specific duties and ensuring that Public Sector Equality Duty is considered when providers make changes to services that will impact on patients

As we share our geographical boundaries with Sefton Council, we frequently work in partnership. For example, the CCG and the Council developed a plan for the Better Care Fund (BCF). This will provide support for integrating health and social care services locally, so that they are more joined up.

Most CCG member practices have their own Patient Participation Groups, and representatives have attended Patient Participation and other CCG forums to help inform the development of the CCG's plans.

The CCG is an active member of the Sefton Health and Wellbeing Board which meets regularly to decide on shared priorities and actions to promote the health and wellbeing of people who live or work in Sefton, or are registered with Sefton GPs.

The Board has developed a Joint Health and Wellbeing Strategy that shows how it intends to make improvements for local people. This is based on a Joint Strategic Needs Assessment that identified the biggest issues facing our population. Furthermore, our joint work includes an innovative programme entitled Shape Sefton, which is aimed at developing models of care that meet the needs of our population. This work is being conducted jointly with our Health and Wellbeing Board and with the Kings Fund.

Our commissioning priorities has incorporated the implications of the National NHS Five Year Forward View, published in October 2014, which sets out the changes needed to close widening gaps in the health of the population, quality of care and funding of services.

It calls for:

- A radical upgrade in prevention and public health;
- Far greater patient control;
- Steps to break down barriers in how care is provided.

Our Transformation Programme is about making a fundamental shift in the way in which we approach things.

Our Transformation Model is based on the characteristics of a sustainable health and social care system, which include citizens being at the heart of what we do. We also need to acknowledge that we will have difficult commissioning decisions to make under the current financial pressures against a backdrop of increasing demands on our current services. We will endeavour to ensure that our public is involved and consulted when necessary and that these processes are equality assessed.

The CCG also utilises its EPEG Committee to work with our partners in the Council and across the Voluntary Sector to support our models of inclusive engagement.

Throughout the EDS 2 Engagement Process, the stakeholder identified a range of issues and barriers that need to be addressed in order to improve access and outcomes linked to this goal. These issues have formulated into an Action Plan which will form part of our long term equality objectives. Once these issues are addressed in mainstream plans, the grading status will progress from *developing* status to *achieving* status.

Outcome 1.2: Individual people's health needs are assessed and met in appropriate and effective ways – Developing

We are committed to overcoming any disadvantages people have experienced, on the basis of any of the protected characteristics covered by the Equality Act 2010.

The CCG has worked towards reducing inequalities through the commissioning of safe, high quality services, in partnership with the local population and its stakeholders. As part of the recognition and commitment of the CCG to provide sustainable and high quality services for the future, we have been engaging extensively with patients, the public, provider organisations, the Health and Wellbeing Board and ensuring that Sefton Blueprint for Services is fit for purpose and delivered to the population of Southport and Formby.

We commission and work closely with the Black and Minority Ethnic (BME) Community Development Service, which aims to tackle discrimination and improve access to mental health and wellbeing services for BME communities.

As part of this service, community development workers raise awareness and understanding among local health providers about the needs of BME communities, including how mental illness is perceived in different cultures.

Our Equality Objectives Plan for 2013-17 is in line with the CCG's statutory requirements and commissioning priorities. These set out clearly how we will meet our Public Sector Equality Duty to eliminate discrimination, advance equality of opportunity and foster good community relations. These objectives will help us to make fair and transparent commissioning decisions and improve the equality performance of our providers, and will be significantly refreshed as a result of the EDS process which we undertook.

Key additions to the revised objectives plan include implementing:

- The new NHS England Accessible Information Standard to ensure that people receive information about services in an appropriate format, which involves finding out if a patient has additional communication needs because of a disability or sensory loss;

- The new NHS Workforce Race Equality Standard, which requires NHS organisations to take positive action to ensure that employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Following our EDS 2 Assessment, the Equality Objective Plan has been significantly refreshed.

During the year, we collaborated with neighbouring CCG's to ensure that contracts with key local providers include requirements to achieve and to improve equality and diversity standards, including through the Equality Delivery System.

Providers will be expected to:

- Agree an equality objectives plan;
- Complete an EDS self-assessment with plans to achieve at least five outcomes;
- Provide evidence of compliance with Equality Act 2010 specific duties;
- Only take decisions about service redesign after an equality analysis or equality impact assessment has been carried out;
- Provide data on the use of translation and interpretation services;
- Ensure that providers are effectively equipped to carry out Reasonable Adjustments.

We have other examples of how services have been commissioned to reflect the specific needs of those with protected characteristics, including the Pan Merseyside Maternity Review of Services, which will be subject to targeted consultation and equality assessments. The CCG has also embarked on a CVF sector grant programme to enable the community and voluntary sector to support groups which share protected characteristics in accessing health services, thereby improving the patient experience and improve health outcomes.

Throughout the EDS 2 Engagement Process, the stakeholder identified a range of issues and barriers that need to be addressed in order to improve access and outcomes linked to this goal. These issues have formulated into an Action Plan which will form part of our long term equality objectives. Once these issues are addressed in mainstream plans, the grading status will progress from *developing* status to *achieving* status.

Outcome 1.3: Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed – Developing

We have also developed a robust Quality and Improvement team to ensure that sustained efforts take place to raise standards and support all residents to live well in a homely environment.

Our wider ambition, as set out in Commissioning Priorities, is to support patients to transfer safely between types of care, working as single health service and team, with patients' needs at the heart of the service.

The CCG has signed up to the Merseyside Crisis Care Concordat. The Concordat commits NHS bodies, local councils, the police and others to support people in a mental health crisis to find the help that they need - whatever the circumstances and whichever service they turn to first.

We are collaborating with our main mental health service providers, including Mersey care, to monitor the Concordat's progress, and will work together to prevent crises happening whenever possible by intervening at an early stage.

The CCG developed also local Action Plans across a range of areas to ensure that transition across services is smooth, and we monitor this through contract performance processes.

As part of the Transformation Programme, the CCG has embarked on a programme to ensure that patients, their families and carers, plus health and social care practitioners are empowered and enabled to make the right choice and access the most appropriate service to meet their needs.

Throughout the EDS 2 Engagement Process, the stakeholder identified a range of issues and barriers that need to be addressed in order to improve access and outcomes linked to this goal. These issues have formulated into an Action Plan which will form part of our long term Equality Objectives. Once these issues are addressed in mainstream plans, the grading status will progress from *developing* status to *achieving* status.

Outcome 1.4: When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse – Developing.

Southport and Formby CCG has in place robust contract management and governance processes to effectively monitor quality and safety standards and to put Action Plans in place where required. These processes include collaborative contract management arrangements with other CCG's. This work is overseen and scrutinised through the organisation's Governance Committee structure. The Senior Management Team has embedded a culture of high performance through effective programme management, and a proactive approach to governance and risk management.

The stakeholder relationships which influence the performance of the CCG include:

a) Patients, public, community groups and representative organisations such as Healthwatch whose engagement and involvement are key to informing effective commissioning, monitoring, evaluating and improvement of services via our EPEG Committee;

b) Commissioned healthcare providers, including acute, mental health and community trusts from which the majority of healthcare services are commissioned, together with the third sector, which offers a new way of delivering health and social care in the future;

c) Strategic partnership arrangements with Sefton Council which address the wider determinants of health through joint working and effective membership of the Health and Wellbeing Board. This will deliver service transformation.

The Clinical Leads have been involved in the provider organisation Quality Boards, the CCG's Primary Care Quality Network and in ensuring nursing home quality, and have challenged, supported, and clinically led the continuous improvement of the quality of services commissioned by the CCG.

The CCG is an active member of the local Quality Surveillance Group: some of the recommendations of the EDS 2 Assessments include tackling issues through the remit of this Group: for example, on the issues around outcomes associated with our transgender population.

As the CCG commissions from several major providers, it has been actively involved in a number of quality improvements and quality reviews, resulting in increased surveillance. The Governing Body has oversight of the Action Plans and discusses quality at each meeting. The Quality Committee provides a close level of scrutiny of the quality of commissioned services, including inviting providers to the Committee when a more in-depth analysis and discussion is warranted. E and D currently feeds into to the decision making structure via the EPEG Committee and Governance Group.

The CCG has a dedicated Quality and Safeguarding Team which has focused roles and responsibilities, e.g. care and nursing homes, mental health and across all secondary care providers. Dedicated Safeguarding Quality Reports feed into the Governing Body Meeting, and are addressed at a specific 'Quality' Committee and EPEG Committee.

The Quality Contract Schedule is rigorous and tackles issue, concerns, incidents and serious incidents via the Clinical Quality and Performance Group Meetings (for all local providers) where current performance, issues and risks are discussed together with coordinating commissioners.

Throughout the EDS 2 Engagement Process, the stakeholder identified a range of issues and barriers that need to be addressed in order to improve access and outcomes linked to this goal. These include the need to make reasonable adjustments. These issues have formulated into an Action Plan which will form part of our long term Equality Objectives. Once these issues are addressed in mainstream plans, the grading status will progress from *developing* status to *achieving* status.

Outcome 1.5 -CCG communications and health campaigns reach and benefit all – Developing

As part of the programme and on-going operational work, the CCG has conducted extensive communications and engagement across all parts of the Borough, and has been targeted to include different demographics and socio-economic backgrounds. This work has supported the development of commissioning priorities, and has demonstrated the vast networks available across all protected characteristics.

The EPEG Committee sense checks engagement and communications to its population. The Committee is represented by a range of CCG partners including Healthwatch, the Local Authority and a range of representatives across the community and voluntary sector, including Sefton Equalities Partnership which manages a number of networks across protected characteristics including BME (Equal Voice), Disability (ABILITY and Sefton Access Forum) and LGB (Embrace) . Furthermore, the lay member is Chair of the SPOC; a group that represents the interests of older citizens in the area.

Throughout the EDS 2 Engagement Process, the stakeholder identified a range of issues and barriers that need to be addressed in order to improve access and outcomes linked to this goal, such as improved communications to our BME communities and learning disabled people. These issues have formulated into an Action Plan, which will form part of our long term Equality Objectives.

Outcome 2.1: People, carers and communities can readily access hospital, community health or primary care services, and should not be denied access on unreasonable grounds – Developing

A great deal of work has been carried out to determine the quality of services provided to patients, e.g. mental health services, as this has been identified by the membership and the population as a key area for improvement. The CCG has worked effectively with the provider to improve access and outcomes for patients who require access to psychological therapies.

The CCG will continue to refine and improve its approach to improving quality through its Transformation Programme and with further development of productive relationships with all partners.

Provider delivery against the Contract Quality Schedule has been reviewed throughout the year and was reported to the Clinical Quality and Performance Groups (CQPG). This is enabling greater monitoring and leadership of all quality aspects, quality schedules and Commissioning for Quality and Innovation (CQUIN) Schemes across Southport and Formby CCG providers, including improving access to services.

During the year, the CCG has also established a Primary Care Support function to support both primary care and NHS England, as part of its duty to improve the quality of primary care.

The CCG has been developing systems to better understand the needs of communities, and to improve access and outcomes. Key activity over the year has included:

1. Equality delivery system process and provide the CCG with key qualitative intelligence about barriers patients with protected characteristics face;

2. The work of the Black Minority and Ethnic Community Development Service;

3. The role of EPEG to improve inclusive engagement with communities;

4. The Community Services Review which was underpinned and steered through a robust Equality Assessment Process.

Under Section 106 of the Equality Act 2010, CCG's are vicariously liable for the equality performance of their providers. Key activity over the year has included:

a. The CCG's Quality Contract Schedule being reviewed and updated to include robust equality and quality measures which are designed to drive up equality performance across providers;

b. New contract requirements being implemented for our key NHS providers;

c. Improvements to equality performance being made with regard to ensuring that the internal redesign of Trust services is subject to equality analysis.

The CCG has continued to invest in initiatives to support an anticipated increase in demand throughout the winter by improving hospital discharges and avoiding unnecessary hospital admissions. These have included further additional GP appointments, GP home visits and the introduction of a number of schemes focussing on mental health issues, including assessment of interim measures on elective admissions.

Specific plans are underway to ensure that changes within primary care are properly impact assessed and that they also consider and mitigate the needs of patients with protected characteristics; for example, with our Trinity Practice in Southport which provides key primary care services to our diverse migrant worker population and older citizens.

Access to healthcare is available to all of our population but, should issues with access happen, we have a system in place whereby the CCG's work closely with Healthwatch and other partners and providers to share experiences of NHS services. Regular meetings of the Quality Committee and Clinical Quality and Performance Groups (CQPG's) take place with provider organisations in order that various patient experience information can be triangulated to identify trends and be acted upon. This will include issues identified via the EDS 2 Engagement Plan.

In addition to this, the CCG's ambitious Transformational Plan includes models that will ensure that care takes place closer to home, that there is extended access to Primary Care and improved access channels to other services, including social care, community and the voluntary sector. A comprehensive directory of services will support this.

The CCG is well aware that discrimination is often very difficult to 'detect', as many communities which share protected characteristics do not complain, complete Office for National Statistics and Friends and Family Surveys, and do not access engagement events. Hence, the approach used this year has been to identify barriers specific to people who share protected characteristics, and address them through CCG mainstream functions including strategy development, specification reviews, procurement activity, contract monitoring and key discussions with partners.

The EDS 2 Exercise has identified issues related to transgender, children and young people, race and the frail elderly. These include specific issues on carrying out reasonable adjustments and standards across translation and interpretation.

Outcome 2.2: People are informed and supported to be as involved as they wish to be in decisions about their care – Developing

The CCG is dedicated to ensuring that local populations and vulnerable groups, as well as those from protected characteristics, have been engaged with.

All of the patient experience tools and intelligence discussed above monitor the effectiveness of our systems, and we are aware that EDS 2 Engagement identified a range of issues that need to be addressed to ensure we are doing all we can on this. These issues include variation in standards across translation and interpretation services and being able to carry out reasonable adjustment effectively. Furthermore, the CCG has ensured that the Accessible Information Standard is implemented across secondary care providers, and that communications have been distributed to primary care providers.

Outcome 2.3: People report positive experiences of the NHS – Developing

The CCG works closely with Healthwatch and other partners and providers to share experiences of NHS services. Regular meetings take place of the Quality Committee and Clinical Quality Performance Group with providers and Quality Surveillance Groups. This ensures the sharing and triangulation of patient experience information in order that trends can be identified and acted upon: e.g. complaints. Healthwatch are represented on some of these groups.

The CCG has made a concerted effort through the EDS 2 Engagement Exercise to capture the views of communities and patients that share protected characteristics; so that barriers and experiences can be mainstreamed within commissioning plans and functions.

The CCG recognises that patients and staff who share protected characteristics are less likely to complain, complete NHS surveys or access community networks to provide their feedback. Therefore, this level of engagement with stakeholders will ensure that the entrenched barriers that communities face with regard to accessing healthcare services are understood and mitigated as part of the CCG's strategic and operational programmes. These will include mainstream plans, changes to service specifications, business plans and strategies, procurement activity, contract monitoring and discussions with key partners including NHS England, the Local Authority and community, voluntary and faith sectors.

Outcome 2.4: People's complaints about services are handled respectfully and efficiently – Developing

The CCG has a Complaints Policy covering complaints about the CCG and complaints about providers.

Provider complaint reports are considered by Clinical Quality Provider Groups (CQPG's), which include CCG and provider representatives. These reports feed into the CCG's Quality Committee.

Contracts with providers include complaints responses and management key performance indicators.

The EDS 2 Assessment has identified the need to expand complaints monitoring to identify the barriers preventing people with a protected characteristic from complaining.

Outcome 3.1

Fair NHS recruitment and selection processes lead to a more representative workforce at all levels – Achieving

The CCG is committed to ensure, wherever possible, that its workforce is representative of the community that it serves.

There is an overarching Recruitment and Selection Policy which has been agreed with staff side representatives, and is reviewed every three years.

Jobs are advertised via the NHS Jobs website and, at the short-listing stage, all references to personal details are removed which aims to ensure that candidates are selected for the next stage on the merits of their application. Positive steps have also been built into the process, such as the Interview Guarantee Scheme, for candidates who have a disability and meet the minimum essential criteria for a post.

Work is underway within the CCG with regard to the NHS Workforce Race Equality Standard.

Outcome 3.2

The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations – Achieving

The Agenda for Change Agreement has been equality impact assessed to ensure that it is not discriminatory across all protected characteristics, and that the grading of posts and the rates of pay applicable to them is determined through job evaluation.

Local procedures in place include annual leave, special leave and travel expenses.

The CCG has not received any equal pay claims since its inception.

Outcome 3.3

Training and development opportunities are taken up and positively evaluated by all staff – Developing

The CCG has been operating its appraisal system since 2013.

The HR Committee is developing a robust Personal Development Review Reporting System to ensure that appraisals carried out are monitored and that recovery plans are put in place where the numbers of appraisals undertaken are low.

The CCG has many examples of where equality and diversity runs through, or is a key and essential part of, many learning and development activities, including mandatory training and core training and management development (delivered on an ad hoc basis and based on need).

Outcome 3.4

When at work, staff are free from abuse, harassment, bullying and violence from any source – Developing

Harassment and bullying on the grounds of any of the protected characteristics will not be tolerated.

Various forms of support are in place for employees: these include the provision of counselling via the Occupational Health Service.

This work is underpinned by a robust Harassment and Bullying Policy that was approved by the Staff Side Partnership and ratified locally by the CCG. This Policy includes an escalation process to ensure that staff have recourse to advice, guidance and support within the CCG and across other agencies, including from HR and staff side. Over the course of the years, the CCG has developed and implemented a Workforce Equality Plan to support transition from *developing* to *achieving.*

Outcome 3.5

Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives – Developing

There is a Family Leave Policy and Flexible Working and Special Leave Policy which meets legislative requirements for parents and carers around flexible working. This also extends to all employees and offers several different types of flexible working.

Both Policies reference the Equality and Diversity (Workforce) Policy. The Family Leave Policy is being reviewed due to legislative changes – additional paternity leave entitlement is being replaced by shared parental leave. Over the course of the years, the CCG has developed and implemented a Workforce Equality Plan to support transition from *developing* to *achieving.*

Outcome 3.6

Staff report positive experiences of their membership of the workforce – Developing

The CCG has a number of policies, both existing and in development, to support the health and well-being of its workforce. Staff views are sought through a number of means within the CCG. The CCG also provides support via Occupational Health Services, which includes Counselling and Physiotherapy Services. Over the course of the years, the CCG has developed and implemented a Workforce Equality Plan to support transition from *developing* to *achieving.*

Outcome 4.1: Boards and senior leaders routinely demonstrate their commitment promoting equality within and beyond their organisations – Developing/Achieving

The CCG's constitutional, governance and decision-making arrangements aim to involve patients and the public through the Lay Member for Patient and Public Involvement, who chairs the EPEG Committee. These arrangements include Healthwatch Sefton and patient representation at all levels of the organisation's governance arrangements.

The CCG has worked with the public to make the Governing Body Meetings accessible and understandable, and to ensure that they feel that they and their contributions are valued. Governing Body Meetings are preceded by a public briefing session and have an open forum for questions at the end of each meeting. The Accountable Officer and other Governing Body Members have also been available to meet with members of the public. This has elicited positive feedback from the public, and ensured that meetings are well attended.

Furthermore, the CCG's Lay Member chairs and facilitates the Sefton Partnership Older Citizens (SPOC): a partnership forum that promotes the issues that impact on older citizens.

The Council's Overview and Scrutiny Committee provides opportunities to widen involvement in the work of the CCG, and this is being built upon through members' seminars to increase the knowledge and understanding of health issues among elected members.

The CCG will continue to support the delivery of the Joint Health and Wellbeing Strategy, which is closely aligned to the Transformation Programme and the Better Care Fund as part of that programme.

The CCG is committed to improving access and outcomes for protected groups across the Borough which experience disadvantage in health and wellbeing services. The Governing Body receives annual updates against progress in line with CCG statutory requirements and commissioning priorities. Key additions to the revised plan include:

- Implementing the new NHS England 'Accessible Information Standard' which is about ensuring that NHS service providers give people information in the best format for their needs. This requires all organisations to ascertain whether a patient has extra communication needs because of a disability or sensory loss, and to take steps to meet those needs;

- The new Department of Health, Workforce Race Standard. NHS organisations are required to take 'positive action' to ensure that employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace;

- Comprehensive equality analysis against key commissioning priorities, and embedding this process into the CCG's programme management processes, project initiation and approval documentation.

The CCG has also worked with its key providers, in collaboration with neighbouring CCGs, to include equality requirements in the Contract Quality Schedule, as mentioned earlier.

The CCG continues to work in partnership with Sefton Council (through a Section 75 Agreement), as an active member of the Sefton Health and Wellbeing Board, and as a member of the wider Sefton Strategic Partnership, including representation on the Partnership Board, the Executive Team and the Area Partnership Boards to develop a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy.

Outcome 4.2: Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed – Developing

The CCG has appointed Clinical Leads as members of the Governing Body who lead on the Sefton priorities, as outlined above.

The Clinical Leads have been involved in the Provider Organisation Quality Boards, the CCG's Primary Care Quality Network and nursing home quality and have challenged, supported, and clinically led the continuous improvement of the quality of services commissioned by the CCG.

The CCG is keen to ensure that it has the right skills, processes and governance arrangements in place to meet the Public Sector Equality Duty as commissioning decisions are made. Key activity has included:

a. PSED training for the Governing Body;

b. Comprehensive equality and engagement guidance for key programmes and other key operational work streams;

c. High level and detailed Equality Impact Assessment processes have been developed, including the decommissioning and guidance on cessation to ensure that, during these challenging financial times, PSED will be considered and, wherever possible, mitigated.

A sample of ten Governing Body Reports during 2015 identified that only some papers identified equality related risks. Undertaking Equality Assessments, and outlining equality risks, implications and solutions for mitigation, is essential for future reporting and CCG decision-making.

Outcome 4.3: Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination – Developing

Face-to-face Equality and Diversity Training (Public Sector Equality Duty) has been provided to all CCG staff, and this is monitored to ensure compliance.

One to one support is available to support programme leads to undertake equality assessments.

A number of briefs on current case law and guidance documents have been developed to support the capacity, skills and understanding.

Dedicated CCG specific equality and diversity training over the last eighteen months has included commissioner, decision-maker and decommissioning guidance (Governing Body) sessions.

NHS employee policies and procedures adhere to all the requirements of the Equality Act.

One key recommendation of the EDS 2 Process is to ensure that commissioners have better access to culturally competent training, which is to be delivered by experts and specialist providers.

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/45	**Author of the Paper:** Tracey Forshaw Head of Vulnerable People Email: tracey.forshaw@southseftonccg.nhs.uk Tel: 0151 247 7247
Report date: March 2016	

Title: Personal Health Budgets for NHS Funded Packages of Care for Adults and Children Policy & Practice Guidance

Summary/Key Issues:

This paper is in support of the policy for personal health budgets for all NHS Funded Packages of Care for Adults and Children in line with current government policy and national guidance. The Governing Body are requested to review and approve the draft policy and practice document from which the CCG can base it's 'local offer' for PHB's, which is required to be published on the CCG website from April 2016.

Government policy requires Clinical Commissioning Groups (CCGs) to ensure that people in receipt of a health funded package of care, either by Continuing Health Care (CHC) for adults and or Complex Care (CC) for children, have a 'right to have' a Personal Health Budget (PHB) form October 2014. Alongside this the Government has confirmed a commitment in the NHS mandate 2014-2015 that anyone with a long term condition, who can benefit from a PHB, should have the right to ask for one by April 2015.

Recommendation

The Governing Body is asked to approve this policy and practice guidance.

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.
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.
x	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			Sefton Carers Centre, Sefton CVS are supporting the public consultation and engagement processes
Clinical Engagement	x			NHS Liverpool Community Health NHS Trust, Merseycare NHS Trust, Commissioning Support Unit, CCG Clinical and Locality Leads have been included as part of the consultation process
Equality Impact Assessment	x			Completed and approved by the Equality & Inclusion Panel on 4th November 2015
Legal Advice Sought	x			Via CCG Solicitors Hill Dickinson
Resource Implications Considered	x			Presented and discussed at Senior Management Team
Locality Engagement				
Presented to other Committees	x			Corporate Governance and Support Group NHS South Sefton CCG Quality Committee Engagement and Patient Experience Group CCG / CSU CHC Steering Group

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
	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 Governing Body
March 2016

1. Executive Summary

1.1 NHS Southport and Formby CCG are required to have in place a policy outlining the CCG's plan to implement the Government's requirements to ensure that people in receipt of a health funded package of care, either by Continuing Health Care (CHC) for adults and or Complex Care (CC) for children, have a 'right to have' a Personal Health Budget (PHB) from October 2014. Running alongside, a directive from Government which has confirmed a commitment in the NHS mandate 2014 - 2015 that anyone with a long term condition, who can also benefit from a PHB, should have the right to ask for one from April 2015.

1.2 NHS Southport and Formby Governing Body are requested to ratify the CCG PHB policy from which the CCG can base its 'local offer' for PHB's, as a national requirement which can be published on the CCG website by April 2016.

2. Introduction and Background

2.1 Following a successful pilot programme by the Department of Health, which ended in October 2012, the Government announced that from April 2014, Eligible Persons will have the "right to ask" for a Personal Health Budget (PHB), including by way of a direct payment. From October 2014, this right to ask was converted to a "right to have" a PHB. The Government has also confirmed a commitment in the NHS mandate 2014 - 2015 that anyone with a long term condition, who can benefit from a PHB, should also have the right to ask for a PHB by April 2015.

2.2 A PHB is an allocation of NHS funding which patients, after an assessment and planning with their clinical team, are able to personally control and use for the services they choose to support their health needs. This enables them to manage identified risks and to live their lives in ways which best suit them. Enabling people to exercise choice and control over their lives is central to achieving better outcomes for individuals. For Eligible Persons there is a duty on CCGs to:

- Consider any request for a PHB;
- Inform them of their right to ask for a PHB (April 2014);
- Inform them of their right to have a PHB (October 2014);
- Provide information, advice and support in relation to PHBs.

There are five essential characteristics of a PHB. The person with the PHB (or their representative) must:

1. be able to choose the health outcomes they want to achieve;
2. know how much money they have for their healthcare and support;
3. be enabled to create their own care plan, with support if they want it;
4. be able to choose how their budget is held and managed;
5. be able to spend the money in ways and at times that make sense to them, as agreed in their plan.

Deciding to have a PHB is a voluntary arrangement, with no requirement on individuals to take up this option. There are three mechanisms by which people can be supported to utilise a PHB: Notional Budget, 3rd Party Budget and or a Direct Payment. For all PHB's where a 3rd party and or Direct Payment has been the chosen option, the CCG utilises the services of non NHS independent brokerages to support the individuals to develop the support plans and manage the monies aligned to the PHB.

2.3 Following a period of Stakeholder consultation and engagement, and taking into account existing integrated budget arrangements that exist for joint funding arrangements for adults and children, the CCG has determined PHB's will be available for NHS Southport and Formby CCG residents in the following cases:

- Adults who are CHC eligible and or in receipt of 100% health funding, will be eligible and be offered a PHB;

- Adults who have learning disabilities and mental health with complex health needs or challenging behaviour, who are in receipt of a joint funding arrangement with South Sefton CCG and Sefton MBC, have the right to explore whether their needs can be met by utilising a personal budget. The integrated personal budgets under joint funding arrangements for Southport and Formby CCG will be managed by Sefton MBC, this includes access to a direct payment. Adults with a learning disability and or mental health difficulty, who are in receipt of a joint funded package of care, and receiving a direct payment, will by nature already be in receipt of an integrated PHB;

- Children Complex Care - In the case of children where continuing care is being received, the child and or family will have an, education, health and social care plan in place (EHC) or will be in the process of transferring over to an EHC. For children, personal health budgets can contribute to some or all of the social, health and educational elements of this plan. Within Southport and Formby CCG this will be provided by the SEND 'local offer', the joint funding arrangements will be managed via by Sefton Metropolitan Council (MBC) as a direct payment. Children across Southport and Formby CCG who are already in receipt of a direct payment, will by nature already be in receipt of an integrated PHB;

- Individuals who have a long term condition who may benefit from personal health budget who are not in receipt of NHS funded packages of care.

2.4 The CSU and CCGs are using a 'ready reckoner' approach to set the level of the PHB. This approach uses an existing care plan / package of support to calculate an indicative budget. Where there is no existing care plan or package of support already in place, the budget will be based on a standard hourly rate. Whilst the 'ready reckoner' approach is based on existing services, it can be simpler to use, more transparent and easier to understand. In principle, the allocation of monies that would have been spent on NHS Services as part of an individual's CHC, CC and or long term conditions could be available to use as a PHB. As much of this budget as possible should be included in a PHB.

In the case of individuals with long term conditions, who are not in receipt of a health funded package of care. The CCG will need to work out the indicative budget in terms of the overall cost of NHS Services used, and determine which elements cannot be utilised e.g. regular routine hospital consultant appointments and which elements could form the basis of the indicative budget as part of the PHB, with the emphasis of reducing overall NHS expenditure.

3. Key Issues

3.1 The CCG is required to have a policy in place to support the implementation of PHB's for eligible groups of people e.g. CHC / CC under the 'Right to Have' from October 2014 and the governments mandate 2014-2015 that anyone with a long term condition, who can also benefit from a PHB, should have the right to ask for one by April 2015.

3.2 The CCG is required to publish the 'local offer' for PHB's on CCG websites from April 2016

4. Conclusions

Southport and Formby CCG are required to have a policy in place outlining the CCG's plan to implement the Government's requirements to ensure that people in receipt of a health funded package of care, either by Continuing Health Care (CHC) for adults and or Complex Care (CC) for children, have a 'right to have' a Personal Health Budget (PHB) from October 2014. Running alongside this directive, the Government has confirmed a commitment in the NHS mandate 2014-2015 that anyone with a long term condition, who can also benefit from a PHB, should have the right to ask for one by April 2015.

The policy submitted which has been subject to wide engagement and consultation sets out the CCG plans to whom and how PHBs will be implemented for the residents of the borough of Sefton.

5. Recommendations

NHS Southport and Formby CCG Governing Body are requested to receive and approve the policy.

Appendices

Appendix 1: Southport & Formby CCG Personal Health Budgets for NHS Funded Packages of Care for Adults and Children Policy & Practice Guidance

Tracey Forshaw
March 2016

Appendix 1

NHS
Southport and Formby
Clinical Commissioning Group

NHS Southport and Formby Clinical Commissioning Group

Personal Health Budgets for NHS Funded Packages of Care for Adults and Children

Policy & Practice Guidance

Title:	NHS Southport and Formby Clinical Commissioning Group Personal Health Budgets for NHS Funded Packages of Care for Adults and Children Policy & Practice Guidance
Version:	Draft 0.5 under consultation
Ratified by:	NHS Southport and Formby CCG Governing Body
Date ratified:	
Name of originator/author:	Katy Murray, Interim PHB Project Manager. Midlands and Lancashire Commissioning Support Unit Tracey Forshaw Head of Vulnerable People
Name of Lead:	Chief Nurse
Date issued:	
Review date:	
Target audience:	CCG, CSU, NHS Community Providers, NHS Mental Health Providers

In the event of any changes to relevant legislation or statutory procedures this policy will be automatically updated to ensure compliancy without consultation. Such changes will be communicated.

Version Number	Type of Change	Date	Description of change

NHS
Southport and Formby
Clinical Commissioning Group

Table of Contents

1.0 Purpose & Introduction

This document sets out the policy and practice guidance developed to ensure the consistent and transparent delivery of Personal Health Budgets ("PHBs") for Eligible Persons (see section 3.1 for definition). This policy took effect from April 2014. The policy has been revised for the "right to have a PHB" for Eligible Persons from October 2014, and the wider expansion of PHBs at the CCGs discretion from April 2015 onwards. National policy in this area is still developing and the CCGs will review this paper when new guidance, regulations or national policy is published.

NHS Southport and Formby CCG (CCG) will ensure that PHBs are value for money for patients and the CCG. This will be done though the way in which PHBs are set up, through robust support planning and through effective monitoring of direct payments.

NHS Southport and Formby CCG would like to acknowledge Midlands and Lancashire Commissioning Support Unit, for the development of this policy, practice guidance and supporting documentation.

1.1 Consultation

This policy was developed in consultation with:

- NHS South Sefton CCG: Lead Commissioner – Learning Diversity, Children and Mental Health, Head of Finance, Head of Communications, Senior Governance Manager (Equality and Diversity).
- NHS Southport and Formby CCG meetings: Corporate Governance Support, Clinical Quality Committee, Evaluation of Patient Experience Group, NHS South Sefton Governing Body, CCG / CSU CHC Steering Group.
- CCG Legal representation – Hill Dickinson
- Sefton Metropolitan County Council: Dwayne Johnson, Tina Wilkins, Nick Roberts, Margaret Milne, Carol Cater, Mark Waterhouse, Lauren Sadler, Lesley McCann, Mike McSorely.
- Commissioning Support Unit (CSU) – Continuing Health Care / Complex Care and Quality Team: Lorraine Norfolk, Jo Ryder, Margie Learie, Lead for Children, Mental Health and Learning Disability
- Service user / Patient consultation: Commissioned and delivered by Sefton Carers Centre,
- Personal Health Budget Brokerage: Salvere, Your Life Your Way, SOLO Support Services, Sefton MBC Consultation and Engagement Panel
- Third sector Organisations: Sefton Carers Centre, Sefton Council for Voluntary Services, HealthWatch Sefton
- NHS Community Provider: Director of Nursing: Southport and Formby NHS Trust, Liverpool Community Health NHS Trust and Merseycare NHS Trust.

1.2 Ratification

This policy and practice guidance will be ratified by NHS Southport and Formby CCG Governing Body.

1.3 Scope

This policy applies to all employees of NHS Southport and Formby / South Sefton CCG, Commissioning Support Unit, NHS Providers commissioned to deliver services by Southport and Formby CCG.

1.4 Other Relevant Legislation

- Human Rights Act 1998, including the Article 8 Right to respect for private and family life, and Article 14 Prohibition of discrimination
- The Data Protection Act 1998
- The Carers (Equal Opportunities) Act 2004 provides carers with the right to receive assessment for support and a duty on various public authorities to give due consideration to a request to provide services to carers.
- The Mental Capacity Act 2005 ("MCA"). The Mental Capacity Act provides a framework for decision making applicable where people lack capacity to make a decision for themselves. The overriding principles of the Mental Capacity Act are set out in section 1 and include a requirement to ensure that all practicable steps are taken to seek to enable a person to make a decision for himself. Where a person is unable to make a decision, any decision made on their behalf must be made in accordance with his/her best interests and must be the least restrictive of the person's rights and freedom of action. A person is not to be treated as unable to make a decision simply because he makes an unwise decision.
- The Equality Act 2010. The Equality Act brought together the various earlier discrimination laws under one statute. It is unlawful to act in a discriminatory manner against any "protected characteristics", including race, sex and disability.
- The Children and Families Act 2014. This Act intends to improve services for key groups of vulnerable children (e.g. those in adoption and those with special educational needs and disabilities).
- The National Health Service (Direct Payments) Regulations 2013 (SI 2013 No.1617)
- The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulations 2013. These Regulations set out the duties of CCG's relating to NHS Continuing Healthcare rights and personal health budgets.
- NHS England – The Forward View into action: Planning for 2015 / 2016
- Department of Heath The Government's Mandate to NHS England 2016 / 2017

2.0 Overview

2.1 History

Following a successful pilot programme by the Department of Health, which ended in October 2012, the Government announced that from April 2014, Eligible Persons will have the "right to ask" for a PHB, including by way of a direct payment. From October 2014, this right to ask was converted to a "right to have" a PHB, specifically for Continuing Health Care (CHC) and Continuing Care (CC) for children with complex care needs.

This development mirrors other changes within the NHS, including the drive generally for greater patient choice, shared decision-making and innovation in managing funds. The Government has confirmed a commitment in the Mandate to NHS England 2016-2017 that PHB's including direct payments, should be an option extended to anyone who could benefit from a PHB from April 2015. The Mandate requires the consideration of more personalised care, including variant forms of PHBs even when a person is not suitable to receive a direct payment, with the emphasis on identifying any way in which the person's care could be personalised.

2.2 What is a PHB?

PHBs are the allocation of NHS funding which patients, after an assessment and planning with their NHS clinical team, are able to personally control and use the services they choose to support their health needs. This enables them to manage identified risks and to live their lives in ways which best suit them. Enabling people to exercise choice and control over their lives is central to achieving better outcomes for individuals.

For Eligible Persons there is a duty on CCGs to:

- Consider any request for a PHB;
- Inform them of their right to ask for a PHB (April 2014);
- Inform them of their right to have a PHB (October 2014)
- Provide information, advice and support in relation to PHBs.

There are five essential characteristics of a PHB.

The person with the PHB (or their representative) must:

1. be able to choose the health outcomes they want to achieve
2. know how much money they have for their healthcare and support
3. be enabled to create their own care plan, with support if they want it
4. be able to choose how their budget is held and managed
5. be able to spend the money in ways and at times that make sense to them, as agreed in their plan.

The CCG is committed to promoting service user choice, where available, while supporting them to manage risk positively, proportionately and realistically. As part of good practice, health care professionals should support and encourage service users' choices as much as possible, and keep them informed, in a positive way, of issues associated with those choices and how to take reasonable steps to manage them.

2.3 Principles

There are six key principles for PHBs and personalisation in health:

1. *Upholding NHS principles and values* - The personalised approach must support the principles and values of the NHS as a comprehensive service which is free at the point of use, as set out in the NHS Constitution. It should remain consistent with existing NHS policy, including the following principles:

- Service users and their carers should be fully involved in discussions and decisions about their care using easily accessible, reliable and relevant information in a format that can be clearly understood;
- There should be clear accountability for the choices made;
- No one will ever be denied treatment as a result of having a PHB;
- Having a PHB does not entitle someone to additional or more expensive services, or to preferential access to NHS services;
- There should be efficient and appropriate use of current NHS resources.

2. *Quality* – safety, effectiveness and experience should be central. The wellbeing of the individual is paramount. Access to a PHB will be dependent on professionals and the individual agreeing a care plan that is safe and will meet agreed health and wellbeing outcomes. There should be transparent arrangements for continued clinical oversight, proportionate to the needs of the individual and the risks associated with the care package.

3. *Tackling inequalities and protecting equality* – PHBs and the overall movement to personalise services could be a powerful tool to address inequalities in the health service. A PHB must not exacerbate inequalities or endanger equality. The decision to set up a PHB for an individual must be based on their needs, irrespective of race, age, gender, disability, sexual orientation, marital or civil partnership status, transgender, religion, beliefs or their lack of the requisite mental capacity to make decisions regarding their care.

4. *PHBs are purely voluntary* - No one will ever be forced to take more control than they want.

5. *Making decisions as close to the individual as possible* - Appropriate support should be available to help all those who might benefit from a more personalised approach, particularly those who may feel least well served by existing services / access, and who might benefit from managing their budget.

6. *Partnership* - Personalisation of healthcare embodies co-production. This means individuals working in partnership with their family, carers and professionals to plan, develop and procure the services and support that are appropriate for them. It also means CCGs, local authorities and healthcare providers working together to utilise PHBs so that health and social care work together as effectively as possible.

2.4 Standards for self-directed health support

The following standards for self-directed support are followed nationally and articulated as seven outcomes, which will be delivered through the implementation of this policy. These seven outcomes are:

Outcome 1 - Improved health and emotional well-being: To stay healthy and recover quickly from illness.

Outcome 2 - Improved quality of life: To have the best possible quality of life, including life with other family members supported in a caring role.

Outcome 3 - Making a positive contribution: To participate as an active citizen, increasing independence where possible.

Outcome 4 - Choice and control: To have maximum choice and control.

Outcome 5 - Freedom from discrimination, harassment and victimisation: To live free from discrimination, harassment and victimisation.

Outcome 6 - Economic well-being: To achieve economic well-being and have access to work and / or benefits as appropriate.

Outcome 7 - Personal dignity: To keep your personal dignity and be respected by others.

3.0 PHB eligibility

3.1 Who can have a PHB?

From 1 October 2014, all Eligible Persons acquired a 'right to have' a PHB including by way of a direct payment. Whilst the offer was initially only for CHC and CC, CCG's can at their discretion now offer this to a wider group of people who may benefit from a PHB. This is related to the NHS commitment and mandate to support individuals with long term conditions. This provision has been extended as part of the NHS England 'Moving Forward with Personal Health Budgets' development programme.

For South Sefton CCG this includes:

- People who are eligible for fully funded NHS continuing healthcare (adults), including people with a learning disability, mental health difficulties who have complex health needs and or challenging behaviour, and long term conditions (refer to 3.1.1)
- Families of children eligible for Continuing Care (refer to 3.1.2)
- Individuals who have a long term condition who may benefit from personal health budget who are not in receipt of NHS funded packages of care.

3.1.1 Adults who have learning disabilities and mental health with complex health needs or challenging behaviour, who are in receipt of a joint funding arrangement with Southport and Formby CCG and Sefton MBC, have the right to explore whether their needs can be met by utilising a personal budget. The personal budgets under joint funding arrangements for Southport and Formby CCG will be managed by Sefton MBC, this includes access to a direct payment. Adults with a learning disability and or mental health difficulty, who are in receipt of a joint funded package of care, and receiving a direct payment, will by nature already be in receipt of an integrated PHB.

3.1.2 Children Complex Care - In the case of children where continuing care is being received, the child and or family will have an, education, health and social care plan in place (EHC) or will be in the process of transferring over to an EHC. For children, personal health budgets can contribute to some or all of the social, health and educational elements of this plan. Within Southport and Formby CCG this will be provided by the SEND 'local offer', the joint funding arrangements will be managed via by Sefton Metropolitan Council (MBC) as a direct payment. Children across Southport and Formby CCG who are already in receipt of a direct payment, will by nature already be in receipt of an integrated PHB.

Individuals and their representatives already in receipt of CHC or CC may take up their right for a personal health budget at any time and CCGs must give due consideration to any request made. Individuals and families assessed as eligible for CHC or CC from October 2014 should be informed of their "right to have" their NHS care delivered in this way (see section 5.1 below).

In accordance with the overall drive towards greater patient choice and control, PHBs for patients other than those listed above, can still be considered and offered the benefit of a personalised care plans. In line with the NHS England 'Moving Forward with Personal Health Budget' development programme agenda this will form the basis of the CCG Local Offer which will be published on the CCG website from April 2016.

3.2 Exclusions for PHBs

If an individual comes within the scope of the "right to have" a PHB, then the expectation is that one will be provided. However, the NHS England guidance states:

"There may be some exceptional circumstances when a CCG considers a personal health budget to be an impracticable or inappropriate way of securing NHS care for an individual. This could be due to the specialised clinical care required or because a personal health budget would not represent value for money as any additional benefits to the individual would not outweigh the extra cost to the NHS."

Where a PHB by way of a direct payment is being considered, please also see exclusions listed at section 6.4.

3.3 PHBs for people in nursing or residential care home settings

The Government's intention is for all Eligible Persons to have the "right to have" a PHB where they would benefit from personalised care. Therefore, such Eligible Persons living in nursing or residential care who may benefit from receiving care via a PHB, ought to be offered this option. However, CCGs need to be satisfied that the use of a PHB in such settings is cost effective and is a sensible way to provide care to meet or improve the individual's agreed outcomes. PHBs should not generally be used to pay for care and support services being commissioned by the NHS that a person will continue to access in the same way whether they have a PHB or not. See section 6.10 for further detail relating to direct payments for those in nursing / residential care home settings.

4.0 Options for managing PHBs

The most appropriate way to manage a PHB should be discussed and agreed with the person, their representative or nominee as part of the care planning process. PHBs can now be received and managed in the following ways, or a combination of them:

a) Notional budget – where an individual is informed of the amount of funding available to them and decides how the budget is used (by input into the care plan) but the CCG continues to commission services, manage contracts and make purchases etc. Notional budgets could be an option for individuals who want more choice and control over their healthcare but who do not feel able or willing to manage a budget.

b) Third party budget – A non NHS support service organisation, legally independent of both the individual and the NHS, holds the money for the individual and arranges and pays for all of the services on behalf of the individual in accordance with the care plan.

c) Direct payments - Can differ whether a person lacks or retains capacity:

i. Direct payments for people *with capacity* – where the individual receives the funding that is available to them and they purchase the services and support they want in accordance with the agreed care plan (with or without assistance). The individual can elect to receive and manage the payment themselves or decide for it to be received and managed by a person of their choosing (a nominee). If the individual chooses a nominee, that nominee becomes responsible for managing the funds and services and accounting for expenditure. Support from CCG recommended support services are available for all direct payment recipients.

ii. Direct payments for people who lack capacity – where the individual lacks capacity, an 'authorised representative' (agreed by the CCG – see 5.4 for further detail) receives the funding that is available to the individual as a direct payment. The authorised representative is responsible for managing the funds and services and accounting for expenditure. The 'authorised representative' must involve the individual as much as possible and all decision making must be in line with the individual's best interests, in accordance with s.4 Mental Capacity Act 2005. Support from a CCG recommended support services (a direct payment support service) are available for all direct payment recipients. In the case of children, direct payments can be received by their parents or those with parental responsibility for that child.

Further detail on Direct Payments is set out in Section 6 of this Policy.

5.0 How do PHBs work?

5.1 Informing people about PHBs

All policies relating to NHS Continuing Healthcare and Continuing Care continue to apply alongside the new law and guidance on PHBs. From April 2014, the named health professional will inform Eligible Persons of their right to request a PHB (including by way of direct payments) at the initial assessment, the 12 week review or annual review. From October 2014 the named health professional will inform Eligible Persons of their right to have a PHB (including by way of direct payments) at the initial assessment, the 12 week review and or annual review. See exclusions in Section 3.2 and 6.4. The Personal Health Budget pathway is outlined in Appendix 1.

Health professionals will also seek to identify other patients who do not fall within the scope of the "right to have" but who may benefit from the provision of a PHB. PHBs are not restricted to Eligible Persons and CCGs will seek to offer PHBs on a voluntary basis to those patients with long term conditions for whom it would be appropriate. Where such patients are identified, the health professionals involved in their care will provide them with information about PHBs.

PHBs are entirely voluntary and there is no obligation for a patient to accept the offer. Patients and their families will need to be provided with the CCG PHB standard leaflet or where appropriate Easy Read leaflet.

The CCGs have made arrangements for non NHS support services for example: Salvere (a direct payment support service), SOLO Support Services and Your Life Your Way (third party budget support services) to provide information, advice and guidance to prospective and existing PHB recipients, and their families.

The list of non NHS support services above will be subject to change and extension subject CSU / CCG 3rd Party Assurance Process.

The services provided by these organisations will include:

- Information on how a PHB can be used and managed
- Guidance on producing a personalised care / support plan
- Advice and support to manage a PHB, including a direct payment
- Guidance on record keeping requirements
- Information about direct payments, including the responsibilities around financial monitoring that will need to be taken on by the recipient of the direct payments.

Patients and families who wish to consider and explore PHBs further will be offered a referral to a non NHS support service by the named health professional. This will require the named health professional to complete a PHB enquiry form, as well as a PHB care plan (a copy of which is at Appendix 2) which includes recording the clinical needs of the individual. This will begin the process of identifying risks so the care / support planning process can commence. Enquiries should be made to CMCSU.Care@nhs.net. The lead health professional (see section 5.5) will be supported by the Commissioning Support Officers within the CCG and CSU to progress the request.

5.2 Budget Setting

Under the traditional model of CHC / CC, an assessment would be followed by the named health professional producing a care plan, i.e. a schedule prescribing episodes of care and defining specific tasks for the care worker. Under PHBs, after an assessment, a 12 week review and or an annual review an 'indicative budget' is set. The indicative budget gives a financial envelope within which the PHB Care Plan is completed.

The CSU and CCGs are using a 'ready reckoner' approach to set the level of the PHB. This approach uses an existing care plan / package of support to calculate an *indicative budget.* Where there is no existing care plan or package of support already in place, the budget will be based on a standard hourly rate (see below). Whilst the 'ready reckoner' approach is based on existing services, it can be simpler to use, more transparent and easier to understand.

The PHB amount is therefore based on:

- 90% of the money that would otherwise be spent on meeting the fully funded NHS continuing healthcare needs or continuing care needs for Eligible Persons.
- If no package of care is in place an hourly rate of £13.50 will be used to set as a baseline amount of PHB for each hour of care the patient is assessed as needing.
- In the case of individuals with long term conditions, who are not in receipt of a health funded package of care. The CCG will need to work out the indicative budget in terms of the overall cost of NHS Services used, and determine which elements cannot be utilised e.g. regular routine hospital consultant appointments and which elements could form the basis of the indicative budget as part of the PHB, with the emphasis of reducing overall NHS expenditure.

Following a person being assessed / reviewed and identified or re-confirmed as an individual entitled to receive a PHB, the indicative budget will be agreed by CSU / CCG. See section 6 for additional information.

In principle, the amount of money that would have been spent on NHS Services as part of an individual's CHC, CC and or long term conditions could be available to use as a PHB. As much of this budget as possible should be included in a PHB. Where it is not possible to do so (for example, where money currently being used to commission services cannot be released immediately for use under a PHB), CCGs will work with the patient to tailor services as best as possible until this service can be provided under the PHB arrangement (where appropriate).

5.3 PHB care planning

Everyone who has a PHB will go through a care planning process, which leads to a person-centred Care Plan. Care planning for PHBs is fundamentally different from traditional care planning carried out for CHC / CC for children patients. Whereas a traditional care plan starts with the existing services, the starting point for a PHB Care Plan is the agreement of an indicative budget.

A PHB Care Plan is developed jointly by the individual, their family (if appropriate), a non NHS support services planner, and the individual's lead health professional. The process should be driven by the individual's choices and the Care Plan should clearly show how a PHB will be used to achieve the individual's identified health and care outcomes. This includes:

- the health needs of the individual and the desired outcomes;
- the amount of money available under the PHB;
- what the PHB will be used to purchase;
- how the PHB will be managed;
- who will be managing the budget;
- who will be providing each element of support;
- how the plan will meet the agreed outcomes and clinical needs;
- who is responsible for monitoring the health condition of the individual;
- who the individual should contact to discuss any changes in their needs;
- the anticipated date of the first review;
- how the individual has been involved in the production of the plan;
- how any training needs will be met;
- identifying any risks, consequences and mitigating actions;
- contingency planning.

Good care planning involves looking holistically at the individual's life to improve their health, safety, independence and wellbeing. The individual should be supported throughout the care planning process.

The NHS (Direct Payments) Regulations 2013 ("the regulations") and associated guidance set out what direct payments (using NHS money) can and cannot be used for, and how they should be administered. The CSU / CCGs will apply the regulations to all forms of PHB as far as possible, whether it is received/managed by way of direct payments or otherwise (as detailed at section 4). How a PHB will be used (however it is received / managed) must be set out in the PHB Care Plan. Please see section 6 of this Policy which is to be applied, as far as possible, to all PHBs.

Delay in arranging PHBs should be avoided. Where delay is unavoidable (for example, where circumstances make it difficult to plan for a person's ongoing care), the reasons for it must be made clear to the individual. Regular review should take place so that a person's PHB can be put in place as soon as practicably possible.

The CSU and CCGs will make sure that this delay does not cause a delay in hospital discharges or in ensuring an appropriate package of care is in place pending finalisation of the PHB arrangements. An interim care package may be offered to avoid such delay.

5.4 Representatives for children and people who lack capacity

A PHB arrangement for a person who lacks capacity will require the appointment of a 'representative' by the appropriate CCG. A representative is someone who agrees to act on behalf of someone who is otherwise eligible to receive a PHB but cannot do so because they do not have capacity to consent to receiving one (see Appendix 4) or because they are a child.

An appointed 'representative' could be anyone deemed suitable by the CCG, and who would accept the role. The representative can be:

- a friend, carer or family member;
- a deputy appointed by the Court of Protection;
- an attorney with health and welfare or finance decision-making powers created by a lasting power of attorney;
- someone appointed by the CCG.

In the case of adults who lack capacity, when choosing the 'representative' the CCG must adopt a decision making process in line with the requirements of the MCA and within the context of the individual's best interests as per the checklist at s.4 of the Act. This includes seeking the views of the individual, where possible, about who they would want to manage their PHB.

The decision making process for the appointment of the 'representative' must be documented and discussed as part of care planning process, and agreed by the CSU / CCG.

The representative will take on the responsibilities associated with the PHB. Where it is believed to be appropriate to provide a PHB by way of direct payments, the representative must be fully informed about, and consent to accepting, the responsibilities relating to the receipt and management of the direct payment on the individual's behalf (see section [6.8] below).

The involvement of the representative should be reviewed if the individual regains capacity and/or reaches the age of 16.

5.5 Lead Health Professional

A lead health professional will be named in an individual's Care Plan. This should be someone who has regular contact with the individual and their representative or nominee if they have one. It is likely that the lead health professional will be the most appropriate person to undertake this role. The Care Coordinator is responsible for:

- Managing the assessment of the health needs of the individual as part of the care plan;
- Ensuring that the individual, representative and CSU / CCG clinician have agreed the care plan;
- Undertaking or arranging for the monitoring and review of the care plan and health of the person;
- Liaising between the individual (or their representative or nominee) and the CCG as the primary point of contact.

5.6 Approval of Care Plan

PHB Care Plans are agreed in principle by the named health professional. However, all PHB Care Plans will also need to be signed off by the appropriate CSU & CCG panel (which will include a relevant CCG representative). This process includes reviewing, agreeing and signing off the Care Plan which includes a risk identification and management plan. A PHB checklist has been developed to ensure consistency and adherence to the law and guidance. A copy of this checklist is at Appendix 5 of this Policy.

The CSU / CCG clinician will not agree to any services named in the Care Plan if they believe that the potential health outcomes are outweighed by significant risks to the individual's health. However, the CCGs will not impose blanket prohibitions and will remain open to considering different approaches to achieving outcomes other than those traditionally used, considering the particular circumstances of the individual and balancing the risks and benefits accordingly.

If a service named in the Care Plan is not agreed, the CSU / CCG clinician will provide the individual, representative or nominee the reasons why this decision has been reached. The individual, their representative or nominee may ask the CSU / CCG clinician to reconsider their decision and provide additional evidence or information to inform that decision. The CSU / CCG clinician must reconsider their decision in a timely manner upon such a request being made. The CSU / CCG clinician will notify and explain the outcome in writing to the individual. See sections 6.7 & 6.8 for further detail on the process to be followed.

If a part of the Care Plan is refused, the CCG should make every effort to work in partnership with the individual, their representative or nominee to ensure their preferences are considered and taken into account.

5.7 PHB Agreement

When taking up a PHB, the patient, their representative and / or their nominee must sign a 'PHB agreement', which explains the responsibilities associated with the PHB and sets out the agreement that the PHB will be spent as set out in the Care Plan.

If the patient is receiving the PHB as a direct payment, the PHB agreement will confirm that the PHB will be spent in accordance with the NHS (Direct Payments) Regulations 2013. A copy of this Agreement is at Appendix 5 for an adult and Appendix 6 for children in this Policy.

5.8 Assistance to manage PHBs

The CCGs have arranged for non NHS support services e.g. Salvere, Your Life Your Way and SOLO Support Services to provide support to individuals in receipt of PHBs. It is envisaged that over time a wider range of organisations will become available to offer support and that this will be reflected in the choices available to PHB recipients, this will be subject to CSU / CCG 3rd Party Assurance Process. Salvere offers support services for those in receipt of direct payments. It can also support individuals in activities such as recruiting, employing staff and payroll. Further detail on these services can be found at section 6.12.

SOLO Support Services and Your Life Your Way offer services for those with third party budgets, including options where they become the employer and manage the PHB on an individual's behalf.

The costs associated with utilising a non NHS support service will be met from the PHB allocation. This requires the PHB to be paid directly to these organisations so that their charges can be deducted.

5.9 Monitoring and Review

Regular review is required in order to ensure that an individual's Care Plan continues to meet their needs.

In respect of continuing healthcare for adults, this review is carried out in line with the continuing healthcare national service framework, i.e. three months after patients become eligible for continuing healthcare and annually thereafter. Reviews will also confirm whether or not the patient remains eligible and in need continuing healthcare.

In respect of continuing care for children, the care package should be reviewed after three months and then at least every six months to ensure it continues to meet the child or young person's needs. Reviews will also confirm whether or not the child or young person still has continuing care needs.

Reviews may need to take place sooner or more frequently if the CCG or CSU become aware that:

- the health needs of the individual have changed significantly;
- the care plan is not being followed or expected health outcomes are not being met; or
- the individual, their representative or their nominee requests it.

It should be made clear under the Care Plan who the PHB holder should contact to discuss changes to their PHB should their needs change. In most cases, the Care Coordinator will be best placed to undertake this role.

5.10 Stopping or reclaiming PHBs

Arrangements under PHBs can be stopped and, where applicable, money can be reclaimed. The details of this are set out at section 6.16 and 6.17 but, to the extent possible, this applies to all types of PHB.

6.0 Direct Payments

The National Health Service (Direct Payments) Regulations 2013 set out how direct payments should be administered and on what they can be spent. The regulations are similar to the regulations and guidance for social care direct payments. PHB Guidance on the new direct payments for healthcare regulations was published in March 2014. Although the NHS (Direct Payments) Regulations 2013 apply to direct payment PHBs, as noted above the CCG has agreed to apply these regulations, as far as possible, to all forms of PHB to ensure transparency, fairness and best practice. References in this section to "direct payments" should therefore be treated as referring to all forms of PHB.

6.1 Who can receive a direct payment PHB?

A direct payment PHB can be made to any Eligible Person, where they are:

- In receipt of any benefit that may or must be provided or arranged by a health body under the NHS Act 2006 or under any other enactment and;
- A person aged 16 or over, who has the capacity to consent to receiving a PHB by way of a direct payment and consents to receive one (please see Appendix 4 in relation to capacity);
- A child under 16 where they have a suitable representative who consents to a PHB by way of a direct payment;
- A person aged 16 or over who does not have the capacity to consent to receiving a PHB by way of a direct payment but has a suitable representative who consents to it.
- A direct payment PHB is appropriate for that individual with regard to any particular condition they may have and the impact of that condition on their life;
- A direct payment PHB represents value for money and, where applicable, any additional cost is outweighed by the benefits to the individual;
- The person is not subject to certain criminal justice orders for alcohol or drug misuse (see Section 6.4). However, such a person may be able to use another form of PHB to personalise their care.

The CCG will only provide direct payments if it is satisfied that the person receiving the direct payments (which may be the patient, a nominee or representative) understands what is involved, and has given consent.

People aged 16 or over who have capacity, representatives of people aged 16 or over who lack capacity, and representatives of children can request that the direct payment is received and managed by a nominee (see Section 6).

Decisions about providing direct payments for healthcare should be based around need rather than being based around a particular medical condition or severity of condition.

Health professionals will also seek to identify other patients who do not fall within the scope of the “right to have” but who may benefit from the provision of a PHB. PHBs are not restricted to Eligible Persons and CCGs will seek to offer PHBs on a voluntary basis to those patients with long term conditions for whom it would be appropriate. Where such patients are identified, the health professionals involved in their care will provide them with information about PHBs.

6.2 Considerations when deciding whether to make a direct payment

The CCG will adhere to the requirements as detailed at Regulation 7 of the NHS (Direct Payments) Regulations 2013 when deciding whether to make a direct payment. In doing so the CCG will contact a range of people for information to help make the decision whether a direct payment may be suitable. From this range will be any health or social care professional involved in the provision of care/treatment to the individual e.g. a personal assistant, occupational therapist, community mental health nurse or social care team. The CCG will also consult:

- Anyone identified by the individual as a person to be consulted for this purpose.
- If the individual is a person aged 16 or over but under the age of 18, a person with parental responsibility for the individual.
- The person primarily involved in the care for the individual.

- Any other person who provides care for the patient.
- Any Independent Mental Capacity Advocate (IMCA) or Independent Mental Health Advocate (IMHA) appointed for the individual.

The CCG will consider whether the individual will be able to manage the direct payment (see section 6.3 below).

If the person is aged between 16 and 18, a parent or guardian with parental responsibility will be assessed, to look at whether they could manage a direct payment.

If the individual has a deputy appointed by the Court of Protection in relation to matters about which direct payments may be made, this will be considered and the CCG may consult the appointed person to help decide whether or not the person would want to receive direct payments.

In considering whether to provide direct payments, the CCG may ask the individual or their representative for information about:

- Their overall health;
- The details of their condition in respect of which they would receive direct payments;
- Any bank, building society, Post Office or other account into which direct payments would be paid; and
- Anything else which appears relevant.

6.3 Ability to manage direct payments

The CCG will consider whether an individual (whether the patient or their representative) is able to manage direct payments by:

- Considering whether they would be able to make choices about, and manage the services they wish to purchase;
- Whether they have been unable to manage either a heath care or social care direct payment in the past, and whether their circumstances have changed;
- Whether they are able to take reasonable steps to prevent fraudulent use of the direct payment or identify a safeguarding risk and if they understand what to do and how to report it if necessary; and
- Considering any other factor which the CCG may consider is relevant.

If the CCG is concerned that an individual is not able to manage a direct payment they must consider:

- The individual's understanding of direct payments, including the actions and responsibilities on their part.
- Whether the person understands the implications of receiving or not receiving direct payments.
- What kind of support the individual may need to manage a direct payment.
- What help is available to the individual.

Any decision that an individual is unable to manage a direct payment must be made on a case by case basis, taking into account the views of the individual, and the help they have available to them. The CCG will not make blanket assumptions that groups of people will or will not be capable of managing direct payments.

The CCG will inform the individual in writing if the decision has been made that they are not suitable for direct payments and whether an alternative method of receiving the PHB is considered to be suitable instead. See section 6.5 for further information.

6.4 Who cannot receive a direct payment?

There are some people to whom the duty to make direct payments does not apply . This includes those:

a) subject to a drug rehabilitation requirement, as defined by section 209 of the Criminal Justice Act 2003 (drug rehabilitation requirement), imposed by a community order within the meaning of section 177 (community orders) of that Act, or by a suspended sentence of imprisonment within the meaning of section 189 of that Act (suspended sentences of imprisonment);
b) subject to an alcohol treatment requirement as defined by section 212 of the Criminal Justice Act 2003 (alcohol treatment requirement), imposed by a community order, within the meaning of section 177 of that Act, or by a suspended sentence of imprisonment, within the meaning of section 189 of that Act;
c) released on licence under Part 2 of the Criminal Justice Act 1991 (early release of prisoners), Chapter 6 of Part 12 of the Criminal Justice Act 2003 (release on licence) or Chapter 2 of the Crime (Sentences) Act 1997 (life sentences) subject to a non-standard licence condition requiring the offender to undertake offending behaviour work to address drug or alcohol related behaviour;
d) required to submit to treatment for their drug or alcohol dependency by virtue of a community rehabilitation order within the meaning of section 41 of the Powers of Criminal Courts (Sentencing) Act 2000 (community rehabilitation orders) or a community punishment and rehabilitation order within the meaning of section 51 of that Act (community punishment and rehabilitation orders);
e) subject to a drug treatment and testing order imposed under section 52 of the Powers of Criminal Courts (Sentencing) Act 2000 (drug treatment and testing orders);
f) subject to a youth rehabilitation order imposed in accordance with paragraph 22 (drug treatment requirement) of Schedule 1 to the Criminal Justice and Immigration Act 2008 (“the 2008 Act”) which requires the person to submit to treatment pursuant to a drug treatment requirement;
g) subject to a youth rehabilitation order imposed in accordance with paragraph 23 of Schedule 1 to the 2008 Act (drug testing requirement) which includes a drug testing requirement;
h) subject to a youth rehabilitation order imposed in accordance with paragraph 24 of Schedule 1 to the 2008 Act (intoxicating substance treatment requirement) which requires the person to submit to treatment pursuant to an intoxicating substance treatment requirement;

i) required to submit to treatment for their drug or alcohol dependency by virtue of a requirement of a probation order within the meaning of sections 228 to 230 of the Criminal Procedure (Scotland) Act 1995 (probation orders) or subject to a drug treatment and testing order within the meaning of section 234B of that Act (drug treatment and testing order);

j) released on licence under section 22 (release on licence of persons serving determinate sentences) or section 26 of the Prisons (Scotland) Act 1989 release on licence of persons sentenced to imprisonment for life, etc.) 34 or under section 1 (release of short-term, long term and life prisoners) or section 1AA of the Prisoners and Criminal Proceedings (Scotland) Act 1993 (release of certain sexual offenders) and subject to a condition that they submit to treatment for their drug or alcohol dependency;

k) If the individual is subject to certain criminal justice orders for alcohol or drug misuse, then they will not receive a direct payment. However, they might be able to use another form of PHB to personalise their care and alternatives should be considered.

6.5 Deciding not to offer a direct payment.

In addition to section 6.4 above, a CCG may decide to refuse to make a direct payment if it believes it would be inappropriate to do so, for example:

- if there is significant doubt around an individual's or their representative's ability to manage a direct payment;
- if there is a high likelihood of a direct payment being abused;
- if the benefit to the particular individual of having a direct payment does not represent good value for money;
- if it considers that providing services in this way will not provide the same or improved outcomes.

Such a view may be formed from information gained from anyone known to be involved with the individual, including health professionals, social care professionals, the individual's family and close friends, and carers for the individual.

In all cases where a direct payment is refused, the Eligible Person and any nominee or representative will be informed in writing of the refusal and the grounds by which the request is declined. The individual or their representative may request a review of this decision, in which case, the process set out at section 6.7 will be followed.

If a direct payment is refused, other options to personalise the package of care for the individual will be explored and facilitated as much as is possible, and other forms of PHB, such as a notional budget or third party budget, should be considered.

6.6 Decision Making

Where there is a recommendation to accept or reject a request for a direct payment, the CCG will use a Panel to consider this recommendation. This Panel will consist of:

- Senior Nurse CCG (Chair)
- Senior Nurse CSU (Chair) under delegated responsibilities
- CSU Representatives individual commissioning nurse (CHC, CC, Mental Health, LD) – appropriate to individuals needs
- CCG GP representative
- Lead Health Professional
- Co-opted Members as appropriate this may include; medicines management, Sefton MBC representative (this list is not exhaustive)

The Panel will consult the appropriate Terms of Reference when making its decisions.

6.7 Request for review of a decision

Where the CSU / CCG decide that a direct payment would be inappropriate, the patient, their representative or nominee may require the CSU / CCG to reconsider the decision, submitting additional information to support the deliberation. The CSU / CCG must reconsider its decision in a timely manner upon such a request being made but is not required to undertake more than one re-consideration in any six month period following the initial decision.

The CCGs will use an Appeals Panel to make a decision regarding a request for reconsideration of a refusal to provide a direct payment. The membership and terms of reference of the Appeals Panel should be in accordance with the requirements of the relevant CCG. However, with regards to timeframe for the Appeals process, the Panel should seek to follow the recommended timescales set out under national guidance. Details of these timescales are set out at Appendix 9.

No member will have had previous involvement in the case.

The patient, representative or nominee must be informed in writing of the outcome of the review and the reasons for the decision. If the refusal is upheld, other options to personalise the package of care for the individual will be explored and facilitated as much as is possible, and other forms of PHB, such as a notional budget or third party budget, should be considered.

6.8 Representatives and direct payments

Information surrounding the appointment of Representatives is set out earlier in this Policy. When the use of direct payments is being considered, the CCG must be satisfied that a person agreeing to act as a representative understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. They should be informed of the restrictions surrounding employment of a family member or person living in the same household to provide care (see section 7.1).

Full advice, support and information should be provided so that people contemplating taking on the role of representative know what to expect. In addition, the CCG must provide its consent to the representative acting in this role, having duly considered whether the person is competent and able to manage direct payments, either on their own or with whatever assistance is available to them.

A representative may identify a nominee to receive and manage direct payments on their behalf, subject to the nominee's agreement and the approval of the CCG (see section 6.9 below).

A representative must (unless they have appointed a nominee to do so):

- act on behalf of the person, e.g. to help develop a PHB Care Plan and to hold the direct payment
- act in the best interests of the individual when securing the provision of services
- be the principal person for all contracts and agreements, e.g. as an employer;
- use the PHB and direct payment in line with the agreed Care / Support Plan
- comply with any other requirement that would normally be undertaken by the individual (e.g. participating in a review, providing information)

When considering whether to make direct payments to representatives, the CCG will consider:

- Whether the person receiving care had, when they had capacity, expressed a wish to receive direct payments;
- Whether the person's beliefs or values would have influenced them to have consented or not consented to receiving a direct payment;
- Any other factors that the person would be likely to take into account in deciding whether to consent or not to receiving direct payments;
- As far as possible, the person's past and current wishes and feelings.

6.9 Nominees

If a person aged 16 or over has capacity, but does not wish (for whatever reason) to receive direct payments themselves, they may nominate someone else (a nominee) to receive them on their behalf.

A representative (for a person aged 16 or over who does not have capacity or for a child) may also choose to nominate someone (a nominee) to hold and manage the direct payment on their behalf.

Where a nominee is appointed, they become responsible for managing the PHB and direct payment on behalf of the individual or the appointed representative (for individuals without capacity). They must:

- act on behalf of the person, e.g. to help develop a PHB Care / Support plan(s) and to hold the direct payment;
- act in the best interests of the individual when securing the provision of services;
- be the principal person for all contracts and agreements, e.g. as an employer;
- use the PHB and direct payment in line with the agreed Care / Support Plan;
- comply with any other requirement that would normally be undertaken by the individual (e.g. review, providing information).

It is important to note that the role of nominee for direct payments for healthcare is different from the role of nominee for direct payments for social care. For social care direct payments, a nominee does not have to take on all the responsibilities of someone receiving direct payments, but can simply carry out certain functions such as receiving or managing direct payments on behalf of the person receiving them. In direct payments for healthcare, however, the nominee is responsible for fulfilling all the responsibilities of someone receiving direct payments, as outlined above. Those receiving direct payments for healthcare and their nominees must be made fully aware of these responsibilities.

The CCG must be satisfied that a person agreeing to act as a nominee understands what is involved, and has provided their informed consent, before going ahead and providing direct payments. Full advice, support and information should be provided so that people contemplating taking on the role of nominee know what to expect. In addition, the CCG must provide its consent to the nominee acting in this role, having duly considered whether the person is competent and able to manage direct payments, either on their own or with whatever assistance is available to them.

Before the nominee receives the direct payment, the CCG must consent to the nomination. In reaching its decision, the CCG may:

- Consult with relevant people;
- Require information from the person for whom the direct payments will be made on the state of health or any health condition they have which is included in the services for which direct payments are being considered;
- Require the nominee to provide information relation to the account into which direct payments will be made.

If the proposed nominee is not a close family member of the person (see Appendix 8), living in the same household as the person, or a friend involved in the person's care, then the CSU / CCG will require the nominee to apply for an enhanced Disclosure and Barring Service (DBS) certificate (formerly a CRB check) with a check of the 'adults barred' list and consider the information before giving their consent. If a proposed nominee in respect of a patient aged 18 or over is barred, the CCG must not give their consent. This is because the Safeguarding Vulnerable Groups Act 2006 prohibits a barred person from engaging in the activities of managing the person's cash or paying the person's bills.

If the proposed nominee is a close family member of the person, living in the same household as the person, or a friend involved in the person's care, the CCG cannot ask them to apply for a DBS certificate and has no legal power to request these checks.

The CCG must notify any person identified as a nominee where it has decided not to make a direct payment to them. The notification must be made in writing and state the reasons for the decision.

6.10 What can and cannot be bought with direct payments

The NHS direct payments regulations and associated guidance set out what direct payments (using NHS money) can and cannot be used for, and how they should be administered.

A direct payment can be spent on a range of services and equipment that will lead to health outcomes, but only if they have been agreed in the Care Plan (see Appendix 3). The person receiving the direct payment (whether it is the individual requiring support, their nominee or a representative) is responsible for ensuring that it is only used as specified in the care plan. If it is not, the direct payment may have to be stopped and the law allows for certain payments which have been mis-spent to be reclaimed. Please see section 6.17 below.

There are some restrictions on how PHBs can be used. These are not intended to reduce choice and control for individuals, but to ensure that PHBs are used for maximum benefit and to ensure they are administered consistently and fairly for everyone.

Direct payments cannot be used to pay for the following:

- alcohol
- tobacco
- gambling
- debt repayment (other than for a service specified in the support plan)
- core GP services
- planned surgical interventions
- pharmaceutical charges
- services provided through vaccination or immunisation programmes
- any service provided under the NHS health check or National Child Measurement Programme
- Urgent or emergency treatment services

For the avoidance of doubt, as Southport and Formby CCG will apply the regulations to any form of PHB insofar as it is possible, the above restrictions will equally be applied to all forms of PHB insofar as it is possible.

In addition, pending the outcome of a further pilot scheme, caution should be had when considering the use of direct payments for those in nursing/residential care home settings.

Where a request for a direct payment for healthcare is made for a person living in a residential setting the CCG must be certain that providing care in this way adds value to the person's overall care. Generally, direct payments should not be used to pay for care and support services being commissioned by the NHS that a person will continue to access in the same way whether they have a PHB or not. In such instances, where no additional choice or flexibility has been achieved by giving someone a PHB, then allocating a direct payment only adds an additional financial step and layer of bureaucracy into the commissioning of the care. CCGs need to be clear that the use of a direct payment in such settings is cost effective and is a sensible way to provide care to meet or improve the individual's agreed outcomes.

Other types of PHB, for example notional budgets, can be used where direct payments are not a practical route and many people may find great benefit in planning their care using the personalised care planning process associated with developing a PHB.

6.11 Imposing conditions in connection with the making of direct payments

The following conditions may be imposed on the individual, their representative or nominee in connection with the making of direct payments:

- the recipient must not secure a service from a particular person; and/or
- the individual, their representative or their nominee must provide information that the CSU / CCG considers necessary (other than information already covered by other regulations in the NHS (Direct Payment) Regulations 2013.

Conditions should only be imposed in exceptional circumstances. The reasons for the imposed conditions should be documented clearly.

6.12 Assistance to manage a direct payment – Supported Managed Accounts

As outlined at section 5.1 above, the CCGs have arranged for non NHS support services to provide support to individuals in receipt of PHBs.

Where an individual chooses a direct payment there are extra responsibilities on the individual (or their appointed representative and / or nominee) to manage their care package. These are set out within the PHB Agreement – see Appendix 6.

It is essential that either the individual or their representative has the ability to consent to and manage both their direct payment and the dedicated bank account. In certain circumstances, the option of a Supported Managed Account can be considered. These circumstances include:

- Where the individual or representative feels assistance is required;
- Where mental capacity indicates; or

For those in receipt of direct payments, the non NHS support services offer Supported Managed Accounts and can support individuals in activities such as recruiting, employing staff and payroll. This option for support is open to people with PHBs and direct payments. However, in circumstances where Supported Managed Accounts are being considered, it may be more appropriate to consider the use of a notional budget. The respective benefits of each option should be discussed with the individual, their representative or nominee.

The costs of the non NHS support service are met from the PHB allocation. This requires the PHB to be paid directly to the non NHS support service so that its charges can be deducted. In certain circumstances the non NHS support service may make direct health care payments to patients, their representative or their nominee. This can only be carried out with the agreement of the CSU / CCG.

Individuals, representatives and appointed nominees employing staff are strongly recommended to utilise the information, advice, guidance and payroll and HR facilities of the non NHS support services e.g. Salvere, Your Life Your Way or SOLO (or, as the range of organisations offering such services widens, an alternative agreed support service) to ensure the legal responsibilities of being an employer are satisfied. Should the individual, representative or nominee not wish to accept this recommendation the request for a direct payment may be refused because requirements of employment law will fall to the individual, their representative or their nominee as the employer. In such circumstances, the CCG would have to be satisfied that the individual, their representative or nominee are able to manage such responsibilities by other means.

6.13 Receiving a direct payment

Direct payments will be paid in advance on the 15th day of the month, and where this day falls on the weekend, it will be paid on the Friday before. Under no circumstances should individuals have to pay for care and be reimbursed.

With the exception of one-off direct payments (see below), direct payments must be paid into a separate bank account used specifically for the direct payment. The bank account must be in the name of the person receiving the care, or their nominee or representative.

When receiving direct payments, the account holder should keep a record of both the money received and where it is spent. They are responsible for keeping hold of statements and receipts for auditing.

6.14 One-off payments

A one-off payment is used to buy a single item or service, or a single payment for no more than five items or services, where the individual is not expected to receive another direct payment in the same financial year.

When someone is receiving a one-off direct payment, it can be paid into the individual's ordinary bank account (or that of a nominee or representative). Individuals will need to provide evidence that the direct payment was used as agreed in the Care Plan, for example, by producing receipts of items/services purchased.

6.15 Monitoring and review of direct payments

As a minimum, a clinical review of an individual's direct payments should be performed within three months of the first direct payment and then annually. Financial monitoring will take place quarterly. Financial reviews will be completed by the non NHS support service.

There must be a review if the CCG or CSU become aware that direct payments have not been sufficient to secure the services specified in the care plan. If someone wishes to purchase additional care privately, they may do so, as long as it is additional to their assessed needs and it is a separate episode of care, with clearly separate lines of accountability and governance. They may not top up the direct payment with their own money to purchase more expensive care than that agreed in the Care Plan.

Where concerns are raised regarding how the PHB is being spent, the non NHS support service will inform the CCG to alert them to any concerns, and the CHC / CC lead at the Commissioning Support Unit.

These considerations are in addition to those set out at section [5.9] above, which requires review of an individual's Care Plan to ensure it remains appropriate to meeting the individual's needs.

6.16 Stopping or reducing direct payments

There is an ongoing duty to ensure that direct payments are reviewed. The amount provided under direct payments may be increased or decreased at any time, provided the new amount is sufficient to cover the full cost of the individual's care plan. PHBs and direct payments are not a welfare benefit and do not represent an entitlement to a fixed amount of money. A surplus may indicate that the individual is not receiving the care they need or too much money has been allocated. It should be noted that a surplus is different to a contingency – it is permissible to include an amount for contingency in a PHB, for example, to cover employment costs such as redundancy. As part of the review process, the CSU / CCG should establish why the surplus has built up. Under these circumstances, a reduction in direct payment in any given period cannot be more than the amount that would have been paid to them in the same period.

Before making a decision to stop or reduce a direct payment, wherever possible and appropriate, the CSU / CCG should consult with the person receiving it to enable any inadvertent errors or misunderstandings to be addressed, and enable any alternatives to be made.

Where direct payments have been reduced, the individual, their representative or nominee may request that this decision be reconsidered, and may provide evidence or relevant information to be considered as part of that deliberation. Where this happens, the individual, representative or nominee must be informed in writing of the outcome of the reconsideration and the reasons for this decision. The CSU / CCGs are not required to undertake more than one reconsideration of any such decision. If the individual remains unhappy about the reduction, they should be referred to the local NHS complaints procedure.

The CSU will stop making direct payments on behalf of the CCGs where:

- A person with capacity to consent, withdraws their consent to receiving direct payments;
- A person who has recovered the capacity to consent, does not consent to the direct payments continuing; or
- A representative withdraws their consent to receive direct payments, and no other representative has been appointed.

The CSU may stop direct payments if it is satisfied that it is appropriate to do so. For example where:

- the money is being spent inappropriately (e.g. to buy something which is not specified in the support plan);
- direct payments are no longer a suitable way of providing the person with care;
- a nominee withdraws their consent, and the person receiving care or their representative does not wish to receive the direct payment themselves;
- the CSU / CCG has reason to believe that a representative or nominee is no longer suitable to receive direct payments, and no other person has been appointed;
- where there has been theft, fraud or abuse of the direct payment; or
- if the patient's assessed needs are not being met or the person no longer requires care.

Where PHBs and direct payments are stopped, the CSU / CCG will give reasonable notice to the patient, their representative or nominee in writing, explaining the reasons behind the decision. There is no definition as to what constitutes "reasonable notice". It should be noted that, after a direct payment is stopped, all rights and liabilities acquired or incurred as a result of the service purchased by direct payments will be transferred to the CCG. This should therefore be considered. However, in some cases, it may be necessary to stop the direct payment immediately, for example, if fraud or theft has occurred.

6.17 Reclaiming a direct payment

The CSU can claim back PHBs and direct payments on behalf of the CCGs where:

- they have been used to purchase a service that was not agreed in the care plan;
- there has been theft or fraud; or
- the money has not been used (e.g. as a result of a change in the care plan or the individual's circumstances have changed) and has accumulated.

If a decision to reclaim payments is made, reasonable notice must be given to the individual, their representative or nominee, in writing, stating:

- the reasons for the decision;
- the amount to be repaid;
- the time in which the money must be repaid; and
- the name of the person responsible for making the repayment.

The individual, their representative or nominee may request that this decision be reconsidered and provide additional information to the CSU / CCG for reconsideration. Notification of the outcome of this reconsideration must be provided in writing and an explanation provided. The CSU / CCGs are not required to undertake more than one reconsideration of any such decision. If the individual remains unhappy about the reduction, they should be referred to the local NHS complaints procedure.

7.0 Using a direct payment to employ staff or buy services

7.1 Using a direct payment to employ staff

People may wish to use their direct payment to employ staff to provide them with care and support. In so doing, they will acquire responsibility as an employer and need to be aware of the legal responsibilities associated with this. This should not discourage people who would otherwise be willing and able to manage a direct payment. In order to ensure that people are appropriately informed and supported in meeting their duties as an employer, the CCGs have arranged for non NHS support services e.g. Salvere to provide information, advice and support. This includes support in relation to payroll, Human Resources and other employment related services. People should be made aware of the availability of this service, along with any others which may become available. Individuals, representatives and appointed nominees employing staff are strongly recommended to utilise the information, advice, guidance and payroll and HR facilities of non NHS support services (or an alternative agreed support service as a wider range or organisations become available) to ensure the legal responsibilities of being an employer are satisfied.

The costs associated with utilising a non NHS support service are met from the PHB allocation. This requires the PHB to be paid directly to these organisations so that their charges can be deducted. This cost should be factored in when setting the budget.

7.2 Employing a family member or person living in the same household

A direct payment can only be used to pay an individual living in the same household, a close family member (as defined in Appendix 8) or a friend if the CCG is satisfied that to secure a service from that person is necessary in order to satisfactorily meet the individual's need; or to promote the welfare of a child for who direct payments are being made. It is anticipated that this will be permitted in very limited circumstances. The CCGs must make judgements on a case by case basis.

Any arrangement of this nature must be formally agreed by the CSU / CCG, and recorded in writing in both the care plan and the PHB agreement.

The suitability will be reviewed at least every three months, (following the existing pathways for complex, children's and adults). This process includes reviewing, agreeing and signing off the risk identification and mitigation tool.

This restriction is not intended to prevent individuals from using direct payments to employ a live-in personal assistant. The restriction applies where the relationship between the two people is primarily person rather than contractual (for example, if the people concerned would be living together in any case).

7.3 Safeguarding and employment

People may wish to use their direct payment to employ staff to provide them with care and support. When deciding whether or not to employ someone, patients and their families should follow best practice in relation to safeguarding, vetting and barring including satisfying themselves of a person's identity, their qualifications and professional registration if appropriate and taking up references.

The CSU and CCGs have made arrangements with non NHS support services to provide advice and accessible services in relation to the provision of DBS checks for individual employers.

Individuals cannot request DBS checks on other individuals. However, an individual or their nominee or representative may wish to ask the CCG or another Umbrella Organisation e.g. a non NHS support service, if it is possible to arrange for the prospective employee or contractor to apply for an enhanced DBS check with a check of the adult's (or children's if appropriate) barred lists when employing or contracting with people who are not close family members or people living in the individual's household providing care to the individual but who are:

- regulated health care professionals – for example, nurses or physiotherapists
- people providing healthcare under the direction or supervision of a health care professional
- people providing personal care

Alternatively, if the individual can satisfy the DBS that they have a legitimate interest in knowing if that person is barred, the DBS may supply this information.

If the potential employee is barred they must not be used to supply services as they pose an ongoing risk to adults or children.

If the individual is contracting with a close family member or a person who is living in the individual's household or a friend it is not possible to undertake any DBS checks.

The DBS has recently launched the Update Service. This is a service that allows people to reuse their certificate for multiple roles. If a potential employee or contractor has subscribed to the Update Service and has a check of the appropriate level, the individual should ensure they see the person's original certificate and use the free online portal to check for up to date information on that certificate. If the certificate is not up to date the individual should ask the potential employee or contractor to apply for a new certificate.

7.4 Indemnity

Direct payments can be used to pay for a personal assistant (PA) to carry out certain personal care and health tasks that might otherwise be carried out by qualified healthcare professionals such as nurses, physiotherapists or occupational therapists. In such cases the healthcare professional and CSU / CCG will need to be satisfied that the task is suitable for delegation, specify this in the Care Plan and ensure that the PA is provided with the appropriate training and development, assessment of competence and have sufficient indemnity and insurance cover. More information on this can be found in the 'Personal assistants - delegation, training and accountability' document in the toolkit.

Indemnity is a complex area for individual employers, and one where sufficient support will need to be in place from the start to enable people to understand and be supported to meet any obligations they have.

Providers of some services may need to conform with prospective legislation which will implement the Finlay Scott Recommendations (June 2010) on indemnity cover and Article 4(2) (d) of Directive 2011/24/EC. NHS England will provide further guidance on what this covers in due course.

PAs employed via a direct payment do not need to comply with the legislation that will require them to have indemnity cover if practising unless they are a member of a regulated health profession (see Appendix 9), even if carrying out activities which might otherwise be performed by health professionals. Care co-ordinators, the CSU & CCGs will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical tasks being carried by the PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and outcome recorded in the Care Plan.

The person buying services needs to be aware of whether the provider needs to comply with prospective legislation discussed above. If the provider does not need to comply people may, if they wish, buy services from providers who have limited or no indemnity or insurance cover. So long as the person buying the service is aware of the potential risks and implications, limited or no indemnity should not automatically be a bar to purchasing from a provider. This should be included in the discussion around risks when developing the Care Plan.

In the first instance, it will be the responsibility of the person buying the service to check the indemnity cover of the provider from which they are buying services. They must make enquiries to ascertain whether the provider has indemnity or insurance, and if so, whether it is proportionate to the risks involved, and otherwise appropriate.

If the person buying the service asks the CCG to undertake these checks on their behalf, the CCG must do so. Care co-ordinators and care planners should also ensure that people are aware that this is an option, and may wish to offer this as part of the risk assessment and care planning process.

Regardless of who carries out the initial check, the CCG will review this as part of the first review, to ensure the checks have been made and are appropriate.

7.5 Registration and regulated activities

If someone wishes to buy a service which is a regulated activity under the Health and Social Care Act 2008, they will need to inquire as to whether their preferred provider is registered with the Care Quality Commission (CQC). A direct payment cannot be used to purchase a regulated activity from a non-registered service provider.

If a person or related third party employs a care worker directly, without the involvement of an agency or employer, the employee does not need to register with CQC. A related third party means:

(a) an individual with parental responsibility for a child to whom personal care services are to be provided

(b) an individual with power of attorney or other lawful authority to make arrangements on behalf of the person to whom personal care services are to be provided

(c) a group or individuals mentioned in a) and b) making arrangements on behalf of one or more persons to whom personal care services are to be provided

(d) a trust established for the purpose of providing services to meet the health or social care needs of a named individual

This means that individual user trusts, set up to make arrangements for nursing care or personal care on behalf of someone, are exempt from the requirement to register with the CQC.

Also exempt are organisations that only help people find nurses or carers, such as employment agencies (sometimes known as introductory agencies), but who do not have any role in managing or directing the nursing or personal care that a nurse or carer provides.

If someone wishes to use a direct payment to purchase a service which is not a regulated activity, they may do so.

In some circumstances, the provider may also need to be a registered member of a professional body affiliated with the Council for Healthcare Regulatory Excellence. If the Care Plan specifies that a task or tasks require a registered professional to undertake it, only a professional who is thus registered may be employed to perform that task or tasks. See Appendix 8.

In the first instance it will be the responsibility of the person buying the service to check whether the provider they are purchasing from is appropriately registered. They can request the CCG investigate this, and if they ask, the CCG must do so. As with indemnity cover, the CCG must also review this as part of their assessment as to whether the direct payment is being effectively managed.

While some service providers, for example aroma therapists, are not statutorily required to be registered, there are professional associations with voluntary registers that practitioners can choose to join. Typically, such practitioners can only join these associations or registers if they meet the standards of education, training, conduct and performance required by the professional body. However, there is no legal requirement to join these registers, and practitioners can still offer unregulated services without being a member of any organisation. If a provider is not registered with an appropriate body this should not automatically be a bar to purchasing from that provider but this should be included in the discussion around risks when developing the Care Plan.

8.0 Service User Evaluation

It is vital that CCG's have systems and processes in place to review the effectiveness of PHB's to provide assurance that the individual support plans are; clinically safe, effective and meeting individual needs and outcomes. To facilitate evaluation the CCG are utilising the Patient Experience Outcome Tool (POET), which was developed by Lancaster University. POET is designed specifically for PHB budget holders and family carers to provide insight into the experiences of personal health budget holders and their families. POET also aims to shows the impact having control over the budget has on their lives.

All PHB budget holders will be provided with an opportunity and or supported to complete the POET on an annual basis as part of their annual review. The results will be collated and reported to the CCG on an annual basis, as part of ongoing cycle of evaluation. The process of POET will be carried out by the CCG Commissioning Support Unit on behalf of the CCG.

9.0 Equal Opportunities / Equalities Impact Assessment

An Equality Impact Assessment has been completed and approved by the Equality & Inclusion Panel on 4th November 2015 for this policy and procedure and it does not marginalise or discriminate minority groups.

10.0 Review Date

This policy and procedure will be reviewed in April 2016 and will be reviewed and updated at the request of Southport & Formby CCG or earlier in light of any changes to legislation or National Guidance.

11.0 Further Information

The NHS England website has a section dedicated to PHBs. This has information about national policy, the implementation toolkit, stories and other resources.

www.personalhealthbudgets.england.nhs.uk

The Peer Network, a user-led organisation for PHBs, has its own website: www.peoplehub.org.uk

12.0 Appendices

Appendix 1 - Personal Health Budgets Pathway

Appendix 2 - PHB Care Plan

Appendix 3 – Capacity and Consent

Appendix 4 – PHB Checklist

Appendix 5 – Personal Health Budget Agreement (Adult)

Appendix 6 – Personal Health Budget Agreement (Child)

Appendix 7 – Close Family Members

Appendix 8 – Regulatory Bodies

Appendix 9 – Timescales for Appealing Personal Health Budgets Decisions

Appendix 1

Personal Health Budgets Pathway

1.0 Introduction

1.1 This procedure details the steps required from the agreement of a Personal Health Budget (PHB) to promptly expediting the first payment to the relevant organisation/individual.

1.2 Non-compliance with this procedure could cause delays to the commencement date of the PHB funded package of care resulting in dissatisfaction from families and direct payment support services and non NHS support services e.g. Salvere, Your Life Your Way and Solo (or an alternative agreed support service as a wider range or organisations become available).

2.0 Process

2.1 The CCG appropriate panel will approve a PHB for an individual. This will include the financial value of the PHB, specified as an annualised amount.

2.2 From the date of the Panel and the agreement for a PHB, the relevant direct payment support services and third party budget agencies are required to invoice the relevant CCG via SBS. On receipt of an invoice it can take up to 30 calendar days for the invoice to be paid. The invoice must state the correct Broadcare reference number. The value of the invoice should equate to 3 months (i.e. one quarter) of the annualised budget.

2.3 To facilitate this process the CSU are to complete a 'Financial Commitment Form' for all PHBs. The form will include the following details as agreed by the Panel:

- Broadcare reference number
- Type of PHB (notional payment, direct payment or third party budget)
- Type of package (adult, children's, complex mental health etc.)
- Organisation/Individual to whom PHB invoices are to be paid.
- PHB start date (this must be at least 30 days, after the panel date)
- End Date (if applicable)
- Review Date (this must be within 12 weeks if it is a direct payment)
- Annualised value
- Forecast charge in current financial year
- Percentage of PHB to be funded by Local Authority (if applicable)
- Details (including telephone number) of a named CSU contact / DN (named health professional) and locality team contact number
- Space for the form to be signed by a CCG authorised signatory. It is acknowledged that each CCG will have its own Scheme of Delegation and authorisation limits.

2.4 Upon completion the form is to be:

- Retained by the CSU to hold on the individual's file and for entry into Broadcare;
- Sent to the relevant direct payment support service / third party budget agency in order for them to promptly raise an invoice to the CCG;
- Sent to the relevant CCG so they can anticipate and approve the invoice from the third party agency, as well as incorporate the information into financial forecasts. If the invoice is consistent with the amount as specified in paragraph 2.2 then the CCG must not delay approving the payment on SBS. If there is a discrepancy the CCG is to contact the CSU to understand the reasons for this. If the issue is still unresolved then the CSU should query the invoice with the third party agency.

2.5 If the non NHS support service has not received payment by the agreed date then it should escalate the issue to the named contact on the Financial Commitment Form.

Appendix 2

Personal Health Budget Care & Support Plan for Southport and Formby CCG

Tables 1, 2 & 3 to be completed by NHS staff before submitting to the PHB Support Service, Table 3 must be signed by the patient or their representative. The Support Service and Patient complete the remainder of the Tables

Table 1 - To be completed by the NHS Named Health Professional (NHS)

Patients Name	Title	D.O.B (DD/MM/YYYY)
Address		Postcode
Home Telephone	Mobile	E-mail
Named Health Professional Name: Tel: E-mail	Request submitted to the following Support Service:	Indicative Budget amount: Annual £ Weekly £ Number of hours per week:

Table 2 - To be completed by the NHS Named Health Professional (NHS)

Patients Health Needs	Activities / Provisions	How the activities / provisions will meet my health and wellbeing needs
To be completed by the NHS Named Health Professional (NHS)	To be completed by the Support Service & Family	To be completed by the Support Service & Family
Add / delete rows as required		

Table 3 - To be completed by the NHS Named Health Professional (NHS) and patient

Declaration	
Please sign this document to show you give your consent (on the date of signing) that the details within this plan can be shared with the Support Service of your choice	
Signature of Patient	Date
Please provide the name of the chosen Support Service who will support you to develop a plan and a financial budget showing how you intend to meet your health and wellbeing needs	Name of chosen Support Service
If patient/ client is unable to sign, an appropriate adult representative with decision making responsibility OR consent from the patient / client should complete the fields below. This signature confirms that you give your consent to this document being shared with your chosen Support Service	
Name:	Relationship to patient:
Signature	Date

Table 4 - To be completed by the Support Service & Family

Significant People in your life In this section please include family and friends, health professionals, care agencies, carers, colleagues, neighbours and any others who play an important part of your life, even if they are not directly involved in your health care			
Name	Are they registered with CQC (Yes / No or N/A)	Contact Details	Do they help you make decisions?

Table 5 - To be completed by the Support Service & Family

Risk Assessment In this section please include any required risk assessments			
Type of risk assessment	Completed Yes / No / N/A	Proposed Risk Mitigation	Action taken / Agreed by Patient
Equipment (e.g. medical devices, consumables, therapy equipment etc.)			
Moving & Handling			
Environment			
Drug Management including covert medication policy if applicable			
Fire			
Managing Behaviour (Personal Intervention Plan)			
Nutritional (e.g. Malnutrition Universal Screening Tool)			
Pressure Area			
Others (add rows if applicable)			

Table 6 - To be completed by the Support Service & Family

Risks PAs do not need to comply with the legislation that will require them to have indemnity cover, unless they are a member of a regulated health profession, even if carrying out activities which might otherwise be performed by health professionals. The Support Service will need to consider and discuss with the person, their nominee or representative, the potential risks associated with the clinical tasks being carried out by the PAs on a case by case basis. This needs to form part of the risk assessment and care planning process and the outcome recorded in the care plan			
Identified Clinical Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient
Identified Financial Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient
Other Identified Risk	Impact on Health & Wellbeing	Proposed / Advised Mitigation Action	Action Taken / Agreed by Patient

Table 7 - To be completed by the Support Service & Family

Support to Manage Personal Health Budget	How will this be managed and by who
Support for sourcing package of care for either agency or PA's	
Recruitment support - Tax, NI, Pension, Employment Rights / Law, Min Wage etc.	
DBS Checks (formerly CRB) and barred lists have been checked for all staff including nominees, representatives and family members (if applicable)	
Appropriate training and accountability measures including assessment of competencies are in place	
Insurance cover in place (employers and public liability etc.)	
Contracted Health professional(s) are registered with the appropriate body and have appropriate indemnity cover	
Identity, qualifications and professional registration checks for employees and the taking up of references has been explored and an approach to manage this agreed and recorded	
Management of the personal health budget	
Payment to staff i.e. Payroll (dependent on type of budget taken)	
Preparation and submission of financial monitoring information	
If any regulated activities are provided by agencies they must be registered with CQC	

Table 8 - To be completed by the Support Service & Family

Finally, your support plan must demonstrate how you have thought about and addressed any unforeseen or difficult times. To be completed by the Support Service & Family
What happens if something unforeseen happens? Please detail below
Add / delete rows as required

Table 9 - To be completed by the Support Service with the patient

Budget – How the Personal Health Budget will be spent		
Area:	Weekly Cost £	Yearly Total £
Staff: including NI, Pension, holiday pay, holiday cover		
Staff hours for shadow training		
DBS checks		
Redundancy		
Agency Fees		
Respite Costs		
Recruitment & Advertising		
Equipment		
Consumables – PPE; Printing		
Training: including clinical competencies / supervisions		
Transport		
Insurance		
Contingency costs; additional training for the new staff; emergency agency fees		
Support Service Charge		
List others costs as applicable		

Total		

Table 10 - To be completed by the Support Service with the patient

Declaration	
Please sign this document to show you agree (on the date of signing) that the details within this plan meet your Health and Wellbeing needs and that in your opinion you have been sufficiently involved in the putting together of your support plan. That you give your consent for the support planner to share this completed plan with appropriate persons involved in the PHB provision.	
Signature of Patient	**Date**
Name of Organisation Support Planning	
If patient / client is unable to sign, an appropriate adult representative with decision making responsibility OR consent from the patient /client should complete the fields below. That you give your consent for the support planner to share this completed plan with appropriate persons involved in the PHB provision.	
Name	**Relationship to patient**
Signature	**Date**

Appendix 3 **Capacity & Consent**

PHB arrangements can only be made where appropriate consent has been given by:

- a person aged 16 or over who has the capacity to consent to the making of direct payments to them;
- the suitable representative of a person aged 16 or over who lacks capacity to consent themselves to receipt of a PHB by way of a direct payment;
- the suitable representative of a child under 16.

Capacity

Under the MCA, there is a presumption that everyone over the age of 16 has capacity to make decision for themselves, unless they are assessed as lacking capacity.

When assessing a person's capacity to make a decision, the assessor should follow the two stage test set out under the MCA which asks:

1. Does the person have an impairment of the mind or brain, or is there some disturbance in the functioning of their mind or brain?
2. If so, does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made? Are they able to:
    a. A Understand the issues relevant to the decision
    b. Retain the information relevant to the decision
    c. Weight up to the pros and cons of the decision
    d. Communicate their decision having done so

Capacity is time and issue specific. For example, a person may be able to make a decision about who they would like to support them, but not about how to manage a PHB. PHBs should remain an option for all eligible patients regardless of whether they are deemed to have capacity or not.

There are a number of important decision-making points in setting up and managing PHBs. Where a person lacks the capacity to make a particular decision, their views must still be sought to the extent possible.

Wherever possible a person should be supported to be as involved as possible in all aspects of their PHB including the support planning process. To enable a person to understand their options and to help them feel at ease, those supporting them in their decision making need to think about:

- using the person's preferred methods of communication
- a suitable location
- the persons' privacy and dignity
- letting the person make the decision at their own pace

The Best Interests Principle

Under the MCA, anyone making decisions or acting on behalf of someone who lacks capacity has a duty to act in that person's best interests. Therefore, people who lack the capacity to consent to and manage PHBs can still receive one, including by way of a direct payment, if this is believed to be in their best interests (in accordance with the MCA).

Section 4 of the Mental Capacity Act sets out a checklist of factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. This checklist includes a duty to:

- encourage the person to participate or improve their ability to take part in making the decision
- identify all the relevant circumstances
- consider the person's views (past and present)
- avoid discrimination - not simply make assumptions about someone's 'best interests' on the basis of their age, appearance, condition or behaviour
- assess whether the person might regain capacity and whether the decision can wait until that time
- if the decision concerns life-sustaining treatment the decision maker should not be motivated in any way by a desire to bring about the person's death
- consult those close to the patient for their views about the person's 'best interests'
- avoid restricting the person's rights by seeing if there are other options that may be less restrictive of the person's rights
- weigh up all of the above factors in order to determine best interests

This is not an exhaustive list of factors and the decision maker is under a duty to take into account "all relevant circumstances".

Decisions about the treatment and care of a patient who lacks capacity should follow the same best interests framework as outlined above.

Fluctuating Capacity

Where a person who has agreed to a care plan and consented to the making of direct payments to them subsequently loses their capacity to consent, the CCG may, where it is satisfied that the loss of capacity is temporary, allow a representative to be appointed to receive direct payments on their behalf, or an existing nominee to continue to receive them, until they regain capacity. In these circumstances, the role will be similar to that of a representative for someone who has been assessed to lack capacity on an ongoing basis.
Where someone's capacity to consent fluctuates, for example where a person's mental illness is such that it impairs their capacity to make decisions at certain times but not others, it is important that there should be continuity of care, and any disruption should be as minimal as possible. It may be helpful to work with people with fluctuating conditions to draw up advance decisions under the MCA and contingency plans to ensure that their care in a

crisis, better meets their wishes, including the identification of a nominee or representative who may take control of the direct payment at such times.

When a person with fluctuating capacity gains or regains their capacity to consent, their consent is needed to continue the direct payments. If they consent, the representative or nominee must agree to continue their role in respect of the direct payment until a review is held. This is because it is the representative, not the person who has gained or regained capacity who, consented to the arrangements. This allows direct payments to continue until the CCG can arrange a review, which it must do as soon as is reasonably possible. At this review, the CCG and the person receiving care will review and if necessary develop a new care plan. However, if the person who has gained or regained capacity, does not consent to the representative or their nominee continuing in that role until a review is held, or if the representative or nominee does not wish to continue in that role, then direct payments must stop. As in all circumstances when direct payments stop, alternative provision should be made to ensure continuity of care until the required review takes place and new arrangements, which may include direct payments, are put in place.

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Appendix 4

PHB Care Plan Sign Off Sheet – Right to Have

To Be Completed by the Direct Payment / Third Party Support Service

Patient Details

About Whom?	Surname: …… First Name(s): …… Broadcare Number: …….. Responsible CCG: ……

Care Plan Checklist

Named Care Coordinator	Named care coordinator is recorded in the care plan	**Yes / No**	**N/A Please add explanatory text**
Review	Anticipated date of the first review (at least within three months of the person receiving a direct healthcare payment)	**DD/MM/YYYY**	
Risk Assessments Completed	Risk assessments included within the care plan and agreed as appropriate	**Yes / No**	**N/A**
Clinical risks recorded	Clinical risks recorded in the care plan including risk mitigation	**Yes / No**	**N/A**
Regulated activities must be carried out by CQC registered providers	Are or will any 'regulated activities' be commissioned from a provider?	**Yes / No**	**N/A**
Care Agencies	Is the provider CQC registered?	**Yes / No**	**N/A**
Meeting Health Needs	Does the Care Plan set out the health needs that the direct healthcare payment is to address?	**Yes / No**	**N/A**
	Is it clear to both CSU/CCG and the people involved what the direct healthcare payments are meant to achieve?	**Yes / No**	**N/A**
	Does the plan specify the services to be secured by the direct healthcare payment in order to achieve the health (and wellbeing) needs?	**Yes / No**	**N/A**
	Is the budget sufficient to meet all of the above?	**Yes / No**	**N/A**
	Are the identified clinical tasks	**Yes / No**	**N/A**

	suitable for delegation, specified in the care plan, with appropriate training, development and assessment of competence in place and sufficient indemnity and insurance cover?		
	Safeguarding has been considered by CSU/CCG?	**Yes / No**	**N/A**
	Is the liberty of the patient being promoted by the care plan? This is especially important where the patient lacks capacity, and or when there are safeguarding issues and /or the patient is in a vulnerable situation.	**Yes / No**	**N/A**
Provision of Information / Advice & Guidance	Has the person, their representative or nominee received information, advice and support from YLYW, SOLO Support Services or Salvere?	**Yes / No**	**N/A**
Are you satisfied that sufficient support has and will be provided to ensure:	The development and agreement from CSU / CCG of an appropriate care plan?	**Yes / No**	**N/A**
	Payroll, Tax and NI are managed effectively	**Yes / No**	**N/A**
	The direct healthcare payment will be managed appropriately?	**Yes / No**	**N/A**
	Monitoring, audit responsibilities and accountabilities are understood and can be adhered to?	**Yes / No**	**N/A**
	The employment of PAs & understanding of employer responsibilities is fully understood and will be adhered to?	**Yes / No**	**N/A**
	Regulated activities, will and are only commissioned from CQC registered providers?	**Yes / No**	**N/A**
	Appropriate insurances are, and remain, in place for the employer?	**Yes / No**	**N/A**
	Appropriate registration is in place?	**Yes / No**	**N/A**
	Appropriate training & development, assessment of competence, sufficient indemnity and insurance cover is, and remains, in place for employed PAs and providers?	**Yes / No**	**N/A**
	The costs for this and ongoing	**Yes / No**	**N/A**

	support from YLYW / SOLO Support Services / Salvere are set out within the care plan?		
	There are sufficient funds to meet the support service costs and meet all of the health needs safely?	**Yes / No**	**N/A**
	Family members, close relatives and people living in the same home as the patient or their partners will not be employed unless agreed by the CSU / CCG? **(If the CCG is considering such a request please complete appendix 1)**	**Yes / No**	**N/A**
Consent & Capacity	Does the patient or Person with Parental responsibility for a child 16 or under - have capacity to consent to a PHB / direct payment	**Yes / No**	**N/A**
	Has the patient / Person with Parental responsibility for a child 16 or under - consented to a PHB / direct payment **(if no Representatives and Nominees section below must be completed - see below)**	**Yes / No**	**N/A**
Representatives and Nominees	Any representative and / or nominee must be agreed by the CCG / CSU. Does the CCG approve the named representative and / or nominee **(When considering such a request please complete appendix 2)**	**Yes / No**	**N/A**
PHB Start Date	The intended commencement date of the PHB:	**DD/MM/YYYY**	

Appendix 1
Employing family members, close relatives and/or people living in the same household as the patient or their partners
If family members, close relatives and/or people living in the same household as the patient or their partners will be employed using a direct healthcare payment the CCG / CSU must record this here. The CCG / CSU will need to confirm that this is necessary in order to satisfactorily meet the person receiving care's need for that service; or to promote the welfare of a child for whom direct healthcare payments are being made. **Name / Relationship** **……** Has the CCG / CSU agreed to any family members, close relatives, people living in the same household or their partners being employed? **Yes / No / N/A** Please include details below, the name of the person(s), relationship, what has been agreed and the reason for this, including the time period and review timeframe for

this decision.

Appendix 2	
Capacity Does the patient have capacity?	**Yes / No**
Consent Has the patient (16+) consented to a PHB and / or direct healthcare payment or Have the child's (under 16) parent(s) / those with parental responsibility consented to a PHB and / or direct health care payment	**Yes / No** **Yes / No**
Has the Patient consented to receiving a PHB / direct healthcare payment and fulfilling all of the responsibilities of someone receiving a PHB / direct healthcare payment?	**Yes / No**

Representatives	**If No is used Representative do not complete**
For patients (16+) unable to consent to a PHB / direct healthcare payment a Representative can be appointed. For children (under 16) a parent or those with parental responsibility for the child must be appointed as a Representative.	
The CCG / CSU must ensure that the Representative has consented to receiving a direct healthcare payment and fulfilling all of the responsibilities of someone receiving direct healthcare payments.	
Name of agreed Representative:	
Has the Representative consented to receiving a direct healthcare payment and fulfilling all of the responsibilities of someone receiving a direct healthcare payment?	**Yes / No**
The CCG / CSU must give consent and consider whether the person is competent and able to manage direct healthcare payments.	
Does the CCG / CSU consent to the Representative? Does the CCG / CSU consider the representative is competent and able to manage direct healthcare payments?	**Yes / No** **Yes / No**
Has the Representative applied for an Enhanced DBS check? Parents or those with Parental responsibility for a child (under 16) do not ordinarily need to apply, neither do family members living in the same household	**Yes / No / N/A**
Has the Representative been checked against the Adults' / Children's Barred List? Parents or those with Parental responsibility for a child (under 16) do not ordinarily need to apply, neither do family members living in the same household	**Yes / No / N/A**
Are the results of both of these checks satisfactory?	**Yes / No / N/A**

Employing Relatives

Will the Representative be paid or employed in any capacity using the direct healthcare payments?	**Yes / No**
Will / is the Representative paid or employed in any capacity by the PHB support service e.g. YLYW / SOLO Support Services or Salvere?	**Yes / No**
Will any partner, relative, friend or person living in the same household as the patient / their Representative be paid or employed in any capacity using the direct healthcare payment?	**Yes / No**

If the CCG / CSU cannot approve the proposed Representative or wishes to attach conditions to the PHB the reason / conditions must be recorded here:

Nominees	
Is a nominee being requested?	**Yes / No**
If yes please complete the remainder of this section	
A Representative or a person with capacity (16+) can choose a Nominee.	
Has the Nominee consented to receiving a PHB / direct healthcare payment and fulfilling all of the responsibilities of someone receiving a PHB / direct healthcare payment?	
Has the Nominee applied for an Enhanced DBS check?	**Yes / No**
Has the Nominee been checked against the adults'/children's barred list?	**Yes / No**
Are the results both of these checks satisfactory?	**Yes/No /N/A**
Will the Nominee be paid or employed in any capacity using the direct healthcare payments?	**Yes / No**
Will / is the Nominee paid or employed in any capacity by the PHB support service e.g. SOLO Support Services or Salvere?	**Yes / No**
Will any partner, relative, friend or person living in the same household as the patient / their nominee be paid or employed in any capacity using the direct healthcare payment?	**Yes / No**
Does the CCG / CSU consent to the Nominee?	**Yes / No**
Name of agreed Nominee	

If the CCG / CSU cannot approve the proposed Nominee or wishes to attach conditions to the PHB the reason / conditions must be recorded here:

NHS
Southport and Formby
Clinical Commissioning Group

Appendix 5

PERSONAL HEALTH BUDGET AGREEMENT (ADULT)

This document tells you about having a Personal Health Budget

1. Information about You and Community Services

This agreement is between:

[Enter name of relevant CCG here] Clinical Commissioning Group

_____

(Referred to in this agreement as 'we' or 'us')

and

Name and address of person receiving the Personal Health Budget

PLEASE PRINT:

First Name(s) _____

Surname _____

Address _____

_____

Post Code _____

(Referred to in this agreement as 'you')

In certain circumstances, including where you are under 16 or are unable to consent to your direct healthcare payment, someone else may legally consent to and manage your direct healthcare payments on your behalf. That person is called a 'representative'. Your representative will sign and agree to the terms of this agreement, and any other obligations on them under the regulations.

Your representative, if applicable and agreed by us is:

Name and address of Representative* or chosen decision maker

PLEASE PRINT:

First Name(s) ___ _____

Surname _____ _____

Relationship to 'you' _____

Address _____

_____

Post Code _____

*Referred to in this agreement as 'Representative' who has been appointed to arrange the services and manage the direct healthcare payment on behalf of the Patient who lacks capacity, and who has been agreed by 'Us'.

And, if applicable you or your representative is entitled to appoint a nominee to take on the contractual responsibilities including arranging the services and support detailed in your support plan, the nominee will also become responsible for how the money is spent. Where we agree to it your nominee will sign and agree to comply with the terms of this agreement and any other obligations on them under the regulations.

Name and address of Nominee

PLEASE PRINT:

First Name _____

Surname _____

Address _____

_____

_____

Post Code _____

(Referred to in this agreement as 'Nominee')

2. Basis of the Agreement

This agreement is made on the basis that:

- An assessment of your health needs has been completed with a health professional and it has been identified that you are eligible to receive health care funding.
- Your care plan will identify the care and / or support that you need to meet your assessed health care outcomes in order to maintain your independence.
- You are willing and able to secure the care / support detailed in your care plan yourself or with support**,** (from a Representative or Nominee) and we agree to make your Personal Health Budget available to you to purchase the support and / or care that you need.

Any payment made under this agreement will be subject to regular audit and monitoring by Salvere, Your Life Your Way or SOLO Support Services and us which may be reviewed by the Personal Health Budget Programme Board.

Further information about Your Life Your Way, SOLO Support Services and Salvere can be found at Appendix A.

3. Responsibilities of Your Nominated Representative (If you have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Representative, that person must be prepared to accept the following responsibilities:

- To involve you in decisions about your support
- To represent your best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Even if you need a Representative you still have the right to be involved whenever possible. There is a duty placed on the Representative to involve you in all relevant decisions where possible.

If the Representative repeatedly fails to make decisions that reflect these key responsibilities, then their role as a Representative would need to be reconsidered.

Representatives are appointed only with the CCGs approval. Representatives can be appointed for individuals who do not have the capacity to consent to a direct healthcare payment or for a child under 16 when Representatives can include the parents of the child or those with parental responsibility for that child.

If you gain or regain capacity your consent is required to continue your direct healthcare payment.

Where an individual in receipt of a direct healthcare payment subsequently loses their capacity to consent, and the CCG is satisfied this is temporary, the CCG may allow a Representative to be appointed to manage the direct healthcare payments or allow a Nominee to continue to manage them until a review can be arranged.

4. Responsibilities of Your Nominee (If you or your Nominated Representative have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Nominee, that person must be prepared to accept the following responsibilities:

- To involve you in decisions about your support
- To represent your best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Nominees must agree to act in the capacity of your Nominee and provide informed consent; the CCG must also consent to that Nominee acting in this capacity, and consider whether the Nominee is competent and able to manage direct healthcare payments with or without assistance.

You or your Representative may choose to elect a Nominee where you / your Representative wish to delegate all of the responsibilities of managing and receiving a direct healthcare payment.

5. About your Personal Health Budget

The amount of money you will receive

Start Date: _____
(Proposed) Breakdown of Payments:
Weekly (if applicable) £_____
One Off Value (if applicable) £ _____

The frequency of your payments will be discussed with you. However, payments are usually made to Solo Support Services / Salvere in advance on a three monthly basis and will be reviewed within the first 12 weeks and then annually, unless your health care needs change.

How you will receive your money

There are three main ways that you can receive your personal health budget:

1. A direct payment with support from Salvere
2. A cash budget held and managed by Your Life Your Way or SOLO Support Services
3. A 'Notional' budget

You will have all the options explained to you before you decide which is the best option for you. When you have decided which way you would like to receive your budget please mark your choice with an 'X' in the box.

A Direct Healthcare Payment

√

A direct healthcare payment is where we pay money to you. The money will be paid into a bank account set up for this purpose by Salvere.

- Your Personal Health Budget will be paid into a bank account, which will be opened by Salvere in your name / your Representative's name / your Nominee's name and managed by you or your nominated representative or nominee.
- You will need to sign this agreement
- You will need to sign an agreement with Salvere, this sets out the services they will provide to you, your Representative / Nominee and the charges they will deduct from your direct healthcare payment for these services. Salvere will advise you about this.
- You, your Representative or Nominee must take advice on becoming an employer from Salvere, as any employment, insurance and tax issues will be the responsibility of the employer. You will be required to adhere to all aspects of employment law.

- You will be required to provide evidence of how you have spent the money for audit purposes. You will need to keep a record of your income and expenditure including receipts, invoices, timesheets, payslips and bank statements. Salvere can help you to manage this

- The bank account will be audited by Salvere and us and therefore it is important that you / Salvere submit all receipts and invoices for related expenditure.

- Salvere may make direct healthcare payments directly to you / your Representative or Nominee however the CCG will need to approve this.

- See Section 6. Employing your own Staff

A √ **'cash budget' (third party arrangement) held and managed by SOLO / Your Life Your Way**

A cash budget is where the Clinical Commissioning Group pays your allocated budget to an organisation called either Your Life Your Way or SOLO Support Services, who hold the money for you and help you decide what you need. After you have agreed this with us, Your Life Your Way or SOLO Support Services will then buy and pay for the care and support you have chosen. Please note – Your Life Your Way or SOLO Support Services will employ your Personal Assistants if you choose to have a cash budget.

- The account is held and managed by Your Life Your Way or SOLO Support Services on your behalf

- Your Life Your Way or SOLO Support Services will buy the care and support you have chosen and take on the employment responsibilities

- You / your Representative / Nominee will need to sign an agreement with Your Life Your Way or SOLO Support Services; this sets out the services they will provide to you and the charges they will deduct from your Personal Health Budget for these services. Your Life Your Way or SOLO Support Services will advise you about this.

- You can request the balance of your bank account during working hours, Monday-Friday

- The bank account will be audited by Your Life Your Way or SOLO Support Services and us and therefore it is important that you / Your Life Your Way or SOLO Support Services submit all receipts and invoices for related expenditure.

√ **A Notional budget**

A Notional Budget enables you to be involved in planning your own care. The Clinical Commissioning Group will pay your service provider directly for any services that you have been assessed as needing. Please note - you cannot employ your own Personal Assistants if you choose to have a notional budget.

- The Clinical Commissioning Group will purchase and arrange the care and support from the provider(s) you have chosen
- The Clinical Commissioning Group will fund the care and support directly
- You will be involved in planning your care and support including developing your care plan

6. General Rules about How to Use the Money

Your Personal Health Budget enables you to buy the care, support or service that is detailed and agreed in your care plan.

The money cannot be spent on illegal services or activities, alcohol, tobacco, gambling or debt repayment.

You cannot use your Personal Health Budget to pay for primary or general medical services, for example GP services, vaccinations, dental charges, or optical appliances and hospital care.

If funds are used in this way the CCG may cease your Personal Health Budget and recover the inappropriately spent monies from you, your Representative / Nominee as appropriate.

Using a Care Agency

If you wish to use a care agency to provide a regulated activity you must purchase care from a provider who is registered with the Care Quality Commission, who regulate the standards of care agencies nationally. There is a list of registered providers available, please see www.cqc.org.uk for more information. Salvere / Your Life Your Way / SOLO Support Services or your named health professional can also advise you about choosing a care agency.

If you choose to purchase a service through a care agency then please be advised that the contract and agreed price is a private arrangement between you, your Representative or Nominee and the care agency. Should the care agency increase its prices in the future above the agreed personal health budget amount, or require you to give a period of notice, we recommend that you request a review of your care plan and budget by contacting your named health professional. It may be more cost effective for the CCG to commission the service directly from your preferred care agency and the CCG will provide you with the option of a notional budget to ensure value for money.

Employing your own staff

You may also use your Personal Health Budget to purchase a service from any willing trained provider. This may include employing a Personal Assistant. If a provider you choose requires training to enable them to carry out their role effectively, training must be undertaken to ensure that you receive a high quality service. Salvere can support you to access training as an employer and for your Personal Assistant(s).

We strongly recommend that a DBS check (Disclosure and Barring Service) is completed as part of the employment process. If you choose to employ your own staff you will have some legal responsibilities as an employer. These include but are not limited to providing:

- A statement of employment particulars including: providing a written contract; highlighting the location of the work; remuneration; period of notice etc. It is a legal requirement to have a written contract of employment between you and your member of staff

- Deducting Tax and National Insurance Contributions

- Adhering to Minimum Wage, Statutory Sick Pay and Maternity Entitlements and Responsibilities, Paternity leave and pay, Annual leave and pay, Adoption, Redundancy, Equal Opportunities, Unions and Health and Safety policies.

- You are legally required to take out Employers and Public Liability Insurance.

You will be responsible for all the employer responsibilities. Guidance can be obtained online at: www.direct.gov.uk: '*Employing a professional carer or personal assistant'* or www.hmrc.gov.uk

We recommend that you consult Salvere, who support people using direct healthcare payments for information and advice about becoming an employer. You cannot ordinarily employ family members or anyone who lives with you or the spouse / partner of a relative / anyone living in the same house as you*.

This will only be agreed if, the CCG is satisfied that to secure a service from that person is necessary to meet your needs or promote the welfare of a child.
This will be detailed here if agreed by us.

The CCG has agreed that the following family members (detailed above*) are employed by you, your Representative / Nominee: N/A Full Name N/A _____ Relationship _____ Reason _____

Representatives and Nominees and their relatives and partners cannot be employed to avoid any conflict of interest.

7. Record Keeping and Audit

You are required to keep basic records.

Your bank account will be audited through Salvere, Your Life Your Life or SOLO Support Services. Salvere, Your Life Your Way and SOLO Support Services are only able to make payments that are agreed in your care plan. The records will be subject to audit arrangements and Salvere, Your Life Your Way and SOLO Support Services will be audited annually (as a minimum).

The balance of the bank account will be reviewed regularly and any money that has not been allocated to your care or support excluding your contingency funds will be returned to

the Clinical Commissioning Group (unless a prior agreement has been made with your named health professional).

8. Review, Changed Needs, Contingency and Emergency Arrangements

The arrangements agreed within your care plan will be reviewed within the first 12 weeks and then at least annually. The review will determine if your health needs and your personal outcomes have been met or have changed, and to establish what has worked well or not worked well for you.

The Clinical Commissioning Group will arrange a review earlier or if we become aware that your health needs have changed and/or if your Personal Health Budget is insufficient to secure the services. You or your Representative can also ask for a review.

If your needs have changed during this period of time you may request an earlier review of your needs by contacting your named health professional.

You are required to make contingency arrangements within your care plan, which may include having a contingency fund. In crisis situations the Clinical Commissioning Group may, in the absence of alternative support, step in and help on an interim basis.

Primary care services, including access to your GP and emergency services, such as Accident and Emergency, will always be available to you regardless of having a Personal Health Budget. These services are not included in your budget.

If your needs change or something is not working, you or your Representative or Nominee, must contact your named health professional.

If you go into hospital, you or your Representative must inform us

9. Comments, Complaints and Compliments

You have a right to comment, complain or compliment through the Clinical Commissioning Group's complaints procedure about any action, decision or apparent failing of the Clinical Commissioning Group.

Contact the Customer Care Team:
by telephone: 0151 247 700
by email: Southportandformbyccg.complaints@nhs.net
by post: NHS Southport and Formby CCG
3rd Floor Merton House,
Stanley Road,
Bootle
L20 3DL

10. Ending the Agreement

Either you, your Representative or we may end this agreement by giving one months' notice in writing to the other party.

We may end this agreement with immediate effect if, after investigation, it is found:

- You are using the money illegally
- You are not using it in your own best interests
- Your Nominated Representative is found to be acting in a way that is not in your best interests

Wherever possible, we will work with you and your Representative to find a resolution to the issues before ending the agreement.

At the point of ending the agreement, any funds paid to you by the Clinical Commissioning Group which covers the period after the termination date, must be paid back in full.

Following a review if we decide to reduce the amount of or stop making your direct healthcare payment you, your Representative or Nominee may ask us to reconsider this decision, and can provide evidence or relevant information to inform the reconsideration. We will inform you, your Representative or Nominee in writing of the decision following the reconsideration and state the reasons for the decision.

If this agreement ends for any reason and you continue to have health needs, the funding for your health needs will be provided by the CCG as part of the NHS in the usual way.

11. Data Protection and Use of Data

We may share information that we hold or become aware of with other statutory agencies for the prevention of fraud and abuse.

12. Signatures

This is where all parties are signing up to this agreement. This means that we will all work to what has been agreed in this document.

1st Party:

Us – Signature on behalf of the Clinical Commissioning Group:

Signature: _____
Date: _____

2nd Party:

You – The person receiving the Personal Health Budget

Signature: _____
Date: _____

3rd Party:

Representative – the person receiving and managing the Personal Health Budget on behalf of the above named person
Signature: _____
Date: _____

4th Party:

Nominee – the person receiving and managing the Personal Health Budget on behalf of the above named Representative or person

Signature: _____
Date: _____

13. Annex A
SOLO Support Services and Your Life Your Way

SOLO Support Services and Your Life Your Way are the CCGs approved providers for a personal health budget deployed as a 'cash budget' (third party arrangement). SOLO Support Services and Your Life Your Way are both Care Quality Commission (CQC) registered care agencies.

SOLO Support Services and Your Life Your Way work with families to build care plans and hold your personal health budget for you. SOLO and Your Life Your Way buy and pay for the care and support you have chosen. Please note – SOLO and Your Life Your Way will employ your Personal Assistants if you choose to have a 'cash budget' (third party arrangement). SOLO and Your Life Your Way will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Your Life your Way / SOLO Support Services as part of your care plan.

Salvere

Salvere are the CCGs approved provider for making direct healthcare payments for personal health budgets. Salvere are a Community Interest Company who support and assist families to organise, buy and manage their care, including building your own care plan using a direct healthcare payment.

Salvere will help you to manage all of your responsibilities as an employer and help you to employ personal assistants, arrange payroll, pay HMRC, provide staff handbooks, contracts of employment, risk assessment, help you make decisions about disclosure barring service checks, and ensure appropriate training and competency checks are in place and ensure clinical tasks are delegated safely.

Salvere will hold your Personal Health Budget in a bank account, which will be opened in your name / your Representative's name / your Nominee's name and managed by you or your nominated representative or nominee. Salvere will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Salvere as part of your care plan.

Appendix 6

PERSONAL HEALTH BUDGET AGREEMENT (Children)

This document tells you about having a Personal Health Budget

NHS
Southport and Formby
Clinical Commissioning Group

2. Information about You and Community Services

This agreement is between:

(Enter name of relevant CCG here) Clinical Commissioning Group (Referred to in this agreement as 'we' or 'us')

and

Name and address of the child for who the Personal Health Budget is being made PLEASE PRINT: **First Name(s)** : **Surname:** **Address**   **Post Code** (Referred to in this agreement as 'the child')

In certain circumstances, including for people who are under 16 or people who are unable to consent to a direct healthcare payment, someone else may legally consent to and manage the direct healthcare payments on their behalf. That person is called a 'representative'. The representative will sign and agree to the terms of this agreement, and any other obligations on them under the regulations.

Once the child reaches 16 they will be able to consent to and receive the direct healthcare payment in their own right. The CCG will discuss the options with the child and may discuss the options with a person with parental responsibility at this time.

Your representative, if applicable and agreed by us is:

Name and address of Representative* or chosen decision maker

PLEASE PRINT:

First Name(s) :

Surname:

Relationship to 'the child' : Parent or person with parental responsibility

Address

Post Code

*Referred to in this agreement as 'you' or 'Representative' who has been appointed to arrange the services and manage the direct healthcare payment on behalf of a child for whom they have parental responsibility, and who has been agreed by 'Us'.

A representative is entitled to appoint a nominee to take on the contractual responsibilities including arranging the services and support detailed in the child's support plan, the nominee will also become responsible for how the money is spent. Where we agree to it your nominee will sign and agree to comply with the terms of this agreement and any other obligations on them under the regulations.

Name and address of Nominee

PLEASE PRINT:

First Name Not Applicable

Surname _____

Address _____

_____

_____

Post Code _____

(Referred to in this agreement as 'Nominee')

2. Basis of the Agreement

This agreement is made on the basis that:

- An assessment of your child's health needs has been completed with a health professional and it has been identified that your child is eligible to receive health care funding.
- Your child's care plan will identify the care and / or support that your child needs to meet their assessed health care outcomes in order to maintain your child's' independence.
- You - The parent / person with parental responsibility (Representative) is willing and able to secure the care / support detailed in your child's care plan yourself or with support**,** (from a Nominee) and we agree to make your child's Personal Health Budget available to you as the Representative to purchase the support and / or care that your child needs.

Any payment made under this agreement will be subject to regular audit and monitoring by Salvere or Your Life Your Way / SOLO Support Services and us which may be reviewed by the Personal Health Budget Programme Board.

Further information about Your Life Your Way, SOLO Support Services and Salvere can be found at Appendix A.

3. Responsibilities of the Nominated Representative

As part of the Clinical Commissioning Group agreeing to someone acting as a Representative, that person must be prepared to accept the following responsibilities:

- To involve the child in decisions about their support
- To represent the child's best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Even with a Representative a child still has the right to be involved whenever possible. There is a duty placed on the Representative to involve the child in all relevant decisions where possible.

If the Representative repeatedly fails to make decisions that reflect these key responsibilities, then their role as a Representative would need to be reconsidered.

Representatives are appointed only with the CCGs approval. Representatives can be appointed for individuals who do not have the capacity to consent to a direct healthcare payment or for a child under 16 when Representatives can include the parents of the child or those with parental responsibility for that child.

4. Responsibilities of Your Nominee (If you have one)

As part of the Clinical Commissioning Group agreeing to someone acting as your Nominee, that person must be prepared to accept the following responsibilities:

- To involve you and the child in decisions about the child's support
- To represent the child's best interests
- To consent to receiving and managing the direct healthcare payment, and
- Fulfilling all of the responsibilities of someone receiving direct healthcare payments

Nominees must agree to act in the capacity of your Nominee and provide informed consent; the CCG must also consent to that Nominee acting in this capacity, and consider whether the Nominee is competent and able to manage direct healthcare payments with or without assistance.

A Representative for the child may choose to elect a Nominee where the Representative wishes to delegate all of the responsibilities of managing and receiving a direct healthcare payment.

5. About your child's Personal Health Budget

The amount of money you will receive

Start Date: xx/xx/xx **(Proposed) Breakdown of Payments:** **Weekly (if applicable) £** **One Off Value (if applicable) £** **NOT APPLICABLE**

The frequency of the payments will be discussed with you. However, payments are usually made to Your Life Your Way / Solo Support Services / Salvere in advance on a three monthly basis and will be reviewed within the first 12 weeks and then annually, unless your health care needs change.

How you will receive the money

There are three main ways that you can receive the personal health budget:

4. A direct payment with support from Salvere
5. A cash budget held and managed by Your Life Your Way / SOLO Support Services
6. A 'Notional' budget

You will have all the options explained to you before you decide which is the best option for you. When you have decided which way you would like to receive the budget please mark your choice with an 'X' in the box.

A √ **Direct Healthcare Payment**

A direct healthcare payment is where we pay money to you. The money will be paid into a bank account set up for this purpose by Salvere.

- The Personal Health Budget will be paid into a bank account, which will be opened by Salvere in your name or the Nominee's name and managed by you or the Nominee.
- You will need to sign this agreement
- You will need to sign an agreement with Salvere, this sets out the services they will provide to you or your Nominee and the charges they will deduct from the direct healthcare payment for these services. Salvere will advise you about this.
- You or your Nominee must take advice on becoming an employer from Salvere, as any employment, insurance and tax issues will be the responsibility of the employer. You or your Nominee will be required to adhere to all aspects of employment law.
- You will be required to provide evidence of how you have spent the money for audit purposes. You will need to keep a record of all income and expenditure including receipts, invoices, timesheets, payslips and bank statements. Salvere can help you to manage this
- The bank account will be audited by Salvere and us and therefore it is important that you / Salvere submit all receipts and invoices for related expenditure.
- Salvere may make direct healthcare payments directly to you or your Nominee however the CCG will need to approve this.
- See Section 6. Employing your own Staff

A √ **'cash budget' (third party arrangement) held and managed by SOLO or Your Life Your Way**

A cash budget is where the Clinical Commissioning Group pays the allocated budget to an organisation called Your Life Your Way, SOLO Support Services, who hold the money for you and help you decide what you and your child need. After you have agreed this with us, Your Life Your Way, SOLO Support Services will then buy and pay for the care and support you have chosen. Please note – Your Life Your Way, SOLO Support Services will employ your Personal Assistants if you choose to have a cash budget.

- The account is held and managed by Your Life Your Life or SOLO Support Services on your behalf
- Your Life Your Way or SOLO Support Services will buy the care and support you have chosen and take on the employment responsibilities
- You or your Nominee will need to sign an agreement with Your Life Your Way / SOLO Support Services; this sets out the services they will provide to you and the charges they will deduct from your Personal Health Budget for these services. Your Life Your Way / SOLO Support Services will advise you about this.

- You can request the balance of your bank account during working hours, Monday-Friday

- The bank account will be audited by Your Life Your Way / SOLO Support Services and us and therefore it is important that you / SOLO Support Services / Your Life Your Way submit all receipts and invoices for related expenditure.

√ **A Notional budget**

A Notional Budget enables you to be involved in planning your child's care. The Clinical Commissioning Group will pay your service provider directly for any services that your child has been assessed as needing. Please note - you cannot employ your own Personal Assistants if you choose to have a notional budget.

- The Clinical Commissioning Group will purchase and arrange the care and support from the provider(s) you have chosen

- The Clinical Commissioning Group will fund the care and support directly

- You will be involved in planning your child's care and support including developing your child's care plan.

6. General Rules about How to Use the Money

The Personal Health Budget enables you to buy the care, support or service that is detailed and agreed in your child's care plan.

The money cannot be spent on illegal services or activities, alcohol, tobacco, gambling or debt repayment.

You cannot use your Personal Health Budget to pay for primary or general medical services, for example GP services, vaccinations, dental charges, or optical appliances and hospital care.

If funds are used in this way the CCG may cease your Personal Health Budget and recover the inappropriately spent monies from you or your Nominee as appropriate.

Using a Care Agency

If you wish to use a care agency to provide a regulated activity you must purchase care from a provider who is registered with the Care Quality Commission, who regulate the standards of care agencies nationally. There is a list of registered providers available, please see www.cqc.org.uk for more information. Salvere / SOLO Support Services / Your Life Your Way or your child's named health professional can also advise you about choosing a care agency.

If you choose to purchase a service through a care agency then please be advised that the contract and agreed price is a private arrangement between you or your Nominee and the care agency. Should the care agency increase its prices in the future above the agreed personal health budget amount, or require you to give a period of notice, we recommend that you request a review of your child's care plan and budget by contacting your child's named health professional. It may be more cost effective for the CCG to commission the service

directly from your preferred care agency and the CCG will provide you with the option of a notional budget to ensure value for money.

Employing your own staff

You may also use your Personal Health Budget to purchase a service from any willing trained provider. This may include employing a Personal Assistant. If a provider you choose requires training to enable them to carry out their role effectively, training must be undertaken to ensure that your child receives a high quality service. Salvere can support you to access training as an employer and for your child's Personal Assistant(s).

We strongly recommend that a DBS check (Disclosure and Barring Service) is completed as part of the employment process. If you choose to employ your own staff you will have some legal responsibilities as an employer. These include but are not limited to providing:

- A statement of employment particulars including: providing a written contract; highlighting the location of the work; remuneration; period of notice etc. It is a legal requirement to have a written contract of employment between you and your member of staff

- Deducting Tax and National Insurance Contributions

- Adhering to Minimum Wage, Statutory Sick Pay and Maternity Entitlements and Responsibilities, Paternity leave and pay, Annual leave and pay, Adoption, Redundancy, Equal Opportunities, Unions and Health and Safety policies.

- You are legally required to take out Employers and Public Liability Insurance.

You will be responsible for all the employer responsibilities. Guidance can be obtained online at: www.direct.gov.uk: '*Employing a professional carer or personal assistant'* or www.hmrc.gov.uk

We recommend that you consult Salvere, who support people using direct healthcare payments for information and advice about becoming an employer. You cannot ordinarily employ family members or anyone who lives with you or the spouse / partner of a relative / anyone living in the same house as you*.

This will only be agreed if, the CCG is satisfied that to secure a service from that person is necessary to meet the child's needs or promote the welfare of the child.
This will be detailed here if agreed by us.

The CCG has agreed that the following family members (detailed above*) are employed by you or your Nominee: Full Name: _____Not Applicable_____ Relationship _____ Reason _____

Representatives and Nominees and their relatives and partners cannot be employed to avoid any conflict of interest.

7. Record Keeping and Audit

You are required to keep basic records.

Your bank account will be audited through Salvere, Your Life Your Way or SOLO Support Services. Salvere, Your Life Your Way and SOLO Support Services are only able to make payments that are agreed in your child's care plan. The records will be subject to audit arrangements and Salvere, Your Life Your Way and SOLO Support Services will be audited annually (as a minimum).

The balance of the bank account will be reviewed regularly and any money that has not been allocated to your child's care or support excluding your contingency funds will be returned to the Clinical Commissioning Group (unless a prior agreement has been made with your named health professional).

8. Review, Changed Needs, Contingency and Emergency Arrangements

The arrangements agreed within your child's care plan will be reviewed within the first 12 weeks and then at least annually. The review will determine if your child's health needs and personal outcomes have been met or have changed, and to establish what has worked well or not worked well for you and your child.

The Clinical Commissioning Group will arrange a review earlier if we become aware that your child's health needs have changed and/or if the Personal Health Budget is insufficient to secure the services. You can also ask for a review if your child's needs have changed during this period of time - you may request an earlier review of your child's needs by contacting your child's named health professional.

You are required to make contingency arrangements within your child's care plan, which may include having a contingency fund. In crisis situations the Clinical Commissioning Group may, in the absence of alternative support, step in and help on an interim basis.

Primary care services, including access to your child's GP and emergency services, such as Accident and Emergency, will always be available to your child regardless of having a Personal Health Budget. These services are not included in your budget.

If your child's needs change or something is not working, you or your Nominee, must contact your child's named health professional. If your child goes into hospital, you must inform us so that we can consider whether an adjustment to the personal health budget is needed for services which are not provided while your child is in hospital.

9. Comments, Complaints and Compliments

You have a right to comment, complain or compliment through the Clinical Commissioning Group's complaints procedure about any action, decision or apparent failing of the Clinical Commissioning Group.

Contact the Customer Care Team:
by telephone: 0151 247 700
by email: Southport and formbyccg.complaints@nhs.net
by post: NHS Southport and Formby CCG

3rd Floor Merton House,
Stanley Road,
Bootle
L20 3DL

10. Ending the Agreement

Either you or we may end this agreement by giving one months' notice in writing to the other party.

We may end this agreement with immediate effect if, after investigation, it is found:

- You are using the money illegally or for any purpose which is not permitted in this Agreement or in the child's care plan
- You are not using the money in your child's best interests or as agreed with us
- You are found to be acting in a way that is not in the child's best interests

Wherever possible, we will work with you to find a resolution to the issues before ending the agreement.

At the point of ending the agreement, any funds paid to you by the Clinical Commissioning Group which covers the period after the termination date, must be paid back in full.

Following a review if we decide to reduce the amount of or stop making the direct healthcare payment you or your Nominee may ask us to reconsider this decision, and you may provide evidence or relevant information to inform the reconsideration. We will inform you or your Nominee in writing of the decision following the reconsideration and state the reasons for the decision.

If this agreement ends for any reason and your child continues to have health needs, the funding for your health needs will be provided by the CCG as part of the NHS in the usual way.

11. Data Protection and Use of Data

We may share information that we hold or become aware of with other statutory agencies for the prevention of fraud and abuse.

12. Signatures

This is where all parties are signing up to this agreement. This means that we will all work to what has been agreed in this document.

1st Party:

Us – Signature on behalf of the Clinical Commissioning Group:

Signature: _____
Date: _____

2nd Party:

You / The Representative– The person receiving the Personal Health Budget on behalf of a child for who you have parental responsibility

Signature: _____
Date: _____

3rd Party:

Nominee – the person receiving and managing the Personal Health Budget on behalf of the above named Representative

Signature: _Not Applicable_____
Date: _____

13. Annex A
SOLO Support Services & Your Life Your Way

SOLO Support Services & Your Life Your Way are the CCGs approved provider for a personal health budget deployed as a 'cash budget' (third party arrangement). SOLO Support Services & Your Life Your Way are Care Quality Commission (CQC) registered care agencies.

SOLO Support Services & Your Life Your Way work with families to build care plans and hold your personal health budget for you. SOLO & Your Life Your Way buy and pay for the care and support you have chosen. Please note – SOLO & Your Life Your Way will employ your Personal Assistants if you choose to have a 'cash budget' (third party arrangement). SOLO & Your Life Your Way will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and SOLO Support Services & Your Life Your Way as part of your care plan.

Salvere

Salvere are the CCGs approved provider for making direct healthcare payments for personal health budgets. Salvere are a Community Interest Company who support and assist families to organise, buy and manage their care, including building your child's own care plan using a direct healthcare payment.

Salvere will help you to manage all of your responsibilities as an employer and help you to employ personal assistants, arrange payroll, pay HMRC, provide staff handbooks, contracts of employment, risk assessment, help you make decisions about disclosure barring service checks, and ensure appropriate training and competency checks are in place and ensure clinical tasks are delegated safely.

Salvere will hold your Personal Health Budget in a bank account, which will be opened in your name / your child's name / your Nominee's name and managed by you or your nominee. Salvere will deduct their charges for their services from your Personal Health Budget. These charges have been agreed between yourself and Salvere as part of your child's care plan.

Appendix 7

Close Family Members

Who is a close family member?

A person's close family members are described in the regulations as:

a. the spouse or civil partner of the person receiving care
b. someone who lives with the person as if their spouse or civil partner
c. their parent or parent-in-law
d. their son or daughter
e. son- in- law or daughter- in- law
f. stepson or stepdaughter
g. brother or sister
h. aunt or uncle
i. grandparent, or
j. the spouse or civil partners of (c)- (i), or someone who lives with them as if their spouse or civil partner.

Appendix 8

Regulatory Bodies

Which are the statutory regulatory bodies?

- The General Chiropractic Council (GCC) regulates chiropractors.
- The General Dental Council (GDC) regulates dentists, dental nurses, dental technicians, dental hygienists, dental therapists, clinical dental technicians and orthodontic therapists.
- The General Medical Council (GMC) regulates doctors.
- The General Optical Council (GOC) regulates optometrists, dispensing opticians, student opticians and dispensing opticians, specialist practitioners and optical businesses.
- The General Osteopathic Council (GOsC) regulates osteopaths.
- The Health and Care Professions Council (HCPC) regulates the members of 15 health professions: arts therapists, biomedical scientists, chiropodists/podiatrists, clinical scientists, dietitians, hearing aid dispensers, occupational therapists, operating department practitioners, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/orthotists, radiographers, speech and language therapists, and social workers in England.
- The Nursing and Midwifery Council (NMC) regulates nurses and midwives.
- The Royal Pharmaceutical Society of Great Britain (RPSGB) regulates pharmacists, pharmacy technicians and pharmacy premises in Great Britain in England, Wales and Scotland.

Appendix 9

Timescales for Appealing Personal Health Budgets Decisions

1.0 Timescales:

1.1 The appeal must be made within 4 weeks of receiving the CCG's response to the PHB request. Appeals can be made by email, letter, by phone, either direct to the CCG, or via the CSU.

1.2 On receipt of an appeal, the CCG will respond within 10 working days confirming that a meeting will be convened.

1.3 The meeting should take place within 25 working days of the appeal being received.

1.4 The response of the panel will be confirmed to the service user in a letter within 28 working days of acknowledgement the original request meeting. The reasons for the decision will be set out in the decision letter, (together with an information leaflet on the NHS Complaints Procedure if the patient or their representative is not satisfied with the decision).

1.5 In the event of any timescales being exceeded, it is the responsibility of the CCG to keep the patient or their representative informed of reasons and progress.

1.6 Once the review is complete the CCG will inform the patient or their representative of its decision in writing, setting out the reasons for its decision within 28 working days of acknowledgement of the original request. If a patient or their representative is not satisfied that can pursue the matter via the local NHS complaints process.

1.7 If the internal process cannot resolve the concerns of the individual and/or their representative then the appellant can use the NHS Complaints Procedure.

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/46	**Author of the Paper:** Debbie Fagan Chief Nurse Email: debbie.fagan@southportandformbyccg.nhs.uk Tel: 0151 247 7252
Report date: March 2016	

Title: CCG Safeguarding Peer Review Action Plan (v9i)

Summary/Key Issues:

This paper presents the Governing Body with the updated CCG Safeguarding Peer Review Action Plan (v9i). Positive progress has been made against the recommendations. The action plan was last reviewed by the Quality Committee in February 2016 who recommended presentation to the Governing Body for closure due to the CCG Scheme of Delegation and Reservation.

Recommendation
The Governing Body are asked to receive the report / action plan and to support the recommendation from the Quality Committee to approve formal closure of the action plan.

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			X	
Clinical Engagement	X			Via the CCG Safeguarding Service, Named GP for Safeguarding Children and Quality Committee
Equality Impact Assessment			X	
Legal Advice Sought			X	
Resource Implications Considered			X	
Locality Engagement			X	
Presented to other Committees			X	

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
March 2016

1. Executive Summary

This paper presents the Governing Body with the updated CCG Safeguarding Peer Review Action Plan (v9i). Positive progress has been made against the recommendations. The action plan was last reviewed by the Quality Committee in February 2016 who recommended presentation to the Governing Body for closure due to the CCG Scheme of Delegation and Reservation.

2. Progress

2.1 The CCG commissioned a Safeguarding Peer Review the outcome of which has previously been presented to the Governing Body and then to the Local Safeguarding Children Board and the Safeguarding Adult Board.

2.2 The resulting action plan has subsequently been presented to the Quality Committee who have been reviewing progress. In January 2016, Halton CCG confirmed arrangements for supervision for the CCG safeguarding service (hosted service arrangements for the Merseyside CCGs).

2.3 The completed action plan was presented to the Quality Committee in February 2016. The Quality Committee recommendation presentation to the Governing Body for formal closure due to the assurance mechanisms being in place as outlined in section 3. Formal closure sits with the Governing Body due to the CCG Scheme of Delegation and Reservation.

3. Future Assurance

The following is in place regarding future assurance:

- CCG Safeguarding Network Steering Group – via MoU and KPIs for the service;
- MIAA – safeguarding review as part of workplan;
- LSCB – Section 11 audit;
- NHSE – CCG Safeguarding Assurance Tool.

4. Recommendations

The Governing Body are asked to receive the report / action plan and to support the recommendation from the Quality Committee to approve formal closure of the action plan.

Appendices

Appendix 1 – CCG Safeguarding Peer Review Action Plan v.9i

Debbie Fagan
March 2016

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

Peer Reviews of Safeguarding Adults, Safeguarding Children and Looked After Children

Recommendations & Action Plan

Ref	Review Theme	Recommendation	Lead	Initial Timing / Priority	Initial Comments	Initial RAG	Progress update	Updated RAG
1								
1	**The voice of the child young person and vulnerable adult**	Securing the voice of the child young person and vulnerable adult to inform safeguarding arrangements within Sefton CCGs needs accelerated progress and must be managed as a priority area for the CCGs. Further work is required to ensure that outcome measures and quality of experience are included within the safeguarding adults performance reporting	Hosted Service	~~Plan required by Sept 14~~ Plan required by Oct 14 **High priority**	Recommendation from both child and adult reviews	**A**	30.07.14 Update from Safeguarding Service: KPI within provider contract but further work required to strengthen this element of work further. 13.08.14 Update from Chief Nurse: Paper presented to EPEG meeting on 13.08.14. Outcome to be reported to the Quality Committee. 13.08.14 Update from Chief Nurse: Chief Nurse requested Programme Manager Quality & Safety to co-ordinate action plan / collate evidence of the methods by which the CCG secures the voice	~~A~~ ↑ ~~A~~ ↑ ~~A~~ ↑ ~~A~~ ↑ **B**

							of the child, young person and vulnerable adult. 03.10.14 Update from Chief Nurse. Capturing the voice of C&YP has been an agenda item for discussion within provider Quality Contract Meetings. 03.10.14 Update from Chief Nurse. Outcome of agenda item for discussion at EPEG reported to September 2014 Quality Committee. Quality Committee have charged EPEG with having oversight of workplan / action plan. 03.10.14 Update from Chief Nurse. Raised C&YP voice at Corporate Parenting Board. Meeting arranged between CCG and LA on 14 October 2014 to discuss how this can be strengthened for Looked After Children. 09.12.14 Chief Nurse Update: Meeting undertaken between Corporate Parent Board Lead, Safeguarding	

							Service and Programme Manager Quality & Safety to discuss strengthening links. Programme Manager working with CSU to further develop this area of work. Raised at appropriate provider Contract Meeting. 05.03.15 Chief Nurse Update: Meeting scheduled w/c 17.03.15 for CCG, CSU and Safeguarding Service to meet to complete gap analysis work. Amendments to the Complaints policy to ensure C&YP easily understand how they can complain are being completed and will come to the Quality Committee for the purposes of approval once reviewed by the Corporate Governance Support Group 08.08.15 Chief Nurse Update: Confirmation from EPEG received of developments in this area and that this will be on-going work. Updates to be received by the Quality Committee as	

							part of the work plan. **ACTION COMPLETE as this work is to be mainstreamed into the work of EPEG as requested by the Quality Committee.**	
2								
2.1	**Vision, strategy, leadership & capacity to improve**	A Safeguarding Strategy (2014-16) must be developed. The strategy would be endorsed by SS&SF CCGs Governing Bodies and monitored via the governance structure. It is recommended that the strategy as described above is developed in collaboration with all Merseyside CCGs.	Hosted Service	~~1st Draft strategy required by Sept 14~~ 1st Draft strategy required by Nov 14 **High priority**	Recommendation from both child and adult reviews	**R**	30.07.14 Update from Safeguarding Service: Initial draft developed by the team for the Merseyside footprint and circulated within Safeguarding Service. To be shared with CCGs once the whole team has had opportunity to input. 11.08.14 Update from Safeguarding Steering Group: Line manager for Safeguarding Service confirmed status as per 30.07.14. 03.10.14 Update from Chief Nurse. E-mail sent to Halton CCG Chief Nurse on 30.09.14 requesting update on Safeguarding Strategy. Discussion with Safeguarding Service on 01.10.14 - draft Safeguarding Strategy not yet been shared with	~~A~~ ↑ **A→** ~~A~~ ↑ ~~A~~ ↑ **G**

							CCGs as undergoing further work within the team. 09.12.14 Chief Nurse Update: Safeguarding Strategy produced by Safeguarding Service. To be presented to December 2014 meeting of CCGs' Quality Committee for approval to the Governing Bodies in January 2015 05.03.15 Chief Nurse Update: Safeguarding Strategy furthered updated by the Safeguarding Service to incorporate the Care Act. Presented to both CCG Quality Committees in February 2015 – recommended for approval by the Governing Bodies at the March 2015 meeting. Once approved this action will be completed. 03.08.15 Chief Nurse Update: Safeguarding Strategy approved by the Governing Body. CCG Business Manager addressing approval and version control information following	

							MIAA review. **ACTION COMPLETE**	

Ref	Review Theme	Recommendation	Lead	Timing / Priority	Comments	Initial RAG	Progress update	Updated RAG
2.2	**Vision, strategy, leadership and capacity to improve**	The Hosted Service Specification and integral Service Standards/Measurements/Quality Assurance framework to be reviewed in 2014 to ensure that the specification encapsulates the aims and objectives within the newly developed safeguarding strategy.	CCG Chief Nurses	~~Reviewed and revised document required by Oct 14~~ Reviewed and revised document required by Nov 14 **High priority**	Recommendation from both child and adult reviews	**R**	11.08.14 Update from Safeguarding Steering Group: Cross reference to 2.1. Safeguarding assurance framework document discussed that had previously been developed. NHSE(M) supporting the development of KPIs for the Safeguarding Service as part of how the CCGs hold the service to account in terms of performance. To be reviewed on a Quarterly basis at the Steering Group. 03.10.14 Update from Chief Nurse. Awaiting draft Safeguarding Strategy to support progression. E-mail sent to Halton CCG on 10.09.14 and 30.09.14 to request confirmation	~~A~~↑ **A→** ~~A~~↑ **G**

							of meeting date for the Chief Nurses to progress work before next meeting of the Steering Group – awaiting confirmation. 09.12.14 Chief Nurse Update: Safeguarding Service Specification drafted by Halton CCG. Comments fed back by Chief Nurse to Halton CCG Chief Nurse by November 2014 deadline. Assurance framework / Service Standards being amended accordingly by Halton CCG. Ready for sign-off in December 2014 with update to the CCG Network. 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Final version of the service specification and MoU reviewed and agreed. **ACTION COMPLETE**	
2.3	**Vision, strategy, leadership and capacity to improve**	Strengthen the connections between adult safeguarding and domestic abuse by identifying some of the organisational developments which can support	Chief Nurse and Hosted Service	~~Describe strategic direction for this within safeguarding~~	Recommendation from adults review	**R**	30.07.14 Update from Safeguarding Service: Elements of this work is addressed in the draft Safeguarding Strategy	~~A~~↑ **A**→ ~~A~~↑

		best practice in this area. Ensure that the strategic approach for safeguarding commissioning reflects the recently revised definition of domestic abuse to include so called 'honour based violence, female genital mutilation and forced marriage.		~~strategy and business plan by Sept 14~~ Describe strategic direction for this within safeguarding strategy and business plan by Nov 14 **High priority**			that is awaiting circulation to the CCG (cross reference to 2.1). Recently revised definition of domestic violence has been incorporated in the revised Safeguarding Policy which was presented to the Quality Committee in July 2014 with recommendations for approval to the Governing Body. Approved at Governing Body in July 2014. 13.08.14 Chief Nurse Update: Need to share Safeguarding Strategy with CCG Chef Strategy and Outcomes Officer once strategy has been shared with CCG to ensure alignment with CCG Strategic Plan and priorities. 03.10.14 Chief Nurse Update No further progress to report. 09.12.14 Chief Nurse Update: Safeguarding Strategy produced by Safeguarding Service. To be presented to December 2014 meeting of CCGs' Quality Committee for approval	~~G~~

							to the Governing Bodies in January 2015. Meeting held between CCG Chief Nurse, Chief Strategy and Outcomes Officer and CCG Safeguarding Service to ensure explicit links between LSCB/SAB/YOT/Safeguarding Strategy are evident in CCG priorities and commissioning intentions. 06.03.15 Chief Nurse Update: Safeguarding Service have met with CCG Chief Planning & Outcomes Officer to ensure safeguarding priorities are aligned within the CCG plans. Safeguarding Strategy developed, presented to the Quality Committees who have recommended approval by the Governing Bodies in March 2015. Relevant KPIs are included in provider contracts. **ACTION COMPLETE**	
2.4	**Vision, strategy, leadership and capacity to improve**	In conjunction with NHS England Area Team and the Hosted Service, SS&SF CCGs must make accelerated progress	NHSEM & Chief Nurse	~~Plan required by Sept 14~~ Plan required	Recommendation from adults review	**R**	11.08.14 Update from Safeguarding Steering Group: Discussed at meeting. NHSE(M)	~~A~~↑ A↑

		to ensure that MCA / BIA and DoLs principles are embedded within the Health Provider organisations including General Practice.		by Nov 14			discussed central funding that was received in 2013/14 which was distributed to Local Authorities. Reduced funding available for 2014/15 – awaiting confirmation centrally. 13.08.14 Update from Chief Nurse: MCA paper presented to CCG Quality Committee by the Safeguarding Service in June 2014. Quality Committee recommendation that MCA/BIA/DoLS be considered as part of CCG PLT and Governing Body Development session – Chief Nurse has liaised with CCG Chief Corporate Delivery & Integration Officer to make plans for PLT and Governing Body session. 03.10.14 Chief Nurse Update. MCA/DoLS training confirmed for joint CCG Governing Body development session in November 2014. Request for MCA/DoLS update as	A↑ ~~A→~~ B

							part of PLT forwarded to Practice Nurse Facilitators for action at the PLT Meeting Group. MCA/DoLS KPI in provider contract in 2014/15 09.12.14 Chief Nurse Update: Governing Body Development session undertaken in November 2014 re: DoLs/MCA/ Court of Protection. PLT event in planning stage. Safeguarding Service to confirm relevant KPIs in provider contracts for 2015/16 – plans in place for development with support of CSU. 05.03.15 Chief Nurse Update: Relevant KPIs within provider contracts. MCA / DoLs / BIA being discussed as part of PLT planning – for further discussion once Named GP is in post. 08.09.15 Chief Nurse Update: Coroner's circular disseminated to General Practice informing GPs of legal requirements around MCA & Care Homes.	

							Dedicated post in Safeguarding Service to support MCA & DoLS – this postholder will be of support to the Named GP. CCG PLT leads to liaise with Safeguarding Service re: MCA & DoLs training and consider best practice training from across the Merseyside footprint in order to ensure it meets needs. **ACTION COMPLETE as this work is to be mainstreamed into the work of PLT. NHSE as contract holders to lead on any contractual requirements that may be required within primary care and General Practice.**	

Ref	Review Theme	Recommendation	Lead	Timing / Priority	Comments	Initial RAG	Progress update	Updated RAG
2.5	**Vision, strategy, leadership and capacity to improve**	SS&SF CCGs and NHS England should develop a programme to deliver the work that will be required under Care and Support Act; identify a lead person responsible for coordinating and driving delivery of this and model the	Chief Nurse and NHSEM Leads	Plan required by Nov 14	Recommendation from adults review	**R**	13.08.14 Update from Chief Nurse: Action plan shared with NHSE(M). Implications of the Care and Support Act and impact this will have discussed at the Safeguarding Steering	~~**R**~~↑ **R**→ ~~**A**~~↑ **A**↑

		likely costs and other impacts of the Act.					Group meeting held on 11.08.14. Plan still requires development. 03.10.14 Chief Nurse Update. No further progress to report. Requires further liaison with NHSE(M) 09.12.14 Chief Nurse Update: Halton CCG developing costings to be presented to CCGs to enhance hosted service to provide necessary support regarding Care Act. Awaiting receipt. 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. HR consultation commenced on the adult element of the structure to ensure the service can support the requirements of the CCGs in relation to the Care Act 03.08.15 Chief Nurse Update: CCG Safeguarding Service review completed. Re-design completed of Adult element of the	**G**

							team with HR input – posts. Shared CCG post recruited to for a Programme Manager Vulnerable People (12 month fixed term) which will also support the CCGs in service development taking account the requirements of the Care Act. **ACTION COMPLETE**	
3								
3.1	**Governance, accountability and risk management**	Ensure that annual reports are in development for this reporting year (2013-2014) having agreed the data set and safeguarding activity 'Dashboard' so that safeguarding activity across Sefton CCGs can be easily demonstrated.	Hosted Service	Data set agreed. ~~Draft report required by July 14~~ Draft report required by November 14 **Medium priority**	Recommendation from both child and adult reviews	**A**	30.07.14 Update from Safeguarding Service: 2013/14 annual report in draft and in process of being circulated to area leads by end of July 2014 for further population. On CCG Quality Committee workplan to be presented in September 2014/October2014 meeting according to internal/external meeting schedule. Dashboard to be developed. 03.10.14 Chief Nurse Update. Annual Report scheduled to be presented to Quality Committee in October 2014. Safeguarding	~~A~~↑ **A**→ **G**

							Service report this is in draft and requested this be deferred until November 2014. Request granted and deferred until November 2014 Quality Committee 09.12.14 Chief Nurse Update: Annual Report approved by the CCGs' Governing Body in November 2014. **ACTION COMPLETE**	
3.2	**Governance, accountability and risk management**	Mersey CCG Chief / Lead Nurses to work collaboratively to agree 1 reporting framework for safeguarding. This reporting template will be informed by the safeguarding strategy.	CCG Chief Nurses	Complete by July 14 Complete by Nov 14 **Medium priority**	Recommendation from both child and adult reviews. Safeguarding Governance Group has been formed	**A**	13.08.14 Update from Chief Nurse: Progress to be informed by the Safeguarding Strategy (cross reference to 2.1). To continue with current reporting template until Strategy is completed 03.10.14 Chief Nurse Update. No further progress to report. 09.12.14 Chief Nurse Update: Safeguarding Service Specification drafted by Halton CCG. Comments fed back by Chief Nurse to Halton CCG Chief Nurse by November 2014 deadline. Assurance framework / Service Standards being amended accordingly by	~~A→~~ **A→** ~~A↑~~ **G**

							Halton CCG. Ready for sign-off in December 2014 with update to the CCG Network. 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Final version of the service specification and MoU reviewed and agreed. **ACTION COMPLETE**	
3.3	**Governance, accountability and risk management**	Further develop the competency level of primary care practitioners in safeguarding adults area & with a detailed focus on embedding the principles of the MCA / BIA and Deprivation of Liberties Safeguards: link with 2.4	NHSEM & Chief Nurse	~~Plan required by Sept 14~~ Plan required by Nov 14	Recommendation from adults review	**A**	13.08.14 Update from Chief Nurse: Cross reference to 2.4. CCGs discussing a possible model that reflects GP Clinical Lead / Named GP for Safeguarding Children but for Vulnerable Adults. 03.10.14 Chief Nurse Update. Cross reference to 2.4 09.12.14 Chief Nurse Update. Cross reference to 2.4 05.03.15 Chief Nurse Update: Relevant KPIs within provider contracts. MCA / DoLs / BIA being discussed as part of PLT planning – for further discussion	~~A~~↑ ~~A~~↑ ~~A~~↑ ~~A~~→ **B**

							once Named GP is in post. 08.09.15 Chief Nurse Update: Coroner's circular disseminated to General Practice informing GPs of legal requirements around MCA & Care Homes. Dedicated post in Safeguarding Service to support MCA & DoLS – this postholder will be of support to the Named GP. CCG PLT leads to liaise with Safeguarding Service re: MCA & DoLS training and consider best practice training from across the Merseyside footprint in order to ensure it meets needs. **ACTION COMPLETE as this work is to be mainstreamed into the work of PLT. NHSE as contract holders to lead on any contractual requirements that may be required within primary care and General Practice.**	

APPENDIX 1

Ref	Review Theme	Recommendation	Lead	Timing / Priority	Comments	Initial RAG	Progress update	Updated RAG
4								
4.1	**Quality improvement, learning/ workforce development**	Further develop the role of safeguarding GP leads in Sefton. This would include the development of Common Assessment Framework within primary care.	NHSE (Mersey) Safeguarding Leads	Progress report required in Sept 14 Progress report required in Nov 14 **High priority**	Plan is in place. Recommendation from SLAC review	**A**	13.08.14 Update from Chief Nurse: Progress report to be received from current Named GP Safeguarding Children in time for September 2014 03.10.14 Chief Nurse Update. Update awaited from Named GP 09.12.14 Training has been undertaken by the Named GP and a presentation regarding the Early Help offer by LA colleagues. To be further progressed when CCG GP Clinical Lead for Safeguarding comes into post 05.03.15 Chief Nurse Update: To be further progressed once Named GP Safeguarding appointed. 05.08.15 Chief Nurse Update: Discussion with new Named GP Safeguarding Children – will discuss with previous postholder in order to inform next	~~A→~~ **A→** **A↑** ~~A→~~ ~~A↑~~ **G**

							steps and continue work already commenced. Named GP Safeguarding Children has list of all GP Safeguarding Leads in each practice and will be making contact as part of on-going workplan **ACTION COMPLETE**	
4.2	**Quality improvement, learning/ workforce development**	A model of safeguarding supervision to be developed and secured for Designated Nurses and Deputy Designated Nurses within the Hosted Safeguarding Service.	Chief Nurse Halton	~~Implementation to be set for Sept 14~~ Implementation to be set for Nov 14 **High priority**	Recommendation from both child and adult reviews	**R**	13.08.14 Update from Halton CCG Chief Nurse (line manager of the Safeguarding Service): NHS Halton CCG is currently reviewing a number of options for provision of supervision for the service. A decision on the supervision model and implementation of the model is expected to commence in November 2014 as provider capacity to implement needs to be measured and be assured before agreement. 03.10.14 Chief Nurse Update. No further progress to report until November 2014 09.12.14 Chief Nurse Update: Informed by Safeguarding Service	~~A~~↑ **A**→ ~~A~~↑ ~~G~~ ~~A~~ **G**

							that procurement completed and awaiting contract sign-off. Will be notified when complete. 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Supervision has been commissioned for the Safeguarding Service from 5 Borough Partnership. ~~ACTION COMPLETE~~ 08.08.15 Chief Nurse Update: Discussion with CCG Safeguarding Service. Commissioned model of supervision has stalled. Further work being undertaken by the Safeguarding Service with the support from Halton CCG (host CCG) to secure commissioned model until national model becomes apparent. 09.02.16 Chief Nurse Update: Confirmation received from host CCG that supervision has been commissioned for the service.		

							ACTION COMPLETE	
4.3	**Quality improvement, learning/ workforce development**	A model of safeguarding supervision to be developed and secured for the Sefton / Liverpool Named GP.	Chief Nurse / Designated Doctors	~~Implementation to be set for Sept 14~~ Implementation to be set for Nov 14 **High priority**	Recommendation from SLAC review	**R**	30.07.14 Update from Safeguarding Service: Initial meeting took place on 24.06.14 – agreed development of supervision strategy to include Named GP arrangements. 03.10.14 Chief Nurse Update. No further progress to report. 09.12.14 Chief Nurse Update: To be progressed once CCGs' GP Clinical Lead Safeguarding in post – to liaise with other CCGs regarding arrangements they have in place. 05.03.15 Chief Nurse Update: Safeguarding supervision / peer supervision is in place for existing Named GPs. Once the Named GP for safeguarding is in place for Sefton – individual supervision requirements will be discussed in order to ensure it meets the needs of the new appointee.	~~A~~↑ **A→** **A→** ~~**A→**~~ **G**

							03.08.15 Chief Nurse Update: 1:1 with Named GP on 08.07.15 – Supervision discussed. Confirmed C&M Peer Group is in place and good support is available at present. Would prefer to review supervision requirements once in post for longer. Regular 1:1s scheduled between Named GP and Chief Nurse. **ACTION COMPLETE**	
4.4	**Quality improvement, learning/ workforce development**	Audit of supervision to be factored into the safeguarding audit plan of the hosted service for 2014-15 (this relates to an audit of safeguarding supervision commissioned / provided for the safeguarding service to gain assurance re: effectiveness)	Hosted Service	~~Implementation to be set for Sept 14 as part of supervision model~~ Implementation to be set for Nov 14 as part of supervision model	Recommendation from both child and adult reviews	**R**	13.08.14 Update from Chief Nurse: Cross reference to 4.2 due to interdependency 03.10.14 Chief Nurse Update. No further progress to report until November 2014 09.12.14 Chief Nurse Update: Cross reference to 4.2. Will show pace in achievement once supervision is in place. 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Supervision has been	~~**R→**~~ **R→** **R→** **G**

							commissioned for the Safeguarding Service from 5 Borough Partnership – audit is built into this process. **ACTION COMPLETE**	
5								
5.1	**Efficient/effective use of safeguarding resources**	Agree the employment status and support mechanisms for the Named GP with strong links to Designated Doctors and CCG GP Chairs for clinical support.	Chief Nurse	~~Agreement to be reached by July 14~~ Agreement to be reached by Oct 14 **High priority**	Discussions with NHSEM and Liverpool CCG in place. Recommendation from SLAC review	**A**	13.08.14 Update from Chief Nurse: Meeting taken place in July 2014 with LCH Medical Director, Named GP and Chief Nurses for LCCG and SS/SFCCG to discuss future model. SSCCG/SFCCG in the process of serving notice to Liverpool Community Health in order for this function to sit within the CCG. CCGs will need to recruit to this post but interim arrangements discussed with LCCG should these be required (services would be secured from LCCG where the current Named GP will transfer into) 03.10.14 Chief Nurse Update. Liverpool Community Health have served notice to CCGs. Meeting taken place	~~A~~↑ ~~A~~↑ ~~A~~↑ ~~A~~↑ **G**

							between CCGs' C&YP GP Clinical Leads to discuss post. Draft JD developed. For sign-off at SMT in October 2014 re: model and JD. Arrangements in place with LCCG re: SLA for Named GP cover in Liverpool to provide the function in Sefton should the CCG face challenges in recruiting. 09.12.14 Chief Nurse Update: Job description agreed. Awaiting financial envelope from within provider contract and then recruitment to commence 05.03.15 Chief Nurse Update: Named GP role advertised with closing date of 03.03.15. Interview date set for 24.03.15 03.08.15 Chief Nurse Update: Recruitment complete and Named GP now in post. Links established with Designated Doctor for Safeguarding Children. Arrangements established with GP Chairs for any clinical support that may be	

							required. **ACTION COMPLETE**	

Ref	Review Theme	Recommendation	Lead	Timing / Priority	Comments	Initial RAG	Progress update	Updated RAG
5.2	**Efficient/effective use of safeguarding resources**	Service Level Agreement for the Named GP function to be brought up to date in line with the decision making process described above.	Chief Nurse	July 14 **Medium priority**	As above Recommendation from SLAC review	A	13.08.14 Update from Chief Nurse: Cross reference to 5.1 03.10.14 Chief Nurse Update. CCG have served notice on this function by Liverpool Community Health. Agreement reached that this function will now be undertaken within the CCG. **ACTION COMPLETE**	~~A~~↑ ~~G~~
5.3	**Efficient/effective use of safeguarding resources**	Provide the assurance that the Designated Nurse LAC role and function is being delivered and must agree the source of the function. Provide assurance that the monitoring and performance management systems are in place for this and that activity data is being captured.	CCG Chief Nurses	~~July 14~~ Nov 14 **High priority**	Recommendation from SLAC review	R	11.08.14 Update from Safeguarding Steering Group: Cross reference to 5.4. Activity data re: Looked After Children is currently captured via the service that is commissioned via Liverpool Community Health / information made available to the Local Authority 13.08.14 Update from Chief Nurse: CCG Chief Nurse and Deputy Designated Nurse Safeguarding Children	~~R~~↑ ~~R~~→ ~~A~~↑ ~~A~~↑ G

							are now in attendance at the Sefton Corporate Parenting Board 03.10.14 Chief Nurse Update. No further progress to report. Update following next Steering Group meeting and production of Safeguarding Strategy. 09.12.14 Chief Nurse Update: Safeguarding Service Specification drafted by Halton CCG includes Looked After Children. Comments fed back by Chief Nurse to Halton CCG Chief Nurse by November 2014 deadline. Assurance framework / Service Standards being amended accordingly by Halton CCG. Ready for sign-off in December 2014 with update to the CCG Network. 05.03.15 Chief Nurse Update: Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Halton CCG have started the recruitment process for the post of Designated Nurse Looked After	

							Children. 03.08.15 Chief Nurse Update: Designated Nurse Looked After Children now in post within the CCG Safeguarding Hosted Service. Post holder establishing links with local providers. Revised Looked After Children KPIs have been developed and feature in relevant provider contracts for 2015/16. **ACTION COMPLETE**	
5.4	**Efficient/effective use of safeguarding resources**	Consider a detailed re-view of the hosted safeguarding team roles, responsibilities, skill mix options. Agree and align lead areas to the portfolio of the Hosted Service members. This would include allocation of the role and function of Designated Nurse LAC. *Deputy* Designated Nurse title should be re-considered in light of the fact that *Designated* is a *statutory* title and role.	CCG Accountable Officers & Chief Nurses	To commence when safeguarding strategy and associated business plan has been agreed	Recommendation from both child and adult reviews	**R**	11.08.14 Update from Safeguarding Steering Group: Chief Nurses to meet to discuss and report back to SSCCG/SFCCG Chief Officer in September 2014 as current Chair of the Steering Group 03.10.14 Chief Nurse Update. E-mail sent to Halton CCG on 10.09.14 and 30.09.14 to request confirmation of meeting date for the Chief Nurses to progress work before next meeting of the Steering Group – awaiting confirmation. Safeguarding Service	~~A~~↑ A↑ ~~A~~↑ ~~A~~↑ **G**

							informed Chief Nurse on 01.10.14 that the team were in formal consultation phase with Halton CCG re: re-design of the service 09.12.14 Chief Nurse Update: Review undertaken and consultation commenced on new structure. Recruitment has been undertaken to the Safeguarding children element of the service. Safeguarding adults element not yet completed. 05.03.15 Chief Nurse Update: Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Review completed for Children's element of the service and re-structure completed following HR consultation. Now Head of Service role at 8c and Designated Nurse role at 8b – role of Deputy Designated Nurse no longer exists within the structure. HR consultation commenced on the adult	

							element of the structure. Once HR process for adults has ended this action will be complete. 03.08.15 Chief Nurse Update: CCG Safeguarding Hosted Service review now completed for both adult and child elements of the service. Recruitment process completed by Halton CCG. Designated Nurse Looked After Children also in post within Hosted Service. **ACTION COMPLETE**	

Ref	Review Theme	Recommendation	Lead	Timing / Priority	Comments	Initial RAG	Progress update	Updated RAG
5.5	**Efficient/effective use of safeguarding resources**	The Hosted Service Specification and integral Service Standards / Measurements/Quality Assurance framework to be reviewed early in 2014 to accurately reflect the statutory Looked After Children Designated Nurse arrangements	Chief Nurses	~~To be complete in July 14~~ To be complete in Nov 14	Recommendation from both child and adult reviews	**R**	13.08.14 Update from Chief Nurse: Cross reference to 2.2; 5.3; 5.4 03.10.14 Chief Nurse Update. Cross reference to 2.2; 5.3; 5.4 09.12.14 Chief Nurse Update. Cross reference to 2.2; 5.3; 5.4 05.03.15 Chief Nurse Update: CCG Network Safeguarding Steering Group met on 23rd February 2015. Final version of the service specification and MoU reviewed and agreed. **ACTION COMPLETE**	~~A↑~~ ~~A→~~ ~~A↑~~ ~~G~~
5.6	**Efficient/effective use of safeguarding resources**	Sefton and Liverpool CCGs Chief Nurses to have a discussion with LCH Executive Nurse (acting) regarding any **relevant** outcome of the LCH safeguarding service review to support a collaborative approach to the future of effective and efficient use of adult safeguarding resource.	Chief Nurses	~~To be complete by June 14~~ To be complete by Dec 14	Recommendation from adults review	**R**	13.08.14 Update from Chief Nurse: Chief Nurse has requested site of LCH internal review at Contract Meeting and followed up by e-mail to LCH Interim DoN and Deputy DoN 03.10.14 Chief Nurse Update. LCH Safeguarding Review (1) recommendations have been shared with	~~A↑~~ A↑ ~~A→~~ ~~A→~~ G

							the CCGs. Interim Executive Team have commissioned a follow-up review to assess progress made regarding recommendations which they will share with the CCGs once completed. 09.12.14 Chief Nurse Update: Chief Nurse contacted LCH to see if recommendations from their second review is available for sharing. 05.03.15 Chief Nurse Update: Still being awaited – update requested by Chief Nurse 05.03.15 03.08.15 Chief Nurse Update: Action now superseded. CCG have served notice on LCH. Discussion taken place with Local Authority regarding local commissioning arrangements for safeguarding adults. Community Service Specifications in the process of being developed – these will include any safeguarding adult service response that	

							may be required from a locally commissioned provider. **ACTION COMPLETE**	

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/47	**Author of the Paper:** Carmel Farmer Designated Nurse Looked After Children 0151 495 5469
Report date: March 2016	
Title: CCG Looked After Children Strategy	

Summary/Key Issues:

This paper presents the Governing Body with the recommended strategy that the CCG need to adopt and approve with regard to Looked After Children. It has been developed in accordance with the current legislation and guidance published 2015. Once approved the CCG Safeguarding Service will develop a workplan / action plan to support delivery which will be monitored via the Quality Committee.

Recommendation

The Quality committee are asked to approve the CCG Looked After Children Strategy.

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.
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			Via CCG Safeguarding Service and Quality Committee
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement			x	
Presented to other Committees	x			CCG Quality Committee

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to the Governing Body
March 2016

1. Executive Summary

1.1 This report provides the committee with the Looked After Children Strategy. This will support the CCG to demonstrate safe discharge / duty of care to this vulnerable client group.
1.2 The strategy has been developed in accordance with current legislation and guidance published in 2015.
1.3 Once ratified the Work Plan will be further developed and updates provided in accordance with current CCG Governance arrangements.
1.4 The Governing Body is asked to approve this strategy.

2. Introduction and Background

2.1 Looked After Children Strategy

The Looked After Children Strategy (Appendix 1) has been developed, the purpose of which is to understand and plan for the current and future needs of our Looked After Children and Care Leavers to help them achieve positive outcomes.

The strategy development has utilised the commissioning principles and processes in the Joint Commissioning Strategy and Framework for Southport and Formby Children and Young People 2014-2017, Sefton Local Children in Care Pledge and national priorities and included a scoping exercise to develop a Children Looked After baseline assessment for Sefton.

The Strategy has been developed in accordance with the current guidance and conforms with:

- Working Together to Safeguard Children (2015)
- Children Acts (1989, 2004)
- Human Rights Act (1998)
- Promoting the health and well-being of looked-after children (2015)
- Halton Joint Strategic Needs Assessment (2014)
- Looked-after children and young people. Public health guidance 28. NICE (2013)
- Quality standard for the health and wellbeing of looked-after children and young people. Quality standards QS31 NICE (2013)
- Outcomes Framework 2014/15: Domain 4: Ensuring people have a positive experience of care, Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. NHS England (2014)
- Public Health Outcomes Framework 2013/16: Domain 1 Improving the wider determinants of health, Domain 2 health improvements. Public Health England (2013)

2.2 Following submission to the Quality Committee, the CCG Chief Nurse met with the Director of Children's Services and the opportunity was extended to provide any comments on the Strategy before being submitted to the Governing Body.

2.3 The CCG Chief Nurse and CCG Chief Strategy and Outcomes Officer have plans in place to ensure that the CCG can plan for the deliverables outlined in the strategy as appropriate.

3. Key Issues

3.1 This report provides the Governing Body with the Looked After Children Strategy. This will support the CCG to demonstrate safe discharge / duty of care to this vulnerable client group.

3.2 The purpose of this commissioning strategy is to understand and plan for the current and future needs of our Looked After Children and Care Leavers to help them achieve positive outcomes.

3.3 As statutory bodies, CCGs have a responsibility for improvements in the quality of primary medical services, safeguarding and looked after children's services across the local economy.

3.4 As statutory bodies CCGs need to be assured that all children and young people in care have access to appropriate health care services, which will promote health and enable them to make positive life choices.

4. Conclusions

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

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

5. Recommendations

The Governing Body are asked to:

a) Approve the CCG Looked After Children Strategy;

b) Delegate responsibility for overseeing the delivery of the workplan / action plan to the Quality Committee with any concerns against delivery being escalated to the Governing Body.

Appendices

Appendix 1: Looked After Children Strategy

Carmel Farmer
March 2016

NHS Southport and Formby Clinical Commissioning Group

NHS Southport & Formby Clinical Commissioning Group

LOOKED AFTER CHILDREN STRATEGY

2015- 2017

Carmel Farmer, Designated Nurse Looked After Children, January 2016

Southport & Formby Clinical Commissioning Group

Looked After Children Strategy

Index

Southport & Formby Clinical Commissioning Group

Looked After Children Strategy

1. Introduction

1.1 The term Looked After Children has a specific legal meaning based on the Children Act (1989). A child is looked after by a local authority if he or she has been provided with accommodation for a continuous period of more than 24 hours, in the circumstances set out in sections 20 and 21 of the Children Act 1989, or is placed in the care of a local authority by virtue of an order made under part IV of the Act.

1.2 The majority of children who are looked after by the local authority are placed with foster carers, as it has been demonstrated, that for most children, it is best to live within a family environment. For some children where this is not the case, residential care may be more appropriate.

1.3 Local authorities have a duty under the Children Act to safeguard and promote the welfare of children of the children they look after. The NHS has a major role in ensuring that health services are delivered in a timely and effective manner to all looked after children to support local authorities with their duty.

1.4 Most children become looked after as a result of abuse or neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of the children in care have diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy, healthy lives as adults.

1.5 The purpose of this commissioning strategy is to understand and plan for the current and future needs of our Looked After Children and Care Leavers to help them achieve positive outcomes.

1.6 The strategy development has utilised the commissioning principles and processes in the Joint Commissioning Strategy and Framework for Southport & Formby Children and Young People 2014-2017, Sefton Local Children in Care Pledge and national priorities.

1.7 NHS Southport & Formby CCG will ensure:

- Effective partnership working is central to service planning, commissioning and delivery to enhance the child's health and well-being. They will work with the Corporate Parenting Board (CPB) and Sefton Safeguarding Children's Board (LSCB), statutory agencies and its provider organisations to ensure effective multi-agency arrangements are embedded into practice.

- Services are commission based on the needs of looked after children in Sefton that exhibits quality of care of effective, efficient care.

- Individuals are empowered to choose services on the basis of quality and outcomes. This involves providing clear information to the public about the quality of services which are commissioned on their behalf, including information about poor quality, unexplained variation and differential health outcomes.

- Continuous improvement and compliance in quality and safety outcomes for commissioned services is evident and will be demonstrated through the use of specific contractual arrangements and metrics with provider organisations. This will include having in place:

    - Key Performance Indicators (KPI),
    - Commissioning for Quality and Innovation (CQUIN) targets,
    - Quality schedules,
    - Systems to embed learning from incidents and complaints,
    - Comprehensive single and multiagency Safeguarding and Looked After Children's policies and procedures and Looked After Children training strategy and framework, which is in line with Intercollegiate document (2015).

1.8 In addition the CCG will support specific Francis recommendations relating to improving safety for vulnerable groups to develop an on-going culture of quality across the health economy including assurance in relation to the legal requirements for Duty of Candour.

1.9 This strategy should be read in conjunction with the CCG Safeguarding Policy, Safeguarding/ Looked After Children Training Strategy and other relevant policies.

2. Background

2.1 Although it is defined that local authorities have a duty to safeguard and promote the welfare of children, and of the children they look after (Children Act 1989), the NHS has a major role in supporting local authorities to fulfil this duty.

2.2 The Mandate to NHS England, Statutory Guidance on Joint Strategy Needs Assessments, Joint Health and Wellbeing Strategies and NHS Constitution for England defines NHS responsibilities. In fulfilling these responsibilities the NHS contributes to meeting the health needs for looked after children in three ways:

- commissioning effective services
- delivering through provider organisations
- individual practitioners providing coordinated care for each child

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

2.4 Statutory guidance such as 'Making arrangements to promote the welfare of children under section 11 of the Children Act 2004' (2007) reinforces and describes the duties of health services. Working Together to Safeguard Children (2015) and Promoting the health and wellbeing of looked after children (2015) recognise the changing commissioning arrangements within the health service and clarifies the role of the CCGs.

3. Responsibilities

3.1 The overall accountability for Looked After Children within Southport & Formby CCG rests with the Accountable Officer (AO). The Chief Nurse (CN) is responsible for senior clinical leadership and advocates for vulnerable groups across the CCG health economy.

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

3.3 As statutory bodies, CCGs have a responsibility for improvements in the quality of primary medical services, safeguarding and looked after children's services across the local economy.

3.4 NHS England and the CCG will work closely with the local authorities, Corporate Parenting Board, Children in Care Scrutiny Panel and Sefton Safeguarding Children Boards to ensure there are effective NHS arrangements for looked after children across the health communities. At the same time, ensuring absolute clarity about the underlining statutory responsibilities that each commissioner has for the services that they commission, together with a clear leadership role for NHS England.

3.5 Role of designated professionals

The designated doctor and nurse role is to:

- Provide advice to the service planning and commissioning organisation and to the local authority, on questions of planning, strategy, commissioning and the audit of quality standards including ensuring appropriate performance indicators are in place in relation to health services for looked after children.
- Work with all healthcare organisations to monitor performance of local health services for looked after children and young people.
- Ensure expert health advice on looked after children is available to children's social care, healthcare organisations, residential children's homes, foster carers, school nurses, clinicians undertaking health assessments and other health staff.
- Advise colleagues in health and children's social care on issues of medical confidentiality, consent and information sharing.
- Work with health service planners and commissioners to ensure there are robust arrangements to meet the health needs of looked after children placed outside the local area and ensure there are robust arrangements to meet the health needs of looked after children placed outside the local area and ensure.
- Close working relationships with Local Authorities to achieve placement decisions which match the needs of children.
- Work with local service planners and commissioners to advocate on behalf of and ensure looked after children benefit as appropriate from the implementation of wider health policies such as in England - any qualified provider, personal health budgets.
- Work with commissioners and providers to gain the best outcome for the child/ young person within available resources, including involvement in fostering and adoption panels according to local arrangements.

4. Strategy

4.1 Southport & Formby CCG's Vision

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

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

4.3 Principles:

- strive for excellence
- embed a focus on early intervention and prevention into the routine delivery of all services to children, young people and families to
- safeguard and protect vulnerable children within a framework of universal services to improve the well-being of every child
- narrow the gap in outcomes between the most vulnerable children and their peers
- consult, listen to and hear the voices of children, young people and families and provide them with opportunities to participate in decision making
- use evidence on outcomes for children as the basis for improving standards and targeting resources
- commission the right services in the right place at the right time for all children, young people and families
- promote interaction between children and families from different backgrounds; and deliver excellent, integrated working across services through investing in a skilled, well trained and valued children's workforce

4.4 We know we will have achieved our vision when:

- all children and young people in care have access to appropriate health care services, which will promote health and enable them to make positive life choices
- communication between Local Authority and NHS organisations is outstanding
- children new into care will receive a comprehensive Initial Health Assessment in a timely manner to inform the first multi-agency meeting
- the number of children and young people attending annual health and dental checks will increase
- screening and referral for emotional health services is integral to the routine health assessments
- the quality of health assessments will be outstanding
- referral for specialist services, once identified, are actioned promptly
- health outcomes for looked after children will improve, as health needs are identified and addressed
- young people leaving care will feel prepared and supported. They will have access to their health history and be in receipt of information how to access universal (and specialist, as appropriate) health services
- looked after children have their voices heard and we maximise their rights to choice and control

4.5. Strategic objectives

The key strategic objectives are to:

Provide senior and board-level leadership

- Senior leadership responsibility and lines of accountability for the CCG safeguarding/looked after children arrangements are clearly outlined to employees and members of the CCG as well as to external partners.
- Contribute to the work of the Corporate Parenting Board and LSCB to ensure that the boards meet their statutory responsibilities. This would include engagement with specific work streams, such as, Child Sexual Exploitation (CSE) and Emotional Health.
- Support designated individuals to contribute to the work of the corporate parenting board and LSCB subgroups and other national and local safeguarding implementation networks.
- The CCG will ensure that its designated clinical experts are integral to decision making within the CCG and have the authority to work across local health economies, to influence and shape the culture and practice within provider services.
- The designated professionals will work with neighbouring and national CCGs to ensure that looked after children receive seamless care regardless of their geographical placement.

Ensure looked after children's arrangements are in place

- Integrate looked after children within other CCG functions, such as quality and safety, patient experience, healthcare acquired infections, management of serious incidents
- Secure the expertise of designated professionals. This includes the expertise of a designated doctor for looked after children.
- Ensure key priorities such as Child Sexual Exploitation and emotional health needs are delivered effectively locally.
- The CCG, through its designated professionals, will ensure that local and national learning for looked after children is disseminated and actioned.
- Notification systems between local authority and the CCG are developed to enable coordination of care for children placed out of area.
- To support children and young people with special educational needs or disabilities.

Commission safe services

- Ensure that all safeguarding elements and needs for looked after children are incorporated in all existing provider contracts and Service Level Agreements.
- Service developments take into account the need of all looked after children, and are informed, where appropriate, by the views of this group of children and by a Quality Impact Assessment.
- Strengthen contractual arrangements for looked after children in 'out of area' provision.
- Local mechanisms are in place to establish the responsible commissioner to resolve any funding issues.
- Ensure that there are effective arrangements for sharing information with partners for the protection of children.
- Monitoring systems for looked after children's training for all NHS providers are undertaken by the designated professionals.
- Seek assurance that commissioned providers are meeting their statutory safeguarding responsibilities, and in particular that staff are following approved local, national and NICE guidance.
- Ensure that robust systems are in place to facilitate transition from children's to adult services.

5. Deliver the strategy

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

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

6. Monitor Assurance

6.1. Service specifications and contract quality schedules will include clear service standards and KPIs (key performance indicators) for safeguarding Children and promoting their welfare, consistent with the LSCB procedures and regular reporting on KPI compliance will be made to the CCG. The KPIs will be agreed with the provider as part of contractual negotiations and will include training level requirements, safer recruitment, supervision of staff, voice of the child, early recognition, Looked After Children and CSE action plans.

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

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

6.4 An annual Looked After Children's Report will be provided to CCG Governing Body, Corporate Parenting Board and the Local Safeguarding Children Board.

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

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

6.7 In addition to promoting on-going quality improvement, as commissioners, we need to be assured that existing services meet acceptable standards. Whilst regulators play a key role here, commissioners must still actively monitor the quality of services delivered by our providers. Where we are not assured about the quality of any of the services we commission, detect early warnings of a potential decline in quality or suspect a breach of unacceptable standards we have a responsibility to intervene.

6.8 NHS Southport & Formby Clinical Commissioning Group (CCG) and Sefton Children's Trust strongly believes that commissioning services effectively is a vital step in achieving the best outcomes for children, young people and their families.

6.9 By working together, the partnership can achieve the right level of integration to secure better outcomes, high quality sustainable services and a resulting reduction in the gap in health inequalities, educational attainment, skills and well-being.

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NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/49	**Author of the Paper:** Name: Kevin Thorne Job Title: Integrated Commissioning Manager Email: kevin.thorne@southseftonccg.nhs.uk Tel: 0151 247 7278
Report date: March 2016	

Title: Developing Dementia-Friendly Communities and the Sefton Dementia Action Alliance

Summary/Key Issues:

Sefton has one of the highest percentages of adults with dementia in the UK and figures produced by Oxford Brookes University predict there are considerably more people affected by dementia than are registered with GPs. Current estimates suggest there are 4,446 people aged over 65 affected by dementia, more than double the number registered with GPs. As well as the 4,446 dementia sufferers over the age of 65 in Sefton in 2015 it is estimated that there are 77 people who are affected by Early Onset Dementia.

People with dementia and their carers face many challenges going about their daily lives including whilst shopping, using public transport, socialising and remaining involved in their community. The development of dementia friendly communities will mean that 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.

NHS Southport & Formby CCG can contribute to this growing social movement by signing up to the Sefton Dementia Action Alliance and making a commitment to becoming a dementia friendly organisation. In doing so NHS Southport and Formby must commit to an action plan detailing what it will do as an organisation to contribute to this growing social movement to support people with dementia and their carer's.

Recommendation

The Governing Body is asked to approve the recommendations contained in this report.

Receive	
Approve	x
Ratify	

16/48 Dementia Friendly Communities

Links to Corporate Objectives *(x those that apply)*	
	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.
	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			Staff time
Locality Engagement	x			
Presented to other Committees	x			Local authority is supporting dementia friendly initiatives.

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
	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

Report to Governing Body
March 2016

1. Executive Summary

Sefton has one of the highest percentages of adults with dementia in the UK and figures produced by Oxford Brookes University predict there are considerably more people affected by dementia than are registered with GPs. Current estimates suggest there are 4,446 people aged over 65 affected by dementia, more than double the number registered with GPs. As well as the 4,446 dementia sufferers over the age of 65 in Sefton in 2015 it is estimated that there are 77 people who are affected by Early Onset Dementia.

People with dementia and their carers face many challenges going about their daily lives including whilst shopping, using public transport, socialising and remaining involved in their community. The development of dementia friendly communities will mean that 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.

NHS Southport & Formby CCG can contribute to this growing social movement by signing up to the Sefton Dementia Action Alliance and making a commitment to becoming a dementia friendly organisation. In doing so NHS Southport and Formby must commit to an action plan detailing what it will do as an organisation to contribute to this growing social movement to support people with dementia and their carer's.

2. Introduction and Background

Like most of the country, Sefton is experiencing a continuing rapid increase in the proportion of older people in its population. Older people in Sefton generally enjoy good physical and mental health, and they are a great asset to their communities through their many contributions to local organisations, neighbourhoods and their own families. Nevertheless, this increasing proportion of older people in the population will make increasing demands on health and social care services, including those with dementia.

Dementia can affect adults of any age, but is most common in older people. One person in 20 over 65 has a form of dementia, rising to 1 in five in those over 80. Dementia in people aged under 65 is relatively rare – less than 3% of all those with dementia.

It is estimated that there are around 4,500 in Sefton living with some form of dementia. Positive, proactive approaches to service development providing individualised support can help ensure that physical and mental health are sustained as long as possible, that people live at home for as long as possible and that crises and unnecessary use of intensive costly services are minimised.

The recently published Sefton Dementia Strategy is an extremely important step in facing the challenges of a rising population of people who will have some form of dementia.
Dementia presents a huge challenge to society, both now and increasingly in the future. It is a common condition, which has a significant impact both on carers and society with an increasing cost attached to caring for people within the community.

Providing access to high quality services is appropriate to enable people to remain at home, for as long as possible, however for people trying to live well with dementia requires more than access to statutory services.

3. Key Issues

People with dementia and their carers face many challenges going about their daily lives. This can include difficulty using technology, getting appropriate service in shops, banks and post offices and in using transport, going on holiday, maintaining social contact and hobbies. Although help from health and care services is vitally important, making it possible for people affected by dementia to live well will require help from people and organisations across society and local communities.

Sefton already has pockets of good practice where shops, businesses and organisations came together to form local alliances that committed resources, raised awareness, trained staff and made some simple changes to improve the experiences of people with dementia and their carers using their services.

The Sefton Dementia Action Alliance was formally established at a recent meeting on the 20th January 2016 which brought together interested stakeholders from across Sefton to begin to identify the key changes required to make Sefton a friendlier place.

4. Conclusions

Supporting the development of dementia-friendly communities will mean that 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.

One of the key ways in which this can be done is through supporting the development of local dementia action alliances across England.

NHS Southport & Formby CCG has a leadership role across North Sefton and is in a prime position to demonstrate its support for Sefton Dementia Action Alliance by formally joining the initiative and complete an Action Plan setting out what it can do to make a difference to people living with dementia.

5. Recommendations

1. That NHS Southport & Formby CCG staff and member practices become dementia-friendly by undertaking appropriate awareness training and cascading awareness sessions throughout the organisation;

2. That NHS Southport & Formby CCG joins the Sefton Dementia Action Alliance. Attendance at bi-monthly meetings would be required;

3. That NHS Southport & Formby CCG encourage its member practices to become dementia-friendly and also sign up to the Sefton Dementia Action Alliance;

4. That NHS Southport & Formby CCG actively promotes dementia friends training and awareness with commissioned services via its contracting processes and provider specifications;

5. That NHS Southport & Formby CCG monitors the delivery of actions in the Dementia Strategy "Living Well with Dementia: A Strategy for Sefton 2014-2019". This can be done by continuing to support the strategy group chaired by Cllr. Paul Cummins of Sefton MBC. Kevin Thorne - Dementia Lead could take on this role.

Kevin Thorne
March 2016

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2016

Agenda Item: 16/49	**Author of the Paper:** Geraldine O'Carroll Senior Integrated Commissioning Manager Email: Geraldine.o'carroll@southseftonccg.nhs.uk Tel: 0151 247 7112
Report date: March 2016	

Title: Transforming Care: Implementation of National Plans across Cheshire and Merseyside

Summary/Key Issues:

As a result of the Winterbourne View Review: Concordat: Programme of Action (2012) NHS England is committed to improving the health and outcomes of people with learning disabilities and autism, and transforming services to improve the quality of care throughout peoples' lives.

In line with the priorities of the Transforming Care programme, it is intended that this will involve a significant shift in commissioning towards high quality community-based services over the next 3 years, allowing the closure of inpatient beds and facilities.

Recommendation

The Governing Body is asked to receive 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.
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				
Clinical Engagement				
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered				
Locality Engagement				
Presented to other Committees	x			Health and Well Being Board

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

NHS
Southport and Formby
Clinical Commissioning Group

Report to Governing Body
March 2016

1. Introduction and Background

Purpose of Report

1.1 The purpose of this report is to update Clinical Commissioning Group (CCG) Governing Bodies with regard to the national, regional and local programme of work with regard to Transforming Care for children, young people and adults with learning disabilities. The Care and Treatment Review: Policy and Guidance October 2015 relates to people of all ages with learning disabilities who are at risk of admission or currently in receipt of specialist learning disability or mental health inpatient services and are the commissioning responsibility of NHS England or the Clinical Commissioning Groups.

Background

1.2 As a result of the Winterbourne View Review: Concordat: Programme of Action (2012) NHS England is committed to improving the health and outcomes of people with learning disabilities and autism, and transforming services to improve the quality of care throughout peoples' lives.

1.3 Transforming Care for People with Learning Disabilities - Next Steps, (July 2015) outlined an ambitious programme of system wide change to improve care for people with learning disabilities and/or autism, and behaviour that challenges (learning disabilities).

1.4 Next Steps (July 2015) set out clear expectations that six organisations - NHS England, Department of Health (DH), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Care Quality Commission (CQQ) and Health Education England (HEE) - would work together more effectively, to drive forward change.

1.5 There is now a single shared Transforming Care programme that recognises the scale of the change required, and ensures that we address the underlying causes of why so many people remain in, and are continuing to be placed in, hospital settings.

1.6 The five areas in the Transforming Care programme are:

- **Empowering individuals** – giving people with learning disabilities and/or autism, and their families*, more choice* and say in their care.

- **Right care in the right place** – ensuring that we deliver the best care now, including a new approach to *care and treatment reviews*, whilst re-designing services for the future, starting with five fast-track sites to accelerate service re-design and share learning.

- **Regulation and inspection** – tightening regulation and the inspection of providers to *drive up the quality of care*.

- **Workforce** – developing the *skills and capability* of the workforce to ensure we provide high quality care.

- **Data and information** – making sure the *right information is available* at the right time for the people that need it, and continuing to track and report progress.

1.7 Next Steps (July 2015) set out a clear ambition for a radical re-design of services for people with learning disabilities. A draft service model has been recently published, which sets out nine overarching principles which define what 'good' services for people with learning disabilities and/or autism whose behaviour challenges should look like.

1.8 In line with the priorities of the Transforming Care programme, it is intended that this will involve a significant shift in commissioning towards high quality community-based services over the next 3years, allowing the closure of inpatient beds and facilities.

1.9 Friday 30 October 2015 saw a key milestone in the Transforming Care programme with the publication by NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) of; 'Building the right support: A national implementation plan to develop community services and close inpatient facilities and a 'New Service Model' (2015).

1.10 The establishment of six Fast-Track areas, announced by Simon Stevens at the NHS Confederation conference will 'test; the draft Service model during the summer of 2015.

Cheshire & Merseyside Transforming Care Board

1.11 In response to the national programme (Building the right support, 2015) a Cheshire & Merseyside Transforming Care Board has been established.

1.12 The Board are undertaking 2 pieces of work in the first instance. The first is to establish the population need to enable commissioning of high quality services moving forward. We have commissioned a Joint Strategic Needs Assessment across Cheshire & Merseyside to inform current work programmes in partnership with Public Health England and Liverpool John Moore's University.

1.13 The second is a look back exercise to evaluate were we have come from in terms of bed usage and models of care and where we need to get to as a health and social care economy.

1.14 It is recognised that Cheshire & Merseyside have already undertaken a significant amount of service improvement in this area and recognising the journey so far is significant when reviewing in-patient provision. To this end the Board will:

- Undertake a retrospective review of LD service provision and activity from 2010-2015 focussing on Assessment and Treatment beds, Locked Rehabilitation beds and Neuro Psychiatry beds, both in and out of area. Within this work there will be a look at:
  - The trend analysis and identify complementary activity within local NHS in patient provision in assessment and treatment units.
  - Identify elements of key community services that contribute to care and prevent admission, and accelerate discharge.
  - Performance as measured in the LD Self-Assessment Framework over this period.

- Developing a model of care for the coming 3 years, 2016-2019, for LD services for Cheshire and Merseyside that builds on the strengths identified in the retrospective study that draws on Government Policy and the NHS 5 Year Forward View (NHS England 2015).

1.15 It is expected that the TCPs will now follow the same programme of work as the six national fast track sites. Therefore the programme plan of transformation will include:

- Development of local plans that support the development of new models of care and long term bed closures, underpinned by a robust learning disability joint strategic health needs assessment. The North Mersey Hub is Liverpool and Sefton (as shown in the diagram below).

- Rapid expansion and improvement in community provision, encompassing a range of supported living options and housing with accompanying care and support, to enable the transfer of people from inpatient facilities.

- Any use of in-patient services must be based on robust assessment of an individual's needs. People that do require in-patient care due to the severity of their condition should have the highest quality of care and an agreed plan to return to their community placement as quickly as possible.

- Repatriation of out of area placements.

1.16 There will be one Transforming Care Partnership or unit of planning across the Cheshire & Merseyside footprint to ensure commissioning at scale, with three geographical collaborative commissioning delivery hubs as outlined below.

Cheshire and Merseyside Unit of Planning			
Hub	**CCGs**	**Local Authority**	**Total Population**
Hub 1 Cheshire	Wirral West Cheshire East Cheshire South Cheshire Vale Royal	Wirral West Cheshire & Chester East Cheshire	1,078,886
Hub 2 Mid Mersey	Halton St Helens Warrington Knowsley	Halton St Helens Warrington Knowsley	701,952
Hub 3 North Mersey	South Sefton Southport & Formby Liverpool	Sefton Liverpool	786,383

1.17 This approach builds on:

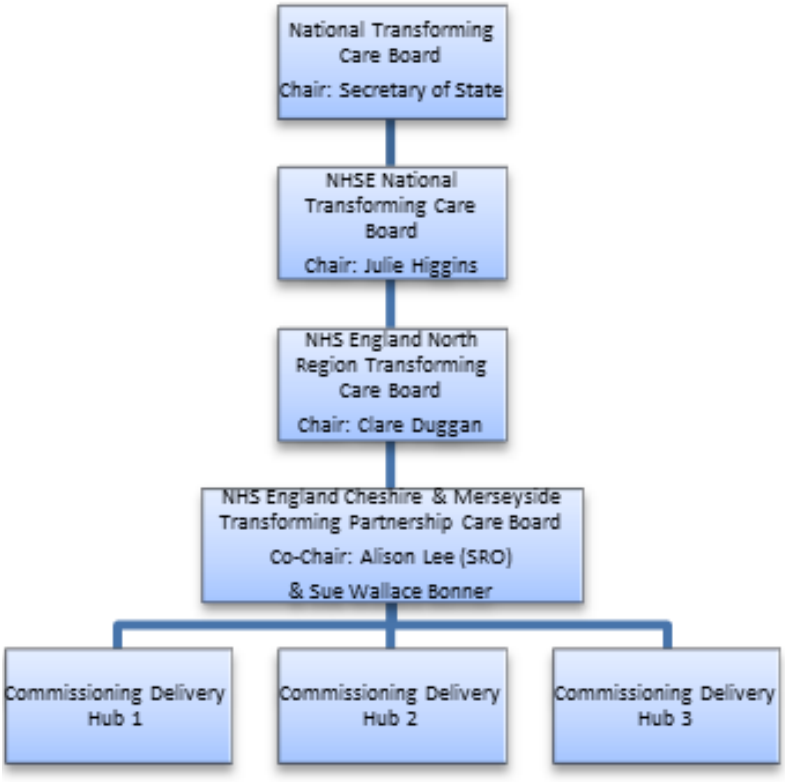
- existing CCG/LA collaborative commissioning arrangements
- current clinical pathway service delivery
- joint purchasing arrangements between some CCGs
- joint CCG/LA arrangements, including governance for joint decision-making
- excellent CCG/Provider working relationships
- provider financial viability and clinical sustainability

Governance Arrangements to Support Delivery

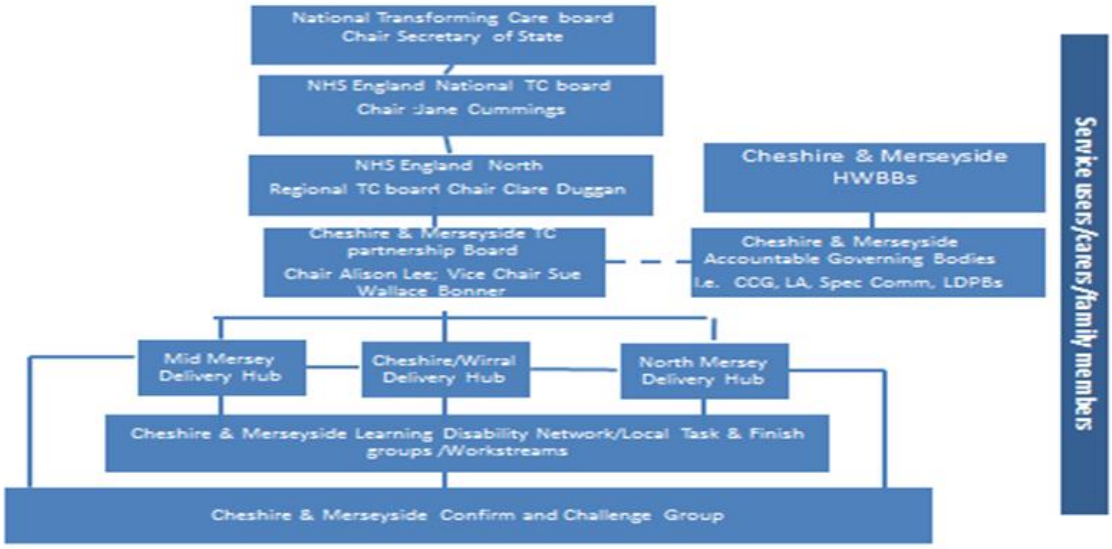
1.18 There is a well-established Cheshire & Merseyside learning disabilities network with CCG, LA, Provider and service user representation. This group will now undertake task and finish work on behalf of the board. One of the current strategic work themes is, 'Safe and Responsive services' for which a full work plan has been developed. However it is envisaged that this work plan will be captured and continue as part of the Cheshire and Merseyside Transforming Care Board which will hold partners to account for delivery of the National Implementation programme (2015).

1.19 There will be financial support via a national budget to progress some of this work; the amount and process for access to funding is still yet to be agreed nationally, but there is local agreement that a project management office function be established to facilitate the work programme locally.

1.20 The **national governance structure** to support delivery of the national plan is outlined below:



1.21 As NHS England is not a Governing body the suggested local governance structure to support delivery of the national plan is outlined below:



Care and Treatment Reviews

1.22 CTRs have been developed as part of NHS England's commitment to improving the care of people with learning disabilities with the aim of reducing admissions and unnecessarily lengthy stays in hospitals and reducing health inequalities.

1.23 CTRs were initiated with a target of supporting the discharge of 50% of the people who were inpatients on the 1st April 2014 by the end of March 2015. The process introduced a level of external scrutiny to existing processes, in effect offering those people in hospital a degree of 'second opinion'.

1.24 Care and Treatment reviews (CTR) are offered to all patients who are or have been an inpatient for 6 months or longer and patients have a right to request these at any time, it is expected that patients should be offered a CTR prior to admission or alternatively within two weeks following admission and then 6 monthly thereafter. It is expected that each Care and Treatment Review will take about a day.

1.25 The review panel will be made up of the responsible commissioner and two independent expert advisers; one expert by experience and one clinical expert. If the commissioner is unable to attend then they must ensure that they send a representative who carries delegated authority. From APRIL 1ST Clinical Lead, will now have to be independent of local services and this will incur a cost to the local CCGS.

1.26 The commissioner responsible for the person's care following discharge, which should include local authority colleagues or joint commissioners, should be involved in the review process. This is vital for planning for the future and understanding and resolving any barriers.

Benefits

- Proactive planning including discharge planning or plans to move to step down accommodation where appropriate. The reviews had a constant focus on repatriating individuals into their local communities or a place closer to home where appropriate. An emphasis on planning for the future including setting target dates for discharge was also inherent to the process, even if a person needed to remain in their current placement in the short-medium term.
- The planned discharge dates for all patients are detailed in the fortnightly and monthly returns.
- Where a date for transfer or discharge has not yet been finalised, the date of the next review has been stated and a reason for this has been given, for example a clinical decision has been made that it is not safe for the person to be in an alternative placement and they require an on-going intervention that can only be delivered within the current environment.

1.27 Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition-Transforming Care Service Model for Commissioners of Health and Social Care Services.

2. Service Model

2.1 This service model is about those people with a learning disability and/or autism who display behaviour that challenges, including behaviour which is attributable to a mental health condition.

2.2 The principles which underpin this service model build on what have been described before, including in Valuing People and Valuing People Now, all of which focus on rights, independence, choice and inclusion for people with a learning disability and/or autism. Good practice guidance around the commissioning of services for people with a learning disability and/or autism who display behaviour that challenges, including the 1993 and 2007 Mansell reports, describe the need to develop high quality local services that understand and support people, and reduce the reliance on out-of-area placements. They focus on ensuring the best outcomes for people by working in partnership with individuals and families/carers and through adopting person-centred approaches – vital to delivering independence and control for people and ensuring that the person's wishes and aspirations for their own life are at the centre of their care and support. This service model is for all health and social care commissioners – not just learning disability commissioners; in particular, this includes mental health commissioners, Continuing Health Care (CHC) commissioners, public health and children's commissioners. It covers the full range of commissioning – strategic, operational and individual/micro commissioning.

2.3 Commissioners should ensure that plans impacting on people of all ages with a learning disability and/or autism align with related initiatives, and identify opportunities for joint working. This should include commissioners seeking to align these plans with the development of their Local Transformation Plans for Children and Young People's Health and Wellbeing, local action plans under the Mental Health Crisis Concordat and the 'local offer' for personal health budgets.

2.4 This service model is intended for a particular juncture in the transformation of services for people with a learning disability and/or autism. It builds on existing NICE guidance (such as that on challenging behaviour and learning disabilities and that on autism and will be superseded as good practice develops and in particular once NICE service model guidance is published in 2017.

3. Financial Underpinnings

3.1 A new financial framework will underpin and enable transformation.

3.2 Local transforming care partnerships (CCGs, local authorities and NHS England specialised commissioning) will be asked to use the total sum of money they spend as a whole system on people with a learning disability and/or autism to deliver care in a different way to achieve better results. This includes shifting money from some services (such as inpatient care) into others (such as community health services or packages of support). The costs of the future model of care will therefore be met from the total current envelope of spend on health and social care services for people with a learning disability and/or autism. NHS estimate that the closure of inpatient services will release hundreds of millions of pounds for investment in better support in the community.

3.3 To enable that to happen, NHS England's specialised commissioning budget for secure learning disability and autism services will be aligned with the new transforming care partnerships, and CCGs will be encouraged to pool their budgets with local authorities whilst recognising their continued responsibility for NHS Continuing Healthcare.

3.4 Dowries will be paid by the NHS to local authorities They should apply to those patients discharged on or after 1 April 2016, and only to those patients who have been in inpatient care for five years or more on 1 April 2016 (not any patient who reaches five years in hospital subsequent to that date) discharge. We expect that NHS England will pay for dowries when the inpatient is being discharged from NHS England-commissioned care, and that CCGs will pay for dowries when the individual is being discharged from CCG commissioned care. Dowries will be recurrent, will be linked to individual patients, and will cease on the death of the individual. In addition to paying for these dowries, the NHS will continue to fund continuing healthcare (CHC) and relevant Section 117 aftercare.

3.5 In addition, from November 2015 *Who Pays* guidance – determining responsibility for payment to providers - will be revised to facilitate swifter discharge from hospital of patients originating from one CCG but being discharged into a different local area. This will ensure continuity of care with responsibility remaining with one CCG rather than being passed from commissioner to commissioner.

3.6 Transformation of this scale will entail significant transition costs, including the temporary double running of services as inpatient facilities continue to be funded whilst new community services are established. To support local areas with these transitional costs, building on the approach tested with fast track areas, NHS England will make available up to £30 million of transformation funding over three years, with national funding conditional on match-funding from local commissioners.

3.7 In addition to this, £15 million capital funding over three years will be made available, and NHS England will explore making further capital funding available following the Spending Review.

3.8 As set out in the national service model, alongside these new financial underpinnings to enable transformation, we expect to see a significant growth in personalised funding approaches (personal budgets, personal health in some parts of the country, local transformation plans will also need to align with Integrated Personal Commissioning (IPC) pilots.

4. Sefton's Local Provision

4.1 At the time of writing this report Sefton is in a strong position as it does not commission out of area placements. Sefton currently commissions 5 inpatient beds at the STAR unit (Mersey Care NHS Trusts learning disability in patient unit as Mossley Hill Hospital; a 9 bedded in patient facility for people with learning disabilities and associated mental health and behavioural problems, which accepts individuals from Sefton and Liverpool either on an informal basis or detained under the Mental Health Act). Sefton's current use of local assessment and treatment beds is around 2 beds per year, which is part of the current block contract arrangement with NHS Mersey Care Trust.

4.2 Formal links with Specialised Commissioning are in place to ensure that information re: reviews undertaken and individuals identified for discharge is communicated to CCG's and community services. There is representation by the CCG's and CLDT at both discharge and CPA 117 reviews at local inpatient services and within Specialised Commissioning placements.

4.3 The table below shows the number of People with Learning Disabilities secure placements that has been commissioned by NHS England at the time of writing this report.

CCG	South Sefton	Southport & Formby
Number under the Mental Health Act	4	2
Number in placement longer than 5 years	2	1

4. 4 All of these placements have been made via Court one however is a recall for a Care Treatment order in South Sefton.

4.5 The joint funding process between Southport & Formby and South Sefton CCGs and Sefton Social Services has been in operation since 1997. The joint funding process is a means of commissioning an integrated package of care, for those individuals with learning disabilities and complex challenging behaviour. Its aim is to enable those individuals to remain living within their local community as opposed to having to access out of area specialist care. There is also a joint funded post to co-ordinate and monitor individual's packages of care.

4.6 Providers that have a track record in supporting individuals with managing individuals with challenging behaviour housing provision that in the main can accommodate learning disabilities.

Response to Winterbourne View - Transforming Care - (Monitoring of patient placements) Fortnightly Winterbourne Patient Tracker

4.7 Individuals are monitored by NHS Area Teams on a fortnightly basis via a return from each CCG. A rota has been established amongst CCG Commissioners to ensure that several members of staff are able to complete this return.

4.8 The governance process is as follows:

- Each fortnight (alternate Tuesdays) each CCG submits the updated return.
- The tracker is then submitted to North Regional office for Merseyside.

Monthly HSCIC Winterbourne Returns

4.9 All CCGs/LAs are required to submit a monthly Winterbourne return which has patient identifiable data on it. This is submitted electronically directly from CCGs to HSCIC.

4.10 Sefton is fully compliant with this return.

4.11 For Sefton there are separate assurances submitted by Merseyside Specialised Commissioning (who report on services users in secure settings) and by the Commissioning Team (who report on services users in non-secure settings) this ensures that all patients are identified and are managed in a co –ordinated way.

Bed Reduction Programme

4.12 Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million populations
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million populations

4.13 South Sefton and Southport & Formby CCGs will work closely with Sefton MBC and Mersey Care NHS Trust to reduce bed occupancy by 10% by March 2016 which is in line with National targets and equates to approximately 182 bed days in total. This will form part of the National target to reduce occupancy by 30%. Sefton's Assessment and Treatment bed Activity from 2010/11 to 2015/16 shows a 47% reduction in bed usage (see - report commissioned by NHS England LD AT bed activity by Colin Vose).

4.14 Throughout this process and as part of partnership working, South Sefton and Southport & Formby CCGs will work closely with Sefton MBC, NHS England and partners to agree a process for managing local resources.

Understanding the Local Population

4.15 A Health needs assessment was commissioned by NHS England from Liverpool Public Health Observatory across Cheshire and Merseyside; (see Appendix 5) Learning disabilities and autism: A health needs assessment for children and adults in Cheshire and Merseyside- January 2016.

4.16 The aforementioned report has provided commissioners with the understanding of different types of need to ensure the availability of the right sorts of support and services in Sefton.

5. Conclusions

5.1 A significant amount of work has been undertaken collaboratively in Sefton in relation to transforming service provision for people with Learning Disabilities and or Autism and/or autism, and behaviour that challenges (learning disabilities).In terms of the Cheshire and Merseyside Transforming Care Plan, Sefton is in a strong position as it does not commission out of area placements and has achieved a 47% reduction in bed usage in assessment and treatment provision over the last 5 years. Our challenge locally is how do we sustain our local position given the financial restraints across the systems.

6. Recommendations

6.1 The Board is asked to receive the content of this report.

Appendices

Appendix 1 - Transforming Care: Implementation of National Plans across Cheshire & Merseyside

Geraldine O'Carroll
March 2016

NHS England

Transforming Care: Implementation of National Plans across Cheshire and Merseyside

January 2016

Transforming Care: Implementation of National Plans across Cheshire and Merseyside

Version number: 1

First published: December 2015

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Chief Nurses and Directors of Quality Cheshire & Merseyside CCG's.

Classification: OFFICIAL

1. **Purpose of report**

   The purpose of this report is to update Clinical Commissioning Group (CCG) Governing Bodies with regard to the national, regional and local programme of work with regard to Transforming Care for people with Learning Disabilities.

2. **Background**

   As a result of the Winterbourne View Review: Concordat: Programme of Action (2012) NHS England is committed to improving the health and outcomes of people with learning disabilities and autism, and transforming services to improve the quality of care throughout peoples' lives.

   Transforming Care for People with Learning Disabilities - Next Steps, (July 2015) outlined an ambitious programme of system wide change to improve care for people with learning disabilities and/or autism, and behaviour that challenges (learning disabilities).

   Next Steps (July 2015) set out clear expectations that six organisations - NHS England, Department of Health (DH), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), Care Quality Commission (CQQ) and Health Education England (HEE) - would work together more effectively, to drive forward change.

   There is now a single shared Transforming Care programme that recognises the scale of the change required, and ensures that we address the underlying causes of why so many people remain in, and are continuing to be placed in, hospital settings.

   The five areas in the Transforming Care programme are:

   - **Empowering individuals** – giving people with learning disabilities and/or autism, and their families*, more choice* and say in their care.

   - **Right care in the right place** – ensuring that we deliver the best care now, including a new approach to *care and treatment reviews*, whilst re-designing services for the future, starting with five fast-track sites to accelerate service re-design and share learning.

   - **Regulation and inspection** – tightening regulation and the inspection of providers to *drive up the quality of care*.

   - **Workforce** – developing the *skills and capability* of the workforce to ensure we provide high quality care.

   - **Data and information** – making sure the *right information is available* at the right time for the people that need it, and continuing to track and report progress (Appendix 1).

3. **National Transforming Care Programme 2015 - 2019**

   Next Steps (July 2015) set out a clear ambition for a radical re-design of services for people with learning disabilities. A draft service model has been recently published,

which sets out nine overarching principles which define what 'good' services for people with learning disabilities and/or autism whose behaviour challenges should look like.

These principles will underpin how local services are redesigned over the coming months and years – allowing for local innovation and differing local needs and circumstances, while ensuring consistency in terms of what patients and their families should be able to expect from local decision-makers.

The establishment of six Fast-Track areas, announced by Simon Stevens at the NHS Confederation conference will 'test; the draft Service model during the summer of 2015.

NHS England have continued to seek the views of clinicians, commissioners, providers, people with learning disabilities and/or autism who have a mental health condition or display behaviour that challenges (including offending behaviours) and their families, ahead of the publication of a final version published in autumn 2015. This will help to support commissioning intentions and financial planning 2016/17.

In line with the priorities of the Transforming Care programme, it is intended that this will involve a significant shift in commissioning towards high quality community-based services over the next 18 months, allowing the closure of inpatient beds and facilities.

Friday 30 October 2015 saw a key milestone in the Transforming Care programme with the publication by NHS England, the Local Government Association (LGA), and the Association of Directors of Adult Social Services (ADASS) of; 'Building the right support: A national implementation plan to develop community services and close inpatient facilities and a 'New Service Model' (2015).

Taken together, these documents have asked Local Authorities, Clinical Commissioning Groups (CCGs) and NHS England specialised commissioners to come together to form Transforming Care Partnerships (TCPs) to build up community services and close unnecessary inpatient provisions over the next 3 years and by March 2019.

Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

While local areas will be able to design bespoke services with those who use them, the national plan (2015) also sets out the need for:

- Local councils and NHS bodies to join together to deliver better and more coordinated services

- local housing that meets the specific needs of this group of people, such as schemes where people have their own home but ready access to on-site support staff
- a rapid and ambitious expansion of the use of personal budgets, enabling people and their families to plan their own care, beyond those who already have a legal right to them
- people to have access to a local care and support navigator or key worker, and investment in advocacy services run by local charities and voluntary organisations so that people and their families can access independent support and advice
- pooled budgets between the NHS and local councils to ensure the right care is provided in the right place
- Using the nine principles set out in the 'New Service Model' (2015) TCPs should have the flexibility to design and commission services that meet the needs of people in their area

There is also an expectation as part of the national Transforming Care programme of work for:

- A 10% reduction in in-patient admissions using the pre 31.3.15 cohort of patients as the baseline, by 31 March 2016 and,
- Care and Treatment reviews (CTRs) for all people in an inpatient bed to become 'business as usual'.

4. Transforming Care Partnerships (TCPs)

Cheshire & Merseyside have had an historic Learning Disability Network that has undertaken much work from the Winterbourne View Recommendations over the past 3 years. Discussions through this network resulted in an agreed consensus to progress developments via one Transforming Care Partnership or unit of planning across the Cheshire & Merseyside footprint to ensure commissioning at scale, with three geographical collaborative commissioning delivery hubs as outline below.

Cheshire and Merseyside Unit of Planning			
Hub	**CCGs**	**Local Authority**	**Total Population**
Hub 1 Cheshire	Wirral West Cheshire, East Cheshire, South Cheshire Vale Royal	Wirral West Cheshire & Chester East Cheshire	1,078,886 Population
Hub 2 Mid Mersey	Halton St Helens Warrington Knowsley	Halton St Helens Warrington Knowsley	701,952 Population
Hub 3 North Mersey	South Sefton Southport & Formby Liverpool	Sefton Liverpool	786,383 population

This approach builds on:

- existing CCG/LA collaborative commissioning arrangements
- current clinical pathway service delivery
- joint purchasing arrangements between some CCGs
- joint CCG/LA arrangements, including governance for joint decision-making
- excellent CCG/Provider working relationships
- provider financial viability and clinical sustainability

NHS England has proactively facilitated the bringing together of local delivery hubs and local discussions have already commenced

4.1 Cheshire & Merseyside Transforming Care Board

In response to the national programme (Building the right support, 2015) a Cheshire & Merseyside Transforming Care Board has been established; with Alison Lee, Accountable Officer, West Cheshire CCG as Senior Responsible Officer for this programme of work and Sue Wallace-Bonner, Director of Adult Social Care Halton Council as Deputy Chair. There are current discussions underway with service user groups to establish a co-chair position.

The Board are undertaking 2 pieces of work in the first instance. The first is to establish the population need to enable commissioning of high quality services moving forward. We have commissioned a Joint Strategic Needs Assessment across Cheshire & Merseyside to inform current work programmes in partnership with Public Health England and Liverpool John Moore's University.

The second is a look back exercise to evaluate were we have come from in terms of bed usage and models of care and where we need to get to as a health and social care economy.

It is recognised that Cheshire & Merseyside have already undertaken a significant amount of service improvement in this area and recognising the journey so far is significant when reviewing in-patient provision. To this end the Board will:

- Undertake a retrospective review of LD service provision and activity from 2010-2015 focussing on Assessment and Treatment beds, Locked Rehabilitation beds and Neuro Psychiatry beds, both in and out of area. Within this work there will be a look at:
    - The trend analysis and identify complementary activity within local NHS in patient provision in assessment and treatment units.
    - Identify elements of key community services that contribute to care and prevent admission, and accelerate discharge.
    - Performance as measured in the LD Self-Assessment Framework over this period.

- Developing a model of care for the coming 3 years, 2016-2019, for LD services for Cheshire and Merseyside that builds on the strengths identified in the retrospective study that draws on Government Policy and the NHS 5 Year Forward View (NHS England 2015).

The target completion date for this work is January 2016.

It is expected that the TCPs will now follow the same programme of work as the six national fast track sites. Therefore the programme plan of transformation will include:

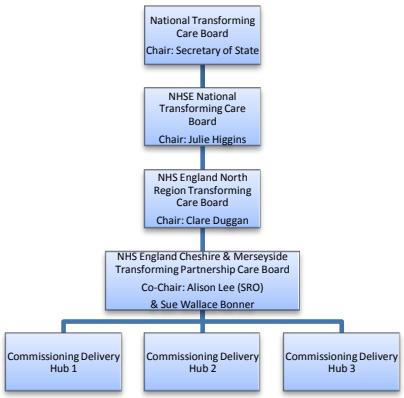
- Development of local plans that support the development of new models of care and long term bed closures, underpinned by a robust learning disability joint strategic health needs assessment.
- Rapid expansion and improvement in community provision, encompassing a range of supported living options and housing with accompanying care and support, to enable the transfer of people from inpatient facilities.
- Any use of in-patient services must be based on robust assessment of an individual's needs. People that do require in-patient care due to the severity of their condition should have the highest quality of care and an agreed plan to return to their community placement as quickly as possible.
- Repatriation of out of area placements

4.2 Governance arrangements to support delivery

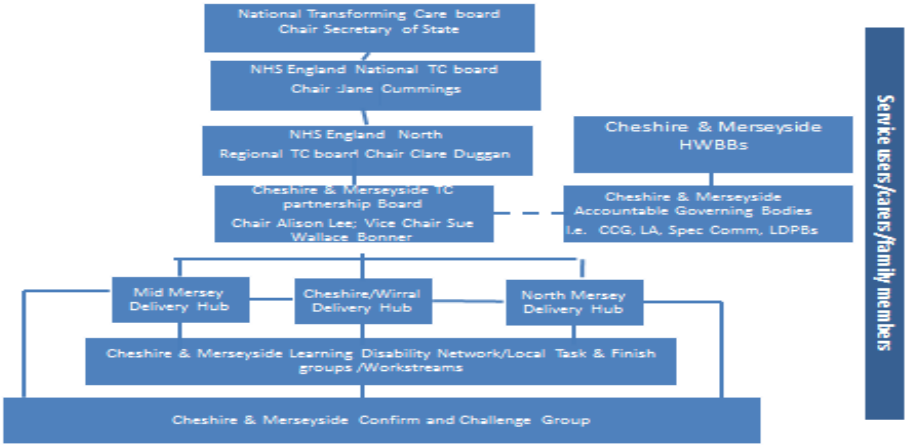
There is a well-established Cheshire & Merseyside learning disabilities network with CCG, LA, Provider and service user representation. This group will now undertake task and finish work on behalf of the board. One of the current strategic work themes is, 'Safe and Responsive services' for which a full work plan has been developed. However it is envisaged that this work plan will be captured and continue as part of the Cheshire and Merseyside Transforming Care Board which will hold partners to account for delivery of the National Implementation programme (2015).

There will be financial support via a national budget to progress some of this work; the amount and process for access to funding is still yet to be agreed nationally, but there is local agreement that a project management office function be established to facilitate the work programme locally.

The **national governance structure** to support delivery of the national plan is outlined below:



As NHS England is not a Governing body the suggested **local governance structure** to support delivery of the national plan is outlined below:



4.3 National and Local Focus 2016 – 2019

The expectation is that the non-fast track areas (Cheshire & Merseyside being one of them), will start to mobilise using the learning from the fast track areas and begin collaborative working to enable the system to realise the start date of April 2016 for:

- A reduction in in-patient admissions using the pre 31.3.15 cohort of patients of 10% by 31 March 2016
- Long term learning disability bed closures in
    - Assessment and Treatment beds
    - Locked Rehabilitation beds
    - Neuro Psychiatry beds

  (Forensic beds, low, Medium and High secure are being led by Specialised Commissioning)
- Development of new models of care.

4.3.1 Care and Treatment reviews

Care and Treatment reviews (CTR) are offered to all patients who are or have been an inpatient for 6 months or longer and patients have a right to request these at any time. More recently the expectation is that patients should be offered a CTR prior to admission or alternatively within two weeks following admission and then 6 monthly thereafter.

Cheshire and Merseyside CCGs and 3 main LD NHS Providers (Merseycare, 5 Borough Partnership and Cheshire Wirral Partnerships NHS Mental Health Trusts) are fully engaged in the CTR process and have pooled clinical resource to enable delivery in a consistent manner. Pathways Associates/North West Training and

Development Team provide Experts by Experience (service users, families and carers). There has been local proactive development of local operational models to ensure CTRs are 'business as usual' from September 2015. The patient stories of individuals who have had Delayed discharges have been collated which is useful in detailing some of the challenges in the system and will be considered in the new service models.

As of December 2015:

- 135 CTRs have been undertaken across CCGs for CCG commissioned services.
- There are 5 patients who have a delayed discharge; the main reasons being accessing an appropriate community provider, no local care package availability and requirement for housing adaptations to be undertaken.
- The use of the pre admission / blue light CTR protocol has avoided 4 hospital admissions during the period October-December 2015

Specialised commissioning

CTRs are also undertaken for patients in forensic/secure commissioned services. The aim being to progress the patient along the secure/forensic pathway into CCG commissioned services or community settings.

To aid progress NW Specialised Commissioning team have established quarterly meetings with local commissioners to ensure the number of Cheshire and Merseyside patients moving along the secure/forensic pathways of care into CCG commissioned placements is planned and funded for.

As of December 2015 the number of Cheshire and Merseyside patients in Specialised Commissioned services is outlined below:

CCG	Stepdown	LSU	MSU
East Cheshire		1	0
West Cheshire		3	0
Halton		0	4
South Cheshire		2	0
Vale Royal		0	0
Warrington		2	1
Wirral		1	2
Knowsley		1	1
South Sefton	1	4	3
Southport		0	0
St Helens		3	2
Liverpool	1	5	4
Totals	2	23	17

(Data source NHS England Specialist Commissioning Tracker Dec 2015)

4.3.2 In patient reduction & bed closure programme

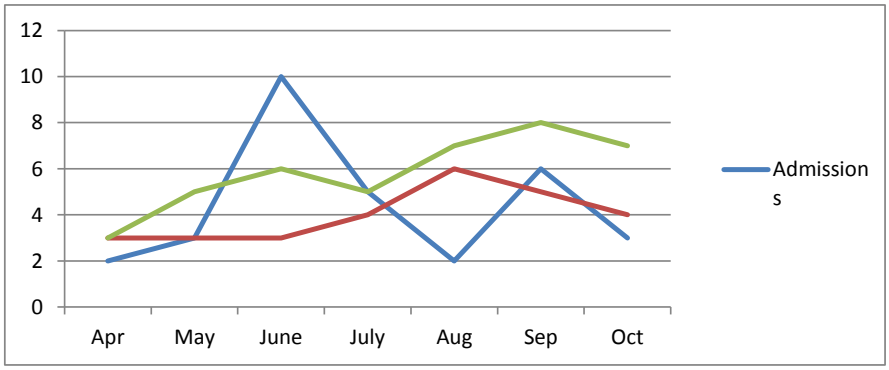
In patient reduction

One of the main responses to the Winterbourne View Concordat (2012) was the requirement to discharge patients from in patient settings if clinical safe to do so. The National Transforming Care board set a national discharge trajectory of between 10% - 13% for patients currently in an inpatient setting as of 31.3.15 to be achieved by 31. 3.16

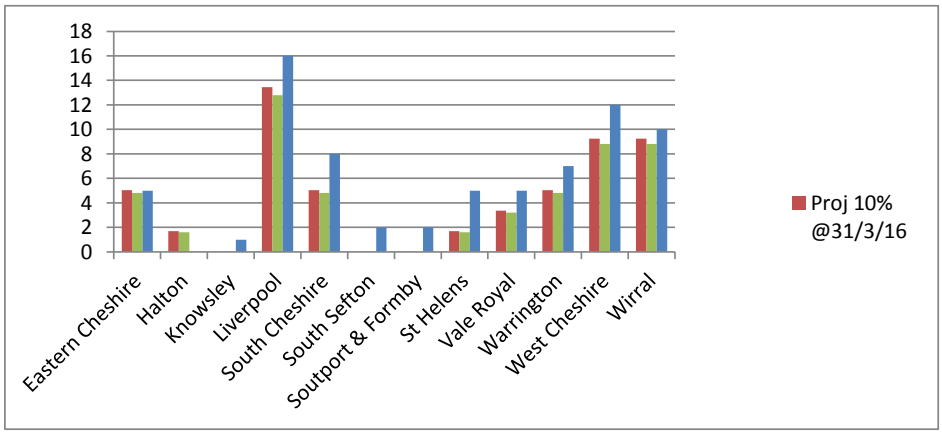
Progress to date for Cheshire and Merseyside's discharge trajectory is outlined below;

Team / CCG	Baseline@31/3/15	April	May	June	July	Aug	Sep	Oct	Nov	Proj 10% @31/3/16	Proj 13% @31/3/16	Diff to P1	Diff to P2
North of England	994	928	950	969	970	979	954	959	947	893	861	-66	-98
Cheshire & Merseyside	64	56	61	66	73	69	71	68	73	54	51	-19	-22
Eastern Cheshire	6	5	5	5	5	6	6	5	5	5	5	0	-0
Halton	2	2	1	0	0	0	0	0	0	2	2	2	2
Knowsley	0	0	0	1	1	1	1	1	1	0	0	-1	-1
Liverpool	16	15	16	15	17	17	17	16	16	13	13	-3	-3
South Cheshire	6	7	7	8	8	6	7	6	8	5	5	-3	-3
South Sefton	0	0	0	1	2	1	1	1	2	0	0	-2	-2
Soutport & Formby	0	0	0	0	1	1	1	1	2	0	0	-2	-2
St Helens	2	1	2	2	4	4	4	5	5	2	2	-3	-3
Vale Royal	4	4	5	5	5	5	5	5	5	3	3	-2	-2
Warrington	6	4	6	6	6	6	7	7	7	5	5	-2	-2
West Cheshire	11	9	9	12	11	10	11	12	12	9	9	-3	-3
Wirral	11	9	10	11	13	12	11	9	10	9	9	-1	-1

Data source: HSCIC Assuring Transformation dataset & NHS England TC Tracker Dec 15



Data source: NHS England TC Tracker Dec 15



Data source: NHS England TC Tracker Dec 15

4.3.3 Bed closure programme

Based on national planning assumptions, it is expected that no area should need more inpatient capacity than is necessary at any time to care for:

- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million populations
    - Cheshire & Merseyside target = 25 – 37 (CCG beds)
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million populations
    - Cheshire & Merseyside target = 50 – 62 (specialised beds)

The Cheshire and Merseyside Transforming Care board are currently undertaking the following baseline exercise which will help inform commissioners of bed activity as the new models are care are developed:

- A retrospective review of LD service provision and activity from 2010-2015 focussing on Assessment and Treatment beds, Locked Rehabilitation beds and Neuro Psychiatry beds, both in and out of area. Within this work look at:

    - The trend analysis and identify complementary activity within local NHS in patient provision with assessment units.

    - Identify elements of key community services that contribute to care and prevent admission, and accelerate discharge.

The detail from the baseline report will be available January 2016.

4. Potential risks that may prevent delivery

Risk	Risk Level	Mitigating Actions
Lack of robust baseline data	Medium	• Commissioned LD JSNA to understand robust population based needs • Timescales for completion of LD JSNA not in line with timescales for service development • Commissioned look back exercise of bed state
Requirement for Efficiency savings	High	• Work with CCG/LAs to ensure funds are ring fenced for LD service development & delivery • Bids for capital funds available for adaptions etc. via NHS England
Viability of Providers	High/medium	• Providers to develop models of care that ensure trust viability • Providers to commence discussions with legal teams regarding consultation • Commission at scale to ensure viability of providers
Delayed discharges / transfers	High	• Work with LAs to ensure robust process in place to move patient to suitably commissioned supported living placements • Map current provision of commissioned services and benchmark against LD profile

Risk	Risk Level	Mitigating Actions
		• Commissioners to hold providers to account in ensuring planned discharge date for individual on admission
Lack of sustainable community LD teams /services	High	• Commissioners to collaborate to develop strategic provider / preferred provider frameworks with commissioning collaborations need to be as local as possible • Work with commissioner to understand what community services are current commissioned – mapping & identifying 'what goods look like' to support shaping of future local service models • Development of bids to 'double run' services
Disruption to natural patient pathway/flows	Medium	• Clinical Leadership • Clear communication
Limited personalised social care	Medium	• Mapping of housing providers and social care providers • Establish market place

5. Service Change Assurance

The scale of change being envisaged (introduction of new care models and removal of beds may be considered a significant change, with associated risk of Judicial Review or referral to the Secretary of State.

To mitigate these risks NHS England with key partners (LGA, ADASS, Service users etc.) has a role in assuring the service change proposal before progress to the next stage. The assurance would need to be tailored to the specific circumstances and scale of the proposal. Details of assurance process to follow from National TC programme leads.

6. Next steps

Following local discussions at the Regional Transforming Care engagement workshop (9 November 2015) the following areas were identified as essential to support delivery of the national implementation plan:

- Clear governance structures
- As the national plan is reflective of all age ranges, further mapping of stakeholders to ensure all relevant stakeholders engaged in local development work i.e. Children's commissioners, CAMHS etc.
- Review of current community learning disability team (CLDT) specifications
- Review of out of area patients and development of repatriation programme
- Mapping of current social care/housing providers with CCG & LA commissioners with the potential to develop a social care framework
- Hold social care provider forum to establish current and potential services on offer
- Consideration of interim residential placements for current in-patients cohort with delayed discharge
- Development of 'Step up Step Down beds' to support crisis management building on what models that are nationally/regionally evidenced to support local developments

- Establish a provider forum
- Strength the 'at risk register' development's with all stakeholders: including development and agreement of data sharing agreements
- Strength local authority involvement in work programme via ADASS leads
- Pooled budgets
- Hold a local stakeholder dialogue event

7. Cheshire & Merseyside Stakeholder event

A local stakeholder event was held on 16 Dec 2016 at Daresbury Park Warrington to understand the local 'ask' of the National Transforming Care programme across the Cheshire & Merseyside footprint.

Over 85 delegates attended the event, with representation from health, local authority, social care, NHS providers, Healthwatch, advocacy, housing, and experts by experience and family members.

Members of the National Transforming Care Programme (NHS England and LGA) outlined the national 'ask' and timescales for mobilisation and delivery. As Senior Responsible Officer for this programme of work, Alison Lee, Accountable Officer, West Cheshire CCG endorsed the progress and work to date in this field across Cheshire & Merseyside, but also acknowledged the challenge ahead.

Moving into their relevant delivery commission hubs, the stakeholders started to work together to:

- Describe the vision for services for people with a Learning disability/autism or behaviours that challenge living in Cheshire & Merseyside?
- Established the strengths and weakness of current LD service provision in their locality
- Identify any key stakeholder that are missing and need to be involved
- Describe what does success look like
- Identify some local quick wins, and
- Begin to prioritise services developments for Years 1, 2 and 3
- Give thought to how the delivery hubs will progress locally

Details from the event have been collated and shared with stakeholders present (Appendix 2). NHS England will now utilise the detail from the event together with the findings of the retrospective reviews to develop a strategic plan for Cheshire & Merseyside which will be shared with the 3 delivery hubs and relevant governing bodies.

8. Conclusion

It is recognised that Cheshire & Merseyside have already undertaken a significant amount of work with regard to service provision for people with learning disabilities and/or autism, and/or behaviours that challenge.

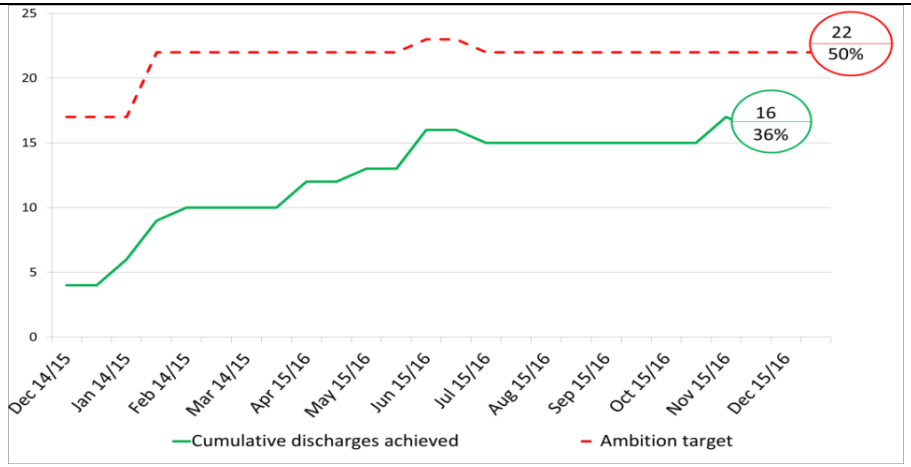
Telling the story of the journey so far is significant when reviewing in-patient provision to ensure we have adequate support for people who require it in times of deteriorating health or crisis. Alongside this the development of high quality services closer to home will enable people to live independent lives closer to their friends, family and carers.

The Cheshire & Merseyside Transforming Care Partnership Board will strive to delivery that national priorities locally, ensuring this is done in a co-productive manner with the patient's voice at the centre of the service model. Governing Bodies are asked to note the content of this report and support its implementation as a high priority area of work.

ENDS

Appendix 1. Cheshire & Merseyside Local Progress 2015/16

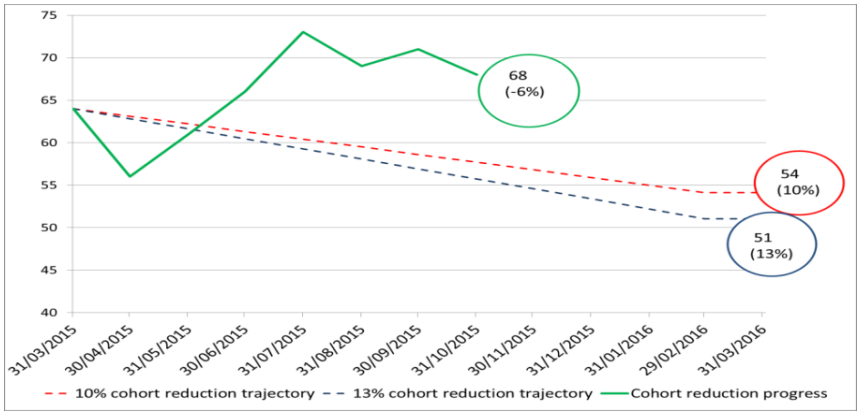
Empowering Individuals	Empowering people with learning disabilities and their families to have greater rights and say in their care, underpins the Transforming Care programme. We have been working with partners across the health, local authority and voluntary sectors to strengthen the collective voice of individuals with learning disabilities and their families, to ensure greater personalisation, increased choice about care, and greater influence over service design and delivery. An important milestone this year was the public consultation issued by the Government, 'No voice unheard, no right ignored', to strengthen the rights of people with mental health issues, learning disabilities and autism, so they can live independently, be included in their community, and make choices about their own lives. Locally we continue to work closely with Pathways Associates in: • Developing an expert hub of clinical reviewers and experts by experience to undertake Care and treatment reviews • ensuring we are asking whether people are getting support from advocacy through the revised approach to Care and Treatment • Reviewing Assuring Transformation data to gather information that tells us what sort of advocacy a person is receiving. • Developed a Co-production workstream to ensure the voice of the service user/Family carers is heard locally, regionally and nationally As a result of the work undertaken local we have successfully presented our methodology and how we have utilised the LDSAF validation process to improve and drive forward quality for people with LD locally at 2 national workshops run by IHAL. The workshops were held in June 2015 in Manchester and Bristol. Wirral CCG presented how this work at been used strategically at a local level to drive forward a joint action plan. As part of this they have streamlined processes, integrated stakeholders and worked towards joint ownership. **Governance: Co-production Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Right Care, Right Place, Right Time	The national ambition is to discharge 50% of patients from an inpatient facility at 1 April 2014 to the community by 31 March 2015; and to carry out care and treatment reviews for any patients in that cohort who have not got a discharge date and are in a low secure setting. Cheshire & Merseyside position at November 2015:



50% discharge ambition: Currently on trajectory to achieve discharge ambition of 65% by Q4 leaving 15 inpatients from the 31 March 2014 cohort with discharge dates during 2016/17

There is a renewed focus on reducing hospital admissions from the 2013/14 baseline by 10% during 2015/16, reducing length of stay and tackling delayed discharges. This will require a focus on developing community based provision locally. Improving the patient experience and outcomes is a key factor to drive this initiative.

Cheshire & Merseyside position at November 2015:



10% discharge ambition: despite an increase in admission numbers over summer months (due to CCG's has found patients who were out of area) now on a downward trend and confident that the 10% ambition will be achieved by end of Q4. Current focus on 3 CCGs with highest admission rate: West Cheshire, Wirral and Liverpool CCGs.

Governance: Commissioning Hubs of the Cheshire & Merseyside Transforming Care Board.

Regulation & Inspection	NHS England has established an Enhanced Quality Assurance Programme (EQAP) with the specific role of making sure people are safe and monitoring the quality of care reviews. EQAP will seek the firmest assurances that patients have clear care plans and are receiving the support they need and deserve. CQC is working to ensure that its assessment methods are fully adapted to ensure robust inspections of hospital and community learning disability services. The CQC is further developing the work on registration, to ensure that: • Applications by any service provider to vary their 'service type', that describes the services that they offer, are only agreed when the new 'service type' accurately reflects a changed model of care. This will also ensure that any inappropriate models of care for people with learning disabilities do not continue after the 'variation' has been agreed; and • new applications are only agreed when the application reflects the agreed model of care for people with learning disabilities, which is currently being defined by the Transforming Care programme and outlined in the new Service Model for commissioners **Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Workforce	Since the publication of Next Steps (July 2015), Health Education England (HEE) has been working with its Transforming Care partners, including Skills for Health and Skills for Care, to ensure that workforce development and planning supports the wider service re-design across health and social care. Work to date will includes the development and testing a new Learning Disability Skills and Competency Framework that outlines the competencies that staff needs to have, to fulfil certain roles, to ensure that we have the right skills in the right place. This Framework will be rolled-out in January 2016. **Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Data and Information	Health and Social Care Information Centre (HSCIC) is the national electronic information data analysis system for the Assuring Transformation Clinical Platform. All local CCGs are registered with HSCIC and actively submitting data. Local CCG/LA leads are also required to submit fortnightly data to NHS England via the local Transforming Care tracker. This enables the local monitoring of CTRs, admissions, in patient length of stay and progress being made towards individual, anticipated and planned discharge dates. Work is currently ongoing between NHS England Transforming Care analytical team and HSCIC to enable all clinical data fields to be submitted via one clinical portal on HSCIC system. It is

	envisaged that the NHS England TC tracker will cease in December 2015. **Governance: Safe and Responsive Services Sub Group of the Cheshire & Merseyside Transforming Care Board.**
Learning Disabilities Mortality Review (LeDeR) Programme	The new Learning Disabilities Mortality Review (LeDeR) Programme has been commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and will run from 2015 – 2018. The Programme has been established as a result of the key recommendations of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD). The aim of the Programme is to make improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce premature mortality and health inequalities faced by people with learning disabilities, through national and local reviews of deaths. There will be a phased roll-out of the programme across the 12 NHS Clinical Senate geographical areas of England from January 2016, following a piloting phase in autumn 2015. Once known, dates for C&M will be disseminated locally. **Governance: Health Inequalities Sub Group of the Cheshire & Merseyside Transforming Care Board.**

Appendix 2

Transforming Care Stakeholders event 16 December 2015 Daresbury Park Hotel Warrington

Cheshire Delivery Hub

Who's missing?
• Family Carer's • Carer's • CCG's • Eastern Cheshire CCG's • Educational Sector • Employment Services
Overall Vision for People with Learning Disabilities
• Care in the community / Closer to home • Safety • Proportionate risk taking • Right care, Right Treatment, Right time. • Own front door (Housing) • Working together (CCG, LA's, Independent Sector) • Forums - Culture change - Workforce development - Market shaping • 'Nothing about us without us'. • Honest • Self-Advocacy • Community Development • Leading 'own' support (Self/peer advocacy) • 'Good Lives' – People leading • Sharing Data • Working with service users. • Reducing Barriers. • Stream less Services / Transitions. • Sharing Resources - Useful tools - More co-production • Gaps in service (Autism) • Good Communication - Person centered. • Culture Change • Right People? - Employers - Children's Services
Shared Vision
• Meeting needs at times of crisis - Appropriate planning - Step up/step down beds - Person led • Individuals taking control of care planning • Safe happy and well • Supporting services to meet peoples neds • Individuals More in control of own budgets
What could be improved?
• Patient voice being heard.

- 24/7 support for service users in the community
- Transparency
- Patient-led care
  - Managing own budget
- Contingency planning
  - Crisis support
- Employment Service Users
  - Autism/LD
  - Opportunities
  - Improving quality of life, achieving goals.
- Involvement of employment and children's service and stakeholder groups.
- Care within home – Not sending out of area / secure units etc.

What does success look like?

- Working alongside service users - Closer collaboration.
  - Getting the best out of the services.
- Transparency
  - Between Services
  - Available Services
  - E.g. Development of land
- Shared Vision
- Meeting needs
  - Times of crisis
  - Appropriate planning step up / step down
  - Person-Led
- Individuals taking control of care planning.
- 'Safe, Happy and Well'
- Supporting services to meet person's needs.
- More In control of own budget (Service users)

What's Working Well?

- Local area coordinator's scoping available services – Individualised.
- Person – centred planning
- Improved communication – Hospitals / GP's
- Lots of work with Hospitals
  - Reasonable adjustments
  - GP Training
  - Health Champions (Training)
- Caring (CQC)
- Effectiveness (CQC)
  - Communication / Staff and carers
- Service users key role in recruitment.
- Service users assessing services
- Fewer people LD in assessment

What keeps you awake at night?

- Safeguarding issues – Problematic providers.
- Quality of service provision – Leadership
- Sending service users out of area
- Isolation
  - No support company

How are you going to progress locally?

- Out of area
  - Jan 16 meeting CCG's service users
- Single plan
  - Commissioner led
  - Strategic group set up
  - Joining commissioners / joined-up commissioners.
- Strategic Visions
  - Work streams working to same vision.
  -

Mid Mersey delivery Hub

Overall Vision for People with Learning Disabilities
• Gaps in provision need to be addressed such as post diagnostic services – for people with Autism / Asperger's. • Clarity of responsibilities of health provider 5BP • Better planning around transition and people coming through the service. • Involvement of voluntary sector to meet needs – potentially? • Housing / Builders being on board with transitional planning (Affordable housing) • Smarter intelligence and how we collate information of people coming through the transitional system. • Greater involvement of people of all ages including younger people. • Greater support for parents to understand the transitional process. Positive communication with people from birth.
What could be Improved
• Autism Post Diagnostics (decisions making) what will be decided when • Transitional Process • Reasonable adjustments process, explaining to people (Staff as well as service users) • Embedding reasonable adjustments in general practice. • Educating the wider population around learning disability awareness – Autism and Aspergers Syndrome. • Community Cohesion / resilience?
Gaps within the Process
• No Children's Service representation. • Ensuring the right cohort of people are involved (E.g. LD Social Work) • We need to ensure all professionals are communicated with. (E.g. GP's/CCG's) • Strategic Planning and building positive relationships with housing providers. • Ensuring people receive the right care in the right setting – -Improving transitional processes -Partnerships is second -Care particularly elder carers
What Does Success Look Like?
• Seamless Services • Establishing what is important to the individual • Co-ordinated support through the journey (navigation role)
What is Working Well?
• Cohesive approach and relationships. • Good advocacy • Integration • Co-production (Partnership boards) • Voluntary sector involvement to develop groups • Learning Disability Pathway • Skill up the workforce (Educate workforce) • Positive behaviour support working well in some areas. • PBS not a short term solution for crisis – Community teams generally pick VWs up.
What keeps you awake at night?
• Impact on family carers, particularly older family carers / significant others. • Needs to be more communication between professionals.

North Mersey Delivery Hub

Who's missing?
• Sefton Local Authority • Liverpool City Council • Autism Initiatives • Options • Natural Breaks • People First • Sefton and Liverpool Partnership • Education
Overall Vision for People with Learning Disabilities
• Right Care, Right Time, Right Place, Right Professionals • Individual/Personalised Care Packages • Care primarily provided in the community not hospital. • Communities that welcome support. • Care pathway relating to OATS • Efficient funding • History of wrap around care – third sector. • Good third sector providers.
What could be improved?
• Information and support to families early on. • Inclusive education systems. • Avoiding the cliff of transition. • Insufficient capacity in the autistic spectrum.
Gaps within the Process
• Post diagnostic support – Autism • Autism (Big Gap) • Crisis management capacity is not robust. • Refresh Green Light Tool Kit • No short term care in the home. • Crisis House – Crash Pads • Lack of agreed definition. • Pool budgets, Joint funding – Something needs sorting out. • Horizontal and vertical care integrated.
Quick wins.
• Develop a pathway – OATS repatriation. • Utilise Merseyside Partners and the Joint Training Partnership – To be invested in. • Review of the past five admissions. • Audit Green Light Tool Kit • Test PBS • Agree Service Specifications – CLT • Repatriate OATS • Revisit SAF • HWB Report • TC-The Local vision for CCGs

REPORT TO THE GOVERNING BODY
March 2016

Agenda Item: 16/50	**Author of the Paper:** Name Karl McCluskey Title Chief Strategy and Outcomes Officer Email: Karl.Mccluskey@southportandformbyccg.nhs.uk Tel: 0151247
Report date: March 2016	

Title: **Southport and Formby Clinical Commissioning Group Integrated Performance Report**

Summary/Key Issues: This report provides summary information on the activity and quality performance of Southport and Formby Clinical Commissioning Group (note time periods of data are different for each source)

Recommendation

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

Receive	x
Approve	
Ratify	

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

NHS
Southport and Formby
Clinical Commissioning Group

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

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

Southport & Formby Clinical Commissioning Group

Integrated Performance Report

NHS
Southport and Formby
Clinical Commissioning Group

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 Month 10 (note: time periods of data are different for each source).

CCG Key Performance Indicators

NHS Constitution Indicators	CCG	Main Provider
A&E 4 Hour Waits (All Types)		SORM
Ambulance Category A Calls (Red 1)		NWAS
Cancer 2 Week GP Referral		SORM
RTT 18 Week Incomplete Pathway		SORM
Other Key Targets	**CCG**	**Main Provider**
A&E 4 Hour Waits (Type 1)		SORM
Ambulance Category A Calls (Red 2)		NWAS
Ambulance Category 19 transportation		NWAS
Cancer 14 Day Breast Symptom		
Cancer 31 Day First Treatment		SORM
Cancer 31 Day Subsequent - Drug		SORM
Cancer 31 Day Subsequent - Surgery		SORM
Cancer 31 Day Subsequent - Radiotherapy		SORM
Cancer 62 Day Standard		SORM
Cancer 62 Day Screening		SORM
Cancer 62 Day Consultant Upgrade		SORM
Diagnostic Test Waiting Time		SORM
Emergency Admissions Composite Indicator		
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)		
Emergency Admissions for acute conditions that should not usually require a hospital admission		
HCAI - C.Diff		SORM
HCAI - MRSA		SORM
IAPT Access - Roll Out		
IAPT - Recovery Rate		
Mental Health Measure - CPA		
Mixed Sex Accommodation		SORM
Patient Experience of Primary Care i) GP Services ii) Out of Hours (Combined)		
PROM: Elective procedures: Groin Hernia		SORM
PROM: Elective procedures: Hip Replacement		SORM
PROM: Elective procedures: Knee Replacement		SORM
PYLL Person (Annual Update)		
RTT 18 Week Admitted Pathway		SORM
RTT 18 Week Non Admitted Pathway		SORM
RTT 18 Week Incomplete Pathway		SORM
RTT 52+ week waiters		SORM
Stroke 90% time on stroke unit		SORM
Stroke who experience TIA		SORM
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s		
Unplanned hospitalisation for chronic ambulatory care		
Local Measure: Access to services BME		

Key Information from this report

Financial Performance - The forecast financial position after the application of reserves is break-even against a planned surplus of £1.800m, which is a shortfall of £1.800m against target. There is a risk that the CCG will not deliver its statutory financial duty to break-even is being mitigated through delivery of the agreed recovery plan, with continued effort, the CCG will achieve a break-even position. However, significant further actions are required to deliver recurrent financial balance.

Referrals – January referrals from GPs are below the previous month but the year to date position is still 9% above 2014/15. Referrals from other sources are also lower than December but again 13% above the previous year.

A&E waits (All Types) – Year to date the CCG failed the 95% target achieving 92.36% (January achieving 84.22%). The target has been failed at CCG level since April 2015. Southport & Ormskirk achieved 92.07% year to date (with January achieving 84.0%) again failing the year to date target. The Trust is developing a new clinical strategy and operational plan to hit 90% by April 16 and 95% by April 2017.

A&E Waits (Type 1) - The CCG failed the 95% target in January reaching 74.10% and are failing year to date reaching 88.90%. In January 488 attendances out of 1884 were not admitted, transferred or discharged within 4 hours. Southport & Ormskirk have failed the target in January reaching 74.13%, and are failing year to date reaching 86.82%. In January 1557 attendances out of 6018 were not admitted, transferred or discharged within 4 hours.

Ambulance Activity - Category A Red 1, 8 minute response time – The CCG failed the 75% target recording 74.02% year to date. The CCG also failed Category A Red, 2 recording 67.10% year to date against a 75% target. Lastly Category 19 Transportation recording 88.60% year to date failing the 95% target. NWAS have achieved Category Red 1 year to date but are failing Red 2 year to date achieving 72.70% and are failing the 95% target for Category 19 achieving 93.70%. The delivery and sustainability of emergency ambulance performance remains a key priority for commissioners. Performance continues to be closely monitored with the support of lead commissioner Blackpool CCG and through monthly contract and Strategic Partnership Board meetings with the NWAS executive team and commissioning leads. Locally the Mersey CCGs continue to meet with NWAS monthly to review performance at county and CCG level.

Cancer Indicators – For January the CCG are achieving all cancer indicators apart from two. The two failing indicators are 2 week breast symptoms which did achieve for the month of January (93.6%) but are still failing year to date due to previous months breaches, recording 89.74%. Also 62 day consultant upgrade achieving 82.81% year to date, and are under plan partly due to previous months breaches. In January there were 2 patient breaches out of a total of 17 (88.24%). Southport & Ormskirk are achieving all cancer indicators apart from 62 day screening where they are failing year to date achieving 79.17% failure due to previous month breaches. In January all patients were treated within 62 days following a referral from an NHS Cancer Screening Service (100%). Year to date there have been the equivalent of 2.5 breaches out of a total of 12 patients.

Diagnostics – The CCG failed to achieve the <1% target in January hitting 2.65% waiting over 6 weeks for their diagnostic test. Out of 2075 patients 55 waited over 6 weeks for their diagnostic tests, 14 waiting over 13 weeks. Majority being audiology assessments at Bridgewater.

Emergency Admissions Composite Measure - Currently this measure is over performing year to date against plan of 1987.96 with January showing a value of 2152.32. Compared with the same period last year the CCG has had 277 less admissions than same period last year. The monthly plans for 2015-16 been split using last year's seasonal performance.

Friends & Family - Southport & Ormskirk Hospital NHS Trust continues to experience difficulties in relation to the three parts for both inpatients and A&E. A&E response rate being 0.7% for past 2 months.

Measure – January 2016	Southport & Ormskirk	England Average
Inpatient – response	19.8%	25.1%
Recommended	94%	96%
Not Recommended	2%	1%
A&E – response	0.7%	12.2%
Recommended	80%	86%
Not Recommended	13%	7%

HCAI – C difficile – The CCG had 6 new cases reported in January and are above target for C. difficile year to date, (actual 32 / plan 31). Year-end plan 38. Southport & Ormskirk also saw 6 new cases in January and are over target (actual 32 / plan 30). 17 cases have been put forward for consideration by the CCG Appeals Panel and 12 have been upheld taking the number of year to date cases to 20. Year-end plan is 36.

HCAI – MRSA – January saw no new cases of MRSA for the CCG. Year to date there has now been 3 cases attributed to the CCG against a zero tolerance target. Aintree saw no new cases reported in January, there was 1 case reported in December. A PIR was held on 04/01/16 and the case was attributed to Aintree Hospital.

IAPT Access – Roll Out – The CCG are under plan for Q3 for IAPT Roll Out and reached 2.54%, which shows an improvement on Q2 (2.05%) plan 3.75%. This equates to 484 patients having entered into treatment out of a population of 19079 (Psychiatric Morbidity Survey). The CCG are also under plan in January reaching 1.10%, out of a population of 19079, 218 patients have entered into treatment. There has been an increase on previous month when the trust reported 1.00%.

IAPT Recovery - The CCG are under the 50% plan for recovery rate In Q3 reaching 43.19%. This equates to 111 patients who moved to recovery out of 280 who completed treatment. The monthly data shows for January the CCG are under plan for recovery rate reaching 47.31%. This equates to 44 patients who have moved to recovery out of 93 who have completed treatment, there has been a dip in performance from the previous month when the trust reported 55.41%.

MSA – In January the CCG reported 1.30 breaches per 1000 FCE, which was 5 breaches, this is above the target and as such are reporting red for this indicator the sixth time in 2015-16. In January Southport & Ormskirk Trust reported 2.00 breaches per 1000 FCE, which was 10 breaches, this is above the target and as such are also reporting red for this indicator for the sixth time in 2015-16. The trust has had 48 breaches year to date. The Provider reports that all the current breaches relate to critical care. From March 2016 this will be an area of priority. The Director of Nursing has set up a system to ensure that breaches are brought to zero as soon as possible.

RTT 18 Weeks – Admitted patients - This is indicator is monitored at local level again the previous statutory target of 90%. The CCG have narrowly failed the target reaching 89.79%, this equates to 67 patients out of 656 not seen within 18 weeks. Southport & Ormskirk also failed the target reaching 82.86%, this equates to 152 out of 887 not seen within 18 weeks.

RTT 18 Weeks – Non Admitted patients – This indicator is monitored at local level against the previous statutory target of 95%. The CCG have failed the target reaching 93.66%. This equates to 194 patients out of 3059 not seen within 18 weeks. Southport & Ormskirk also failed the target reaching 94.54% this equates 230 patients out of 4215 not seen within 18 weeks.

Patient Safety Incidents Reported – Southport & Ormskirk reported 2 Serious Untoward Incidents in January, bringing the year to date total to 83. Both being related to medication, 1 classed an a never event.

Patient reported outcomes measures (PROMS) for elective procedures: **Groin hernia** – Provisional data (Apr 14 – Mar 15) shows Southport & Formby CCG reported 0.071 for average health gain following a groin hernia operation which is higher than the previous year which was 0.67 for 2013-14, but under the plan of 0.082. England average being 0.084. This indicator is flagged as red.
Hip replacement - Provisional data (Apr 14 – Mar 15) shows Southport & Formby CCG reported 0.421 for average health gain following a hip operation which is lower than the plan 0.429. Also lower than the England average 0.437. This indicator is flagged as red
Knee replacement - Provisional data (Apr 14 – Mar 15) shows the Southport & Formby CCG reported 0.310 for knee replacement operation, this is lower than the previous year which was 0.340 for 2013-14 and slightly under the plan of 0.311. England average being 0.315. This indicator is flagged as red.

PROMS have 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.

Stroke 90% time on stroke unit – The CCG failed to achieve the 80% target in January hitting 52.90%, 9 out of 17 patients spending at least 90% of their time on a stroke unit. Southport & Ormskirk failed to achieve the 80% target in January reaching 55.60%, 15 patients out of 27 spending at least 90% of their time on a stroke unit. At the recent stroke operational group there was detailed discussion about the difficulties in hitting the targets despite moving to a smaller unit. Part of the reason is due to the current pressures that the whole trust and especially ED is experiencing. The move has been regarded as successful on the whole especially re the nursing morale.

Local Measure – Access to Community Mental Health Services by BME – The latest data shows access to community mental health services by people from BME groups is over the CCG plan (actual 2202.8 / plan 2200). This is also improvement on the previous year when the CCG rate was 2118.0.

2. Finance Summary

This report focuses on the financial performance for Southport and Formby CCG as at 29 February 2016 (Month 11).

The forecast financial position after the application of reserves is break-even against a planned surplus of £1.800m, which is a shortfall of £1.800m against target. This has resulted from non-delivery of the cost reduction target and 'in year' pressures against operational budgets. These pressures are partly supported by a release of reserves and through other non-recurrent benefits.

The forecast position, prior to the impact of management actions stands at a forecast deficit of £1.448m. This position includes the full application of penalties for non-achievement of NHS constitution targets, currently estimated at £0.700m for the year.

The forecast break-even position and deviation from the target position has required the CCG to submit a recovery plan to NHS England. Delivery of the agreed recovery plan and an improved forecast for other budget areas indicates that the CCG will achieve its statutory target of break-even.

The forecast position of breakeven is reliant on continued delivery of the management action plan.

Figure 1 Financial Dashboard

Key Performance Indicator		This Month	Prior Month
Business Rule (Forecast Outturn)	1% Surplus	✗	✗
	0.5% Contingency Reserve	✓	✓
	2.5% Non-Recurrent Headroom	✓	✓
Surplus	Financial Surplus / (Deficit) *	£0m	£0m
QIPP	Unmet QIPP to be identified > 0	£4.274m	£4.274m
Running Costs (Forecast Outturn)	CCG running costs < National 2015/16 target of £22.07 per head	✓	✓

Note this is the financial position after reserves and reflects the final position before risks and mitigations

2.1 Resource Allocation

Additional allocations have been received in Month 11 as follows:

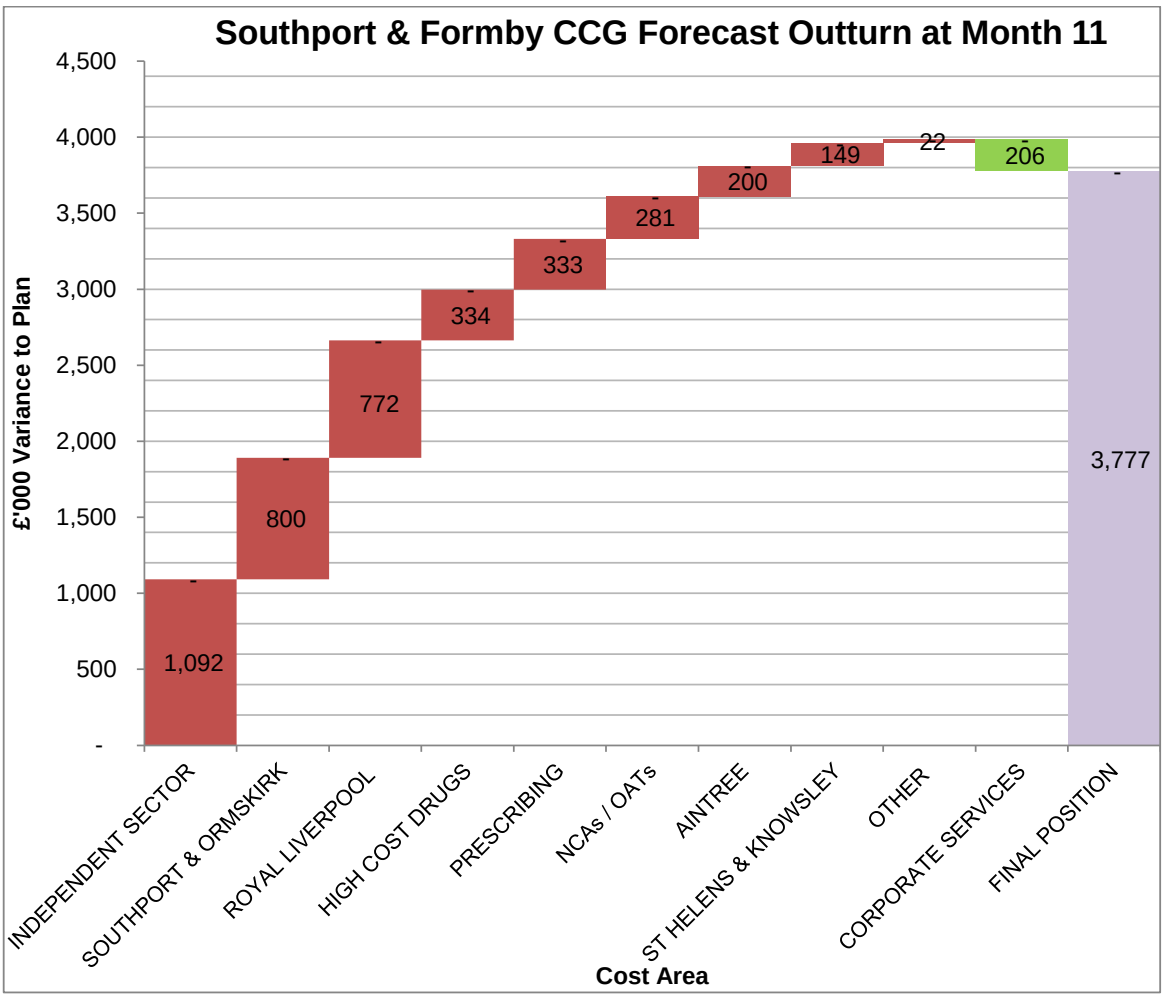
- Cataract Funding - £0.022m
- Tier 3 allocation adjustment in respect of specialised commissioning – £0.425m
- Avoiding Unplanned Admissions - £0.215m
- Mental Health IAPT - £0.016m

2.2 Financial Position and Forecast

The majority of the overspend is with Independent Sector and Acute providers, there are also high overspends in the High Cost Drugs and Prescribing budgets.

It should be noted that whilst the financial activity period relates to the end of February 2016, the CCG has based its reported position on the latest information received from Acute and Independent providers which is up to the end of January 2016.

Figure 2 Forecast Outturn at Month 10



Independent Sector Providers

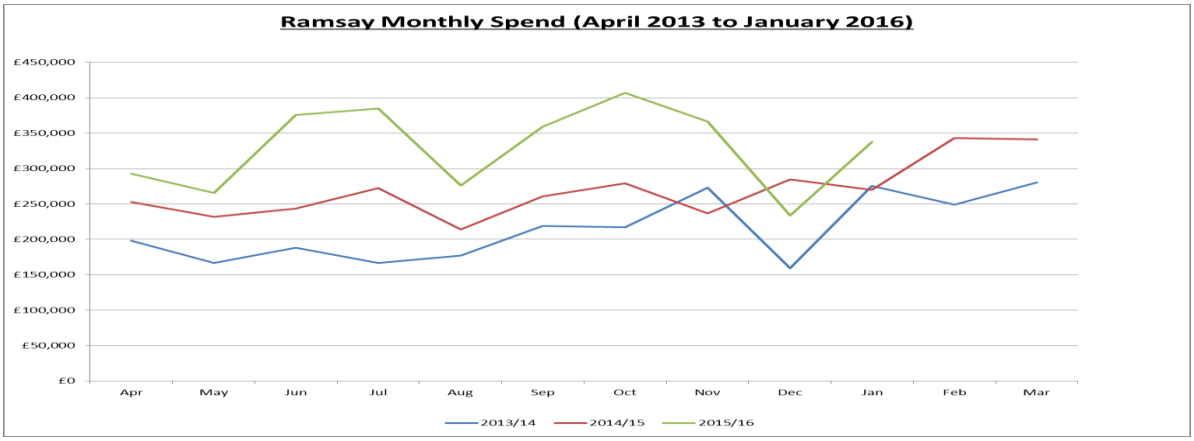
The forecast overspend for independent sector providers is £1.092m, compared with an opening budget of £4.482m, this represents a 25% increase compared with the previous year.

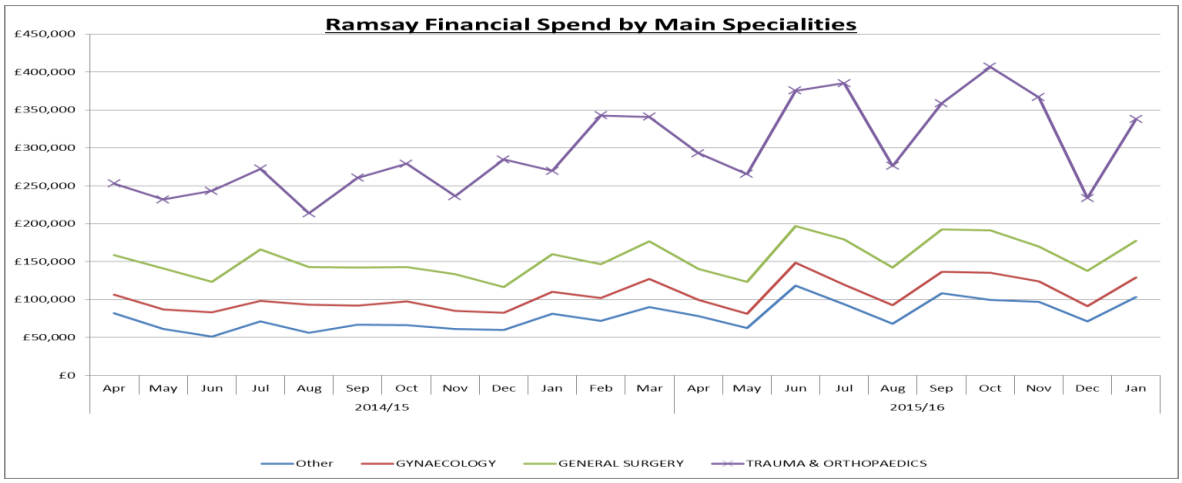
The majority of the overspend is with Ramsay Healthcare for Orthopaedic Surgery and General Surgery. A detailed review of the existing Trauma and Orthopaedic pathway is being undertaken across both CCGs in order to improve the patient pathway and reduce overall activity levels though a more effective use of the MCAS service.

Under the current arrangements, patients accessing independent hospitals are likely to complete their treatment well in advance of the 18 week target set out in the NHS Constitution. Whilst this is positive from both a patient experience and performance perspective, it is becoming increasingly difficult for the

CCG to sustain this position in terms of affordability. Changes in referral patterns are required in both the short and long-term to address the financial affordability issue.

The chart below demonstrates consistent increases annually. October activity was the highest of any month since April 2013, whilst November and December have seen a decrease in activity. A split by specialty demonstrates that Orthopaedic care is growing at the fastest rate compared to other specialties.





Acute commissioning

Southport and Ormskirk NHS Trust

The forecast position for Southport and Ormskirk NHS Trust is projecting an overspend of £0.800m. The position is based on Month 10 data received from the trust and reflects the full application of penalties.

Activity in January exceeded the plan, particularly in the area of A&E attendances, planned inpatient care and outpatients. The main variances to the plan to date are in the following areas:

- A&E attendances – over spend of £0.312m in month 10. This is a continuation of a trend seen throughout the year.

- Planned inpatient care – in the year to date, day case activity is £0.324m higher than plan. This over spend is mainly within pain management and general surgery. There is also a small over spend on electives of £0.066m at month 10.

- Outpatient care – Outpatient attendances are £0.325m higher than budget. The main area of over spend is outpatient procedures £0.498m which is linked to trauma & orthopaedics and dermatology activity. A formal review is currently being under taken in conjunction with West Lancashire CCG to investigate the marked shift from new and follow up attendances to outpatient procedures and the shift in multi-professional coding.

- AQP – Over spend of £0.142m at month 10, the majority (£0.134m) of this relates to AQP audiology. Costs have increased significantly in this financial year and work is undergoing to review services and related costs.

- Non elective admissions (including short stay admissions) – over-spend of £0.279m (includes GPAU activity totalling £0.418m). The overspend has increased during the month due to an increase in non-elective emergency activity, mainly in Trauma and Orthopaedics and Geriatric Medicine.

Royal Liverpool Hospital

Month 10 data received from Royal Liverpool Hospital shows a forecast overspend of £0.772m. The cumulative overspend relates to the following areas:

- Elective and day case surgery (£0.253m to Month 10) in breast surgery (£0.075m) and orthopaedics (£0.072m). This breast surgery activity increase is highly likely to be related to the closure of this service within Southport & Ormskirk NHS Trust.

- Outpatients - £0.103m, the majority of which relates to breast services

- Critical Care (HDU & ITU) - £0.059m to month 10

- Anti TNF and general drugs - £0.092m to month 10

- Age Related Macular Degeneration (ARMD) - £0.077m to month 10

Aintree University Hospitals NHS Foundation Trust

The forecast overspend is £0.200m, The majority of the overspend relates to growth in outpatient activity in relation to breast surgery, nephrology and radiology, there were also increases in ARMD activity, elective care, excluded drugs and diagnostic imaging.

Liverpool Heart and Chest

The forecast overspend for Liverpool Heart and Chest NHS Trust is projected to be £0.107m with anticipated overspends in elective care, particularly for cardiology as well as increases in both non-elective care and outpatients.

St Helens & Knowsley NHS Trust

The forecast overspend for St Helens and Knowsley NHS Trust is projected to be £0.149m with anticipated overspends within planned care and day cases.

Non Contract Activity / Out of Area Treatments

The forecast overspend for Non Contract Activity (NCA) and Out of Area Treatments (OATs) is £0.281m following receipt of a number of high cost invoices from Lancashire Care NHS Trust. This concerns both inpatient and outpatient mental health care provided to a number of Southport residents. A detailed review of these patients is being undertaken, and initial findings indicate that these patients are not S&FCCG, therefore an associated value has been included in the management action plan to offset some of this.

Prescribing / High Cost Drugs

The forecast overspend for the prescribing budget has increased to a projected overspend of £0.333m in Month 11.

The CCG prescribing budget is £21.9m in total and represents 13% of the total CCG budget, a small percentage change in the forecast position has a significant impact on the financial position.

The forecasts provided by the PPA are volatile and can change significantly each month, this risk is increased by the introduction of a new electronic payment mechanism in place at community pharmacies.

Continuing Health Care and Funded Nursing Care

The current forecast for this budget is an underspend of £0.064m. The forecast reflects the current number of patients, average package costs and an estimate for growth until the end of the financial year. There has been a sustained effort from the CCG and the CSU to contain CHC and FNC costs at 14/15 levels through robust case management and reviews.

A recurrent efficiency of £0.769m has been achieved to date, which means forecasted expenditure is now less than 14/15 out-turn figures. The forecast financial position is taken following this budget reduction.

2.3 QIPP

The QIPP savings target for Southport and Formby CCG is £6.151m for 2015/16. This has reduced to £4.274m following delivery of schemes totalling £1.877m.

	£'m
QIPP schemes reported at Month 10	**1.877**
QIPP schemes identified in current Month:	0
QIPP schemes reported as at Month 11	**1.877**

A 1% Transformation Fund was established in CCG reserves 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.

The schemes being considered against the Transformation Fund show that the full year cost of proposals are consistent with the total funding available. However, the 2015/16 position forecasts an underspend position of £1.201m due to delayed implementation of schemes.

2.4 CCG Running Costs

The current year forecast for the running cost budget is an underspend of £0.226m. This relates to non-recurrent savings from vacancies within the year, retention of the Quality Premium to support the financial position and other non-pay underspends across departments.

Budgets for 2016/17 are currently being finalised and prepared against the revised running cost allocations that have now been confirmed. Running costs are presently within the CCGs allocation for 2016/17.

2.5 Evaluation of Risks and Opportunities

A combination of non-achievement of QIPP targets and increased expenditure over budgets led to a critical impact on the CCG's financial position.

The risk that the CCG not delivering its statutory financial duty to break-even is being addressed and actions agreed in the recovery plan implemented. Continued effort and delivery is required to achieve recurrent financial balance.

There are a number of other risks that require ongoing monitoring and managing:

- Acute cost per case contracts – The CCG has experienced significant growth in acute care during the year, from both the independent sector and traditional NHS providers. Although historic growth has been factored into plans, we have continued to experience growth over the year above the initial plans.

- Prescribing / Drugs costs – This is a volatile area of spend, and this risk has increased following implementation of a new electronic prescribing system leading to a change to the process for pharmacies to submit their prescribing scripts resulting in significant movements month on month. In addition to this, the forecast includes a saving relating to Cat M drugs over and above estimates provided by the PPA, which is based on some modelling work undertaken locally by the medicines management team on Cat M actual activity over the year. There is a risk that these savings may have been over-estimated.

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 the financial position is set out in the table below.

The forecast position is breakeven against a planned £1.800m surplus. It should be noted that this forecast is dependent on full application of penalties relating to NHS constitutional standards, and is reliant on delivery of a management action plan of £1.448m.

The deterioration in the CCG's financial surplus target has been escalated within the CCG's risk reporting framework and is considered as the CCG's top priority alongside the commissioning of safe services.

The delivery of the management action plan is extremely challenging and requires co-operation with partners across the healthcare economy. The CCG has recently allocated GP Governing Body member leads to each practice and the leads are asked to continue to meet with practices on a regular basis to stress the financial difficulties faced by the CCG and to discuss how expenditure can be reduced to deliver the CCG financial duties into the next financial year.

Figure 3 Reserves and agreed actions

	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)	(4.777)	1.000	(3.777)
Transformation Fund slippage		1.201	1.201
Reserves	1.939	1.663	3.602
QIPP:			
CM Rehab	0.250		0.250
Contract Adjustments	0.834		0.834
Queenscourt drug charges	0.024		0.024
CHC / FNC	0.769		0.769
QIPP Achieved	1.877	0.000	1.877
Forecast surplus / (deficit)	(5.312)	3.864	(1.448)
Management action plan:			
LQC - further year 1 underpayments		0.010	0.010
CQUIN under-performance		0.400	0.400
Lancs Care - challenge invoices		0.050	0.050
Contract Penalties		0.037	0.037
Primary Care investments		0.840	0.840
Reorganisation Costs		(0.062)	(0.062)
BCF Payment review		(0.200)	(0.200)
Provider PBR review		0.300	0.300
Expenditure Review		0.073	0.073
Reported position	(5.312)	5.312	0.000
Risks	(0.450)		(0.450)
Mitigations	0.450		0.450
Risk adjusted forecast surplus / (deficit)	(5.312)	5.312	0.000

2.6 Conclusions and Recommendations

- The risk that the CCG will not deliver its statutory financial duty to break-even is being mitigated through delivery of the agreed recovery plan, with continued effort, the CCG will

achieve a break-even position. However, significant further actions are required to deliver recurrent financial balance.

- A combination of non-achievement of QIPP targets and increased expenditure above budget led to the critical impact on the CCG's financial position. The CCG will have a challenging QIPP in the next financial year.

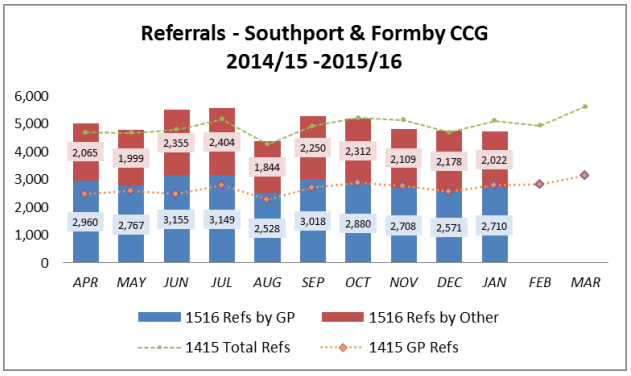
- As described in previous reports, an intensive review of current expenditure is required throughout all levels of the CCG with considerable support from member practices, supported by Governing Body GP leads. The focus must be on reducing access to clinical services that provide low or little clinical benefit for patients.

- The CCG's commissioning team must support member practices in reviewing their commissioning arrangements to identify areas where clinical variation exists, and address accordingly. High levels of engagement and support is required from member practices to enable the CCG to reduce levels of low value healthcare and improve Value for Money.

3. Referrals

3.1 Referrals by source

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



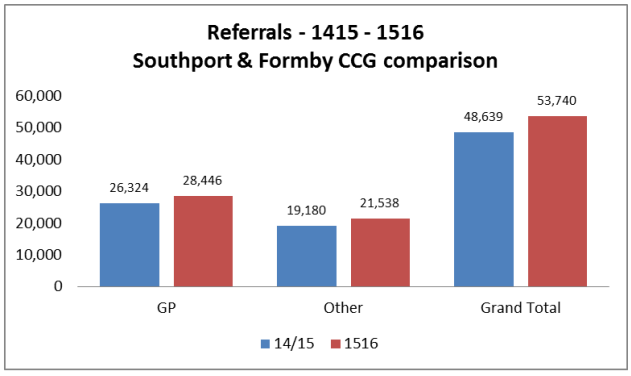


Figure 5 GP and 'other' referrals for the CCG across all providers comparing 2013/14, 2014/15 and 2015/16 by quarter

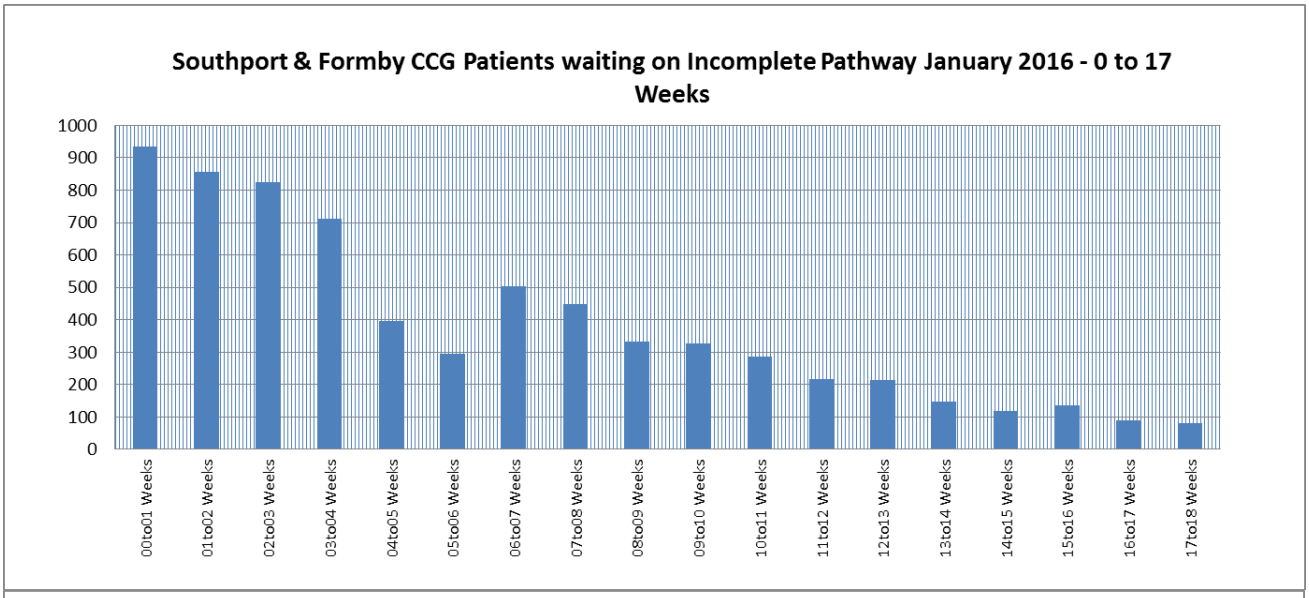
Referral Type	DD Code	Description	1314 Q1	1314 Q2	1314 Q3	1314 Q4	1415 Q1	1415 Q2	1415 Q3	1415 Q4	1516 Q1	1516 Q2	1516 Q3	1314 YTD	1415 YTD	1516 YTD	Variance	% Variance 1415 - 1516	1314 - 1516 Trendline
GP	03	GP Ref	7,523	7,460	7,365	7,489	7,538	7,772	8,209	8,780	8,883	8,693	8,159	22,348	23,519	25,735	2,216	9%	
GP Total			7,523	7,460	7,365	7,489	7,538	7,772	8,209	8,780	8,883	8,693	8,159	22,348	23,519	25,735	2,216	9%	
Other	01	following an emergency admission	611	600	511	570	581	569	145	30	29	27	39	1,722	1,295	95	-1,200	-93%	
	02	following a Domiciliary Consultation	3	1	1	0	0	3	70	95	19	7	3	5	73	29	-44	0%	
	04	An Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)	733	660	645	636	684	726	755	691	848	824	807	2,038	2,165	2,479	314	15%	
	05	A CONSULTANT, other than in an Accident and Emergency Department	2,034	1,950	1,952	2,133	2,078	2,084	2,685	2,635	2,960	3,203	2,917	5,936	6,847	9,080	2,233	33%	
	06	self-referral	248	288	314	293	305	284	356	389	482	395	446	850	945	1,323	378	40%	
	07	A Prosthetist	1	6	2	4	2	7	1	1	2	1	2	9	10	5	-5	-50%	
	10	following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)	17	39	39	54	35	47	36	33	59	51	45	95	118	155	37	31%	
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	191	167	180	179	185	189	140	137	136	147	124	538	514	407	-107	-21%	
	12	A General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)	1	0	0	0	0	1	0	1	2	2	3	1	1	7	6	0%	
	13	A Specialist NURSE (Secondary Care)	9	4	5	4	5	8	7	9	13	19	17	18	20	49	29	145%	
	14	An Allied Health Professional	40	26	29	147	417	438	325	401	446	431	460	95	1,180	1,337	157	13%	
	15	An OPTOMETRIST	129	141	169	196	193	177	125	161	160	184	205	439	495	549	54	11%	
	16	An Orthoptist	1	1	0	1	0	1	0	24	30	25	18	2	1	73	72	0%	
	17	A National Screening Programme	12	2	25	35	82	59	93	105	168	159	181	39	234	508	274	117%	
	92	A GENERAL DENTAL PRACTITIONER	416	402	431	397	403	399	439	389	402	393	385	1,249	1,241	1,180	-61	-5%	
	93	A Community Dental Service	8	2	8	4	5	4	8	3	4	0	1	18	17	5	-12	-71%	
	97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	664	639	653	673	666	676	718	687	659	622	941	1,956	2,060	2,222	162	8%	
Other Total			5,118	4,928	4,964	5,326	5,641	5,672	5,903	5,791	6,419	6,490	6,594	15,010	17,216	19,503	2,287	13%	
Unknown (All are Renacres SOR coding error)			1,119	1,280	1,421	1,264	972	911	917	1,104	1,152	1,198	1,039	3,820	1,883	3,389	1,506	80%	
Grand Total			**13,760**	**13,668**	**13,750**	**14,079**	**14,151**	**14,355**	**15,029**	**15,675**	**16,454**	**16,381**	**15,792**	**18,830**	**19,099**	**22,892**	**3,793**	**20%**	

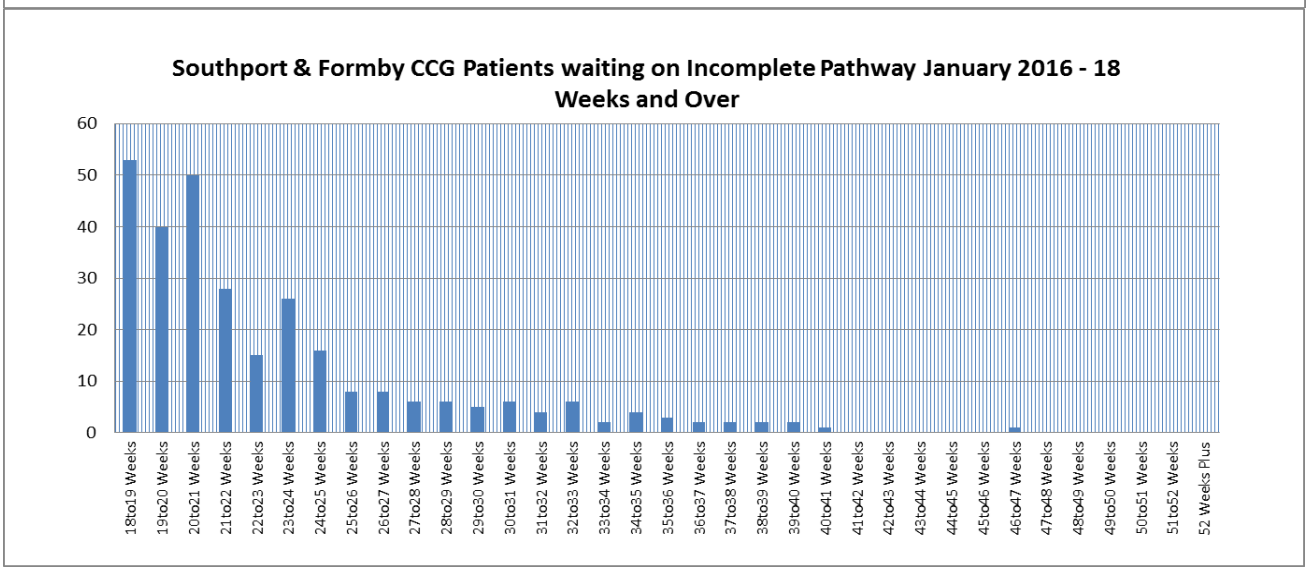
January referrals from GPs are below the previous month but the year to date position is still 9% above 2014/15. Referrals from other sources are also lower than December but again 13% above the previous year.

4. Waiting Times

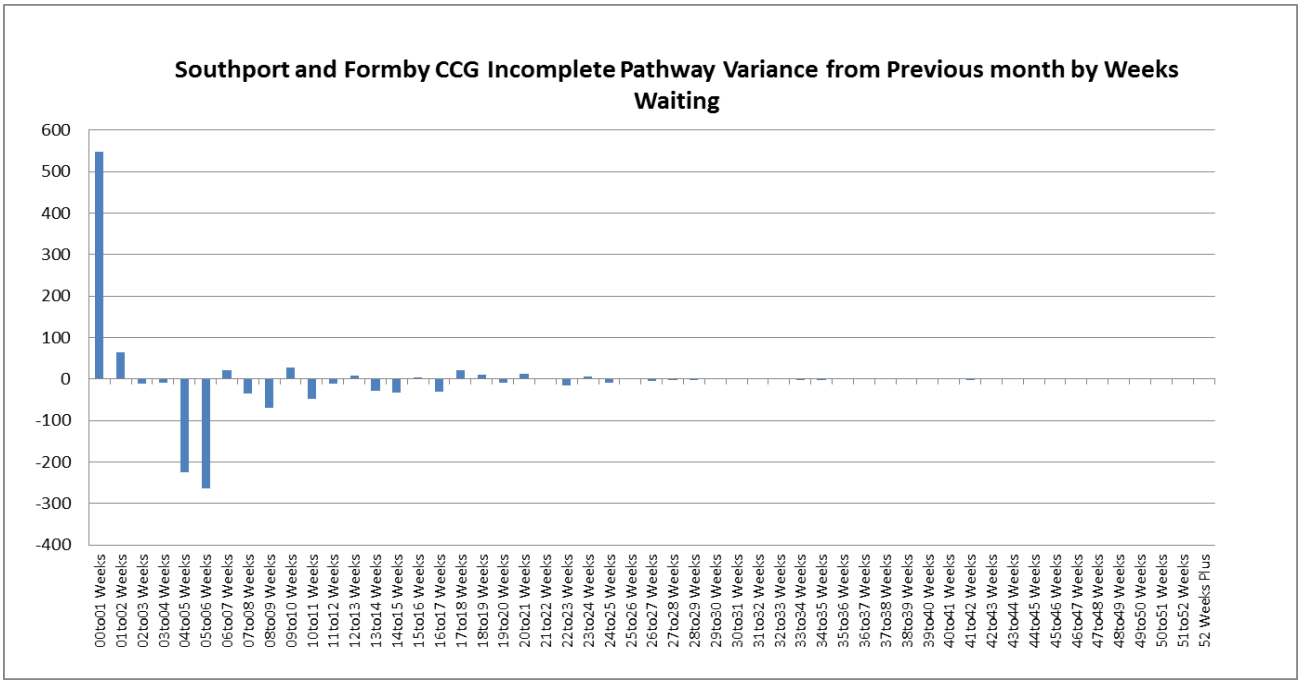
4.1 NHS Southport and Formby CCG patients waiting

Figure 6 Patients waiting on an incomplete pathway by weeks waiting





There were 296 patients (4.1%) waiting over 18 weeks on Incomplete Pathways at the end of January 2016, a decrease of 13 patients (4.2%) from Month 9 (15/16).
There were no patients waiting over 52 weeks in any month of 2015/16 to date.



There were 7,210 patients on the Incomplete Pathway at the end of January 2016, a decrease of 86 patients (1.2%) since December 2015.

4.2 Top 5 Providers

Figure 7 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	3928	778	4706	116	25	4	145	4851
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	362	120	482	17	5	6	28	510
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	297	110	407	29	13	10	52	459
RENACRES HOSPITAL	384	65	449	0	0	0	0	449
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	88	45	133	22	0	5	27	160
Other Providers	566	171	737	28	6	10	44	781
Total All Providers	5625	1289	6914	212	49	35	296	7210

4.3 Provider assurance for long waiters

CCG	Trust	Speciality	No of weeks waited	No patients	Has patient been seen / has a TCI date?	Reason for the delay
Southport & Formby CCG	Central Man	Other	40	1	Clock Stop	Other' specialty patient has been discharged as patient DNA'd the first appointment in March, therefore this will not be reported. The specialty is paediatric orthopaedic and there are long waits.
Southport & Formby CCG	S&O	Other	46	1		Capacity issues within the specialty. The patient was seen on 4 February 2016 and put on a watchful wait. This patient does not appear on the pathway at the end of February.

5. Planned Care

Performance at Month 10 of financial year 2015/16, against planned care elements of the contracts held by NHS Southport & Formby CCG shows an over-performance of £2.9m. This over-performance is driven by increases at Southport & Ormskirk Hospital (£786k), Aintree Hospital (£470k) and Renacres Hospital (£844k).

ARMD is a growing area. Benchmarking has revealed a variance in the prices charged by providers under local tariff arrangements. A review is being undertaken across the region to standardise treatment pathways and prices. This will be completed in Spring 2016.

5.1 All Providers

Figure 8 All Providers (Excl S&O)

ALL Providers (PBR & Non PBR. PBR for S&O)	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	14,895	12,389	15,223	2,834	23%	£3,499	£2,910	£3,380	£470	16%
Alder Hey Childrens NHS F/T	5,048	4,175	4,577	402	10%	£642	£531	£545	£14	3%
Countess of Chester Hospital NHS FT	0	0	79	79	#NUM!	£0	£0	£15	£15	#NUM!
Liverpool Heart and Chest NHS F/T	1,622	1,346	1,731	385	29%	£913	£758	£861	£103	14%
Liverpool Womens Hospital NHS F/T	2,398	2,014	2,084	70	3%	£728	£611	£589	-£22	-4%
Royal Liverpool & Broadgreen Hospitals	14,718	12,216	12,550	334	3%	£3,093	£2,567	£2,847	£280	11%
ST Helens & Knowsley Hospitals	4,280	3,559	3,971	412	12%	£946	£787	£915	£128	16%
Wirral University Hospital NHS F/T	315	263	219	-44	-17%	£103	£86	£61	-£25	-29%
Southport & Ormskirk Hospital	110,470	93,031	95,638	2,607	3%	£22,280	£18,673	£19,459	£786	4%
Central Manchester University Hospitals Nhs FT	236	197	235	38	19%	£44	£37	£57	£20	55%
Fairfield Hospital	103	86	64	-22	-25%	£27	£22	£9	-£13	-57%
ISIGHT (SOUTHPORT)	2,846	2,371	3,034	663	28%	£686	£572	£685	£113	20%
Renacres Hospital	11,606	9,632	12,360	2,728	28%	£3,095	£2,571	£3,416	£844	33%
SPIRE LIVERPOOL HOSPITAL	866	721	505	-216	-30%	£229	£191	£173	-£18	-9%
University Hospital Of South Manchester Nhs FT	199	167	0	-167	-100%	£36	£30	£37	£6	21%
Wrightington, Wigan And Leigh Nhs FT	2,163	1,802	2,520	718	40%	£776	£646	£850	£203	31%
Grand Total	**171,764**	**143,970**	**154,790**	**10,820**	**8%**	**£37,096**	**£30,994**	**£33,899**	**£2,905**	**9%**

5.2 Southport and Ormskirk Hospital NHS Trust

Figure 9 Month 10 Planned Care- Southport and Ormskirk Hospital NHS Trust by POD

S&O Hospital Planned Care (PbR ONLY)	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	11,747	9,799	10,336	537	5%	£6,367	£5,311	£5,635	£324	6%
Elective	1,554	1,289	1,382	93	7%	£4,142	£3,436	£3,503	£66	2%
Elective Excess BedDays	315	261	237	-24	-9%	£70	£58	£52	-£6	-10%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	800	675	1,302	627	93%	£129	£108	£192	£84	77%
OPFASPCL - *Outpatient first attendance single professional consultant led*	18,095	15,260	12,844	-2,416	-16%	£2,767	£2,334	£1,982	-£352	-15%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	1,885	1,590	3,198	1,608	101%	£198	£167	£323	£156	93%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	45,503	38,375	36,876	-1,499	-4%	£4,188	£3,532	£3,470	-£62	-2%
Outpatient Procedure	20,351	17,163	20,175	3,012	18%	£3,599	£3,035	£3,533	£498	16%
Unbundled Diagnostics	10,220	8,619	9,288	669	8%	£820	£691	£769	£78	11%
Grand Total	**110,470**	**93,031**	**95,638**	**2,607**	**3%**	**£22,280**	**£18,673**	**£19,459**	**£786**	**4%**

5.2.1 Southport & Ormskirk Hospital Key Issues

Daycases are showing a £324k over performance against 2015/16 Month 10 plan. Trauma & Orthopaedics and General Surgery are the 2 main contributors to the planned care over performance. 2015/16 has seen a section of daycase activity shift to Outpatient Procedure, resulting in a £498k over performance in Outpatient Procedures. This was raised with the provider through the contract review meeting mechanism and further analysis will be taking place between Provider and Commissioner.

5.3 Renacres Hospital

Figure 10 Month 10 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	1,408	1,171	1,436	265	23%	£1,348	£1,121	£1,442	£321	29%
Elective	208	173	208	35	20%	£718	£597	£905	£308	52%
Elective Excess BedDays	13	11	0	-11	-100%	£4	£3	£0	-£3	-100%
OPFASPCL - *Outpatient first attendance single professional consultant led*	3,412	2,831	3,072	241	9%	£462	£384	£421	£37	10%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	3,213	2,666	5,581	2,915	109%	£263	£218	£347	£129	59%
Outpatient Procedure	2,161	1,793	1,049	-744	-41%	£203	£168	£202	£33	20%
Unbundled Diagnostics	1,190	988	1,014	26	3%	£97	£81	£100	£19	23%
Grand Total	**11,606**	**9,632**	**12,360**	**2,728**	**28%**	**£3,095**	**£2,571**	**£3,416**	**£844**	**33%**

5.3.1 Renacres Hospital Key Issues

Renacres over performance is focused on Daycase and Elective care along with Outpatient follow up single professional consultant led. As expected, Trauma & Orthopaedics makes up 91% of the planned care overspend.
2015/16 daycase activity has seen an increase in Hand, Foot and shoulder procedures.
Elective inpatient analysis shows us that 2 HRGs for major Hip & Knee procedures are up a combined £305k – which equates to circa 118% over performance for the two HRGs. Outpatient Follow Ups over performance continues to increase now showing a 57% price variance or £112k in terms of cost.

5.4 Aintree University Hospital

Figure 11 Month 10 Planned Care- Aintree University Hospital by POD

Aintree University 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	725	602	644	42	7%	£502	£417	£432	£15	4%
Elective	366	304	356	52	17%	£767	£638	£758	£120	19%
Elective Excess BedDays	460	383	196	-187	-49%	£105	£87	£44	-£43	-49%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	56	46	105	59	128%	£11	£9	£19	£10	105%
OPFANFTF - *OP 1st Attendance Multi-Professional Outpatient First. Attendance Non face to Face*	219	182	233	51	28%	£11	£9	£10	£1	14%
OPFASPCL - *Outpatient first attendance single professional consultant led*	2,501	2,079	2,413	334	16%	£404	£336	£394	£58	17%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	137	114	140	26	23%	£17	£14	£16	£2	17%
OPFUPNFTF - *Outpatient Follow-Up Non Face to Face*	84	70	363	293	420%	£2	£2	£9	£7	420%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	6,351	5,281	6,196	915	17%	£589	£490	£583	£94	19%
Outpatient Procedure	2,121	1,764	2,250	486	28%	£326	£271	£371	£99	37%
Unbundled Diagnostics	942	785	1,490	705	90%	£82	£68	£117	£49	73%
Wet AMD	934	779	837	58	7%	£685	£571	£628	£57	10%
Grand Total	**14,895**	**12,389**	**15,223**	**2,834**	**23%**	**£3,499**	**£2,910**	**£3,380**	**£470**	**16%**

5.4.1 Aintree University Hospital Key Issues

Daycase & Elective combined over performance continues to rise to £135k/12%. This is primarily driven by Breast Surgery, however Gastroenterology and ENT have seen an increase in activity over the last two months.

Combined Daycase/Elective Cardiology activity has seen a marked increase in month 10. This is as a result of three heart failure HRGs applicable to the new ambulatory heart failure service. This activity is being coded as Daycase & Electives rather than Outpatient procedures. There has been no agreement with the Trust relating to the cost of the tariff and the commissioners will expect an outpatient procedure cost for this service.

Over performance for Outpatient Follow Ups is in single professional consultant led. 50% of this over performance is related to the increased activity levels in Breast Surgery due to the transfer of activity into Aintree.

Outpatient Procedure over performance is attributable mainly to Interventional Radiology £60k/258% over performing. The Interventional Radiology over performance is linked to HRG 'Unilateral Breast Procedures'. Further analysis of activity carried out under this HRG show that procedures involve fine needles and imaging-guided biopsies, therefore attributable to Interventional Radiology, but also increased due to the transfer of Breast Surgery activity into Aintree and the Breast Surgery over performance in outpatient first attendances.

5.5 Wrightington, Wigan & Leigh Hospital

Figure 12 Month 10 Planned Care- Wrightington, Wigan & Leigh Hospital by POD

Wrightington, Wigan And Leigh Nhs Foundation Trust 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	146	122	142	20	17%	£218	£181	£185	£4	2%
Elective	70	58	86	28	47%	£368	£307	£444	£137	45%
Elective Excess BedDays	62	52	10	-42	-81%	£15	£13	£2	-£10	-83%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	30	25	38	13	52%	£3	£2	£3	£1	24%
OPFASPCL - *Outpatient first attendance single professional consultant led*	281	234	385	151	64%	£32	£26	£46	£19	74%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	46	38	55	17	43%	£4	£3	£5	£2	49%
OPFUPNFTF - *Outpatient Follow-Up Non Face to Face*	46	38	76	38	98%	£1	£1	£2	£1	110%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	1,090	908	1,297	389	43%	£79	£66	£99	£33	50%
Outpatient Procedure	156	130	183	53	41%	£28	£24	£35	£11	47%
Unbundled Diagnostics	236	197	237	40	21%	£28	£23	£28	£5	22%
Grand Total	**2,163**	**1,802**	**2,520**	**718**	**40%**	**£776**	**£646**	**£850**	**£203**	**31%**

5.5.1 Wrightington, Wigan & Leigh Hospital Key Issues

Elective activity is driving the increase in Planned Care at Wrightington. Within T&O Electives, there is a total cost of £175k allocated to HRGs applicable to major hip, shoulder and foot procedures but have no plan in 2015/16. The activity in these HRGs suggests these procedures are revisions to previous hip

and knee replacements as the elderly population require second and third replacements of joints. Further analysis is taking place to understand this in more detail.

6. Unplanned Care

Unplanned Care at Month 10 of financial year 2015/16, shows an under-performance of circa -£325k for contracts held by NHS Southport & Formby CCG.

This underspend is driven by the -£175k underspend at Southport & Ormskirk Hospital. The two main Trusts over spending are Liverpool Women's £110k and Royal Liverpool £123k.

6.1 All Providers

Figure 13 Month 10 Unplanned Care – All Providers

ALL Providers (PBR & Non PBR. PBR for S&O)	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
Southport & Ormskirk Hospital	55,228	46,269	47,437	1,168	3%	£27,674	£23,238	£23,413	£175	1%
Aintree University Hospitals NHS F/T	1,866	1,564	1,234	-330	-21%	£914	£769	£763	-£5	-1%
Alder Hey Childrens NHS F/T	773	644	650	6	1%	£416	£354	£304	-£51	-14%
Countess of Chester Hospital	0	0	46	46	0%	£0	£0	£11	£11	0%
Liverpool Heart and Chest NHS F/T	133	111	115	4	4%	£421	£352	£342	-£10	-3%
Liverpool Womens Hospital NHS F/T	245	206	276	70	34%	£202	£170	£280	£110	64%
Royal Liverpool & Broadgreen Hospitals	1,083	906	1,089	183	20%	£644	£538	£661	£123	23%
ST Helens & Knowsley Hospitals	398	333	343	10	3%	£214	£179	£170	-£9	-5%
Wirral University Hospital NHS F/T	112	93	49	-44	-47%	£45	£37	£24	-£13	-35%
Central Manchester University Hospitals	88	73	71	-2	-3%	£30	£25	£20	-£4	-17%
University Hospital Of South Manchester	47	39	17	-22	-57%	£8	£6	£12	£6	90%
Wrightington, Wigan And Leigh	62	52	67	15	30%	£53	£44	£37	-£7	-16%
Grand Total	**60,035**	**50,290**	**51,394**	**1,104**	**2%**	**£30,620**	**£25,713**	**£26,038**	**£325**	**1%**

6.2 Southport and Ormskirk Hospital NHS Trust

Figure 14 Month 10 Unplanned Care – Southport and Ormskirk Hospital NHS Trust by POD

S&O Hospital Unplanned Care (PbR ONLY)	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A and E	35,509	29,699	30,345	646	2%	£3,951	£3,305	£3,617	£313	9%
NEL/NELSD - *Non Elective/Non Elective IP Same Day*	11,175	9,390	9,314	-76	-1%	£19,185	£16,120	£16,220	£99	1%
NELNE - *Non Elective Non-Emergency*	1,254	1,054	1,418	364	35%	£2,115	£1,777	£1,576	-£200	-11%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	217	182	160	-22	-12%	£68	£57	£48	-£10	-17%
NELST - *Non Elective Short Stay*	1,776	1,492	1,374	-118	-8%	£1,242	£1,043	£953	-£90	-9%
NELXBD - *Non Elective Excess Bed Day*	5,298	4,452	4,826	374	8%	£1,113	£936	£999	£64	7%
Grand Total	**55,228**	**46,269**	**47,437**	**1,168**	**3%**	**£27,674**	**£23,238**	**£23,413**	**£175**	**1%**

6.2.1 Southport and Ormskirk Hospital NHS Trust Key Issues

Within Non Electives, the largest over performing Specialty is Geriatric Medicine, showing a cost variance of £572k. Over performance is offset by a large cost variance of -£1m in General Medicine.

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	Variance from Plan	% Variance
0 Variance	32	44	12	38%
1 Common Mental Health Problems (Low Severity)	35	3	(32)	-91%
2 Common Mental Health Problems (Low Severity with greater need)	45	12	(33)	-73%
3 Non-Psychotic (Moderate Severity)	162	182	20	12%
4 Non-Psychotic (Severe)	128	159	31	24%
5 Non-psychotic Disorders (Very Severe)	29	30	1	3%
6 Non-Psychotic Disorder of Over-Valued Ideas	25	23	(2)	-8%
7 Enduring Non-Psychotic Disorders (High Disability)	96	121	25	26%
8 Non-Psychotic Chaotic and Challenging Disorders	62	68	6	10%
10 First Episode Psychosis	52	64	12	23%
11 On-going Recurrent Psychosis (Low Symptoms)	282	292	10	4%
12 On-going or Recurrent Psychosis (High Disability)	151	157	6	4%
13 On-going or Recurrent Psychosis (High Symptom & Disability)	105	101	(4)	-4%
14 Psychotic Crisis	18	13	(5)	-28%
15 Severe Psychotic Depression	7	7	-	0%
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	6	8	2	33%
17 Psychosis and Affective Disorder – Difficult to Engage	35	25	(10)	-29%
18 Cognitive Impairment (Low Need)	365	243	(122)	-33%
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	465	798	333	72%
20 Cognitive Impairment or Dementia Complicated (High Need)	159	202	43	27%
21 Cognitive Impairment or Dementia (High Physical or Engagement)	50	50	-	0%
Reviewed Not Clustered	30	66	36	120%
No Cluster or Review	46	72	26	57%
Total	2,385	2,740	355	15%

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

			Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
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	Target 95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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

		Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16
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.	Target 95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Quality Overview

At Month 10, Merseycare are compliant with quality schedule reporting requirements. The Trust is working with the CCG Quality team to develop the safer staffing report. At the last CQPG the Trust provided an update on the Quality Strategy and Nurse revalidation. In addition, work continues with Liverpool CCG and Mental Health Quality Leads to develop a new Serious Incident report .

Specific concerns remain regarding DNA's at Clock View site, GP referral pathways, AED assessment and access to psychotherapy. The CCG are monitoring these areas through the CQPG and SRG meetings.

A Contract Performance Notice has been issued to Merseycare regarding the recent A&E waits, a remedial Action Plan is now in place as a result. Meetings have already been held with the Trust, South Sefton CCG, Liverpool CCG and Knowsley CCG. An Escalation Plan has been developed between Merseycare and Aintree, to date there have not been any further mental health long waits. It has been noted that communications have significantly improved between Merseycare and Aintree.

7.2 Cheshire Wirral Partnership -Improving Access to Psychological Therapies Contract

The prevalence position at month 10 is below the planned target. Year to date the actual prevalence rate as at month 10 is 7.45%. If current activity levels continue this would give a forecast outturn that would fall below the 15% target at 2015/16 year end. To achieve the prevalence target the Provider would need 1,438 people entering treatment between February and March.

During the year the recovery rate has fluctuated and has been both above and below the 50% target. This has been a concern from month 5 when the recovery actual was 58.7% as to whether the service could maintain this. At month 10 the recovery is 47.3% and this is a reduction on the position last month.

Total referrals are up on last month and this is probably due to the expected seasonal recovery after the Christmas period. The number of patients self-referring is slightly down on last month however the percentage of referrals from GPs has increased and this may be due to awareness initiatives conducted by the trust.

The number of patients entering treatment is up on last month and corresponds with the increase in referrals received.

The percentage of patients entering treatment in 28 days or less is slightly up on last month however last month will have been affected by Christmas. This is affected by not enough people entering treatment.

There have been 125 cancellations by the patient and this is an increase on last month. Cancellations by the provider are on average 45 per month however at month 10 there is a slight increase with 57 cancellations by the provider. This requires further investigation as this is an on-going issue.

The service has previously confirmed that the provider cancellations have been attributable to staff sickness within the service which the service is continuing to manage. All cancelled appointments are rebooked immediately.

Both DNAs and cancellations are up on last month and the provider will be requested to report how they intend to tackle this further.

Previously Step 2 staff have reported that they are experiencing a high DNA rate and are confirming appointments with clients over the phone who then subsequently do not attend the appointment. The wait to therapy post screening is still part of the timeline and as such the service think that the client may sometimes feel they need to accept the appointment as they have waited a significant time, but then do not feel the need to attend, as essentially the need has past. This may explain the level of

DNAs.

At month 10 self-referrals are lower than last month however there is an increase in GP referrals. The percentage of self-referrals may be impacting on the “watchful wait” that is usually managed by the GP as this is missed and clients referring are assessed promptly. Following the assessment the natural process of managing some level of emotional distress occurs and when appointments are offered the desire to engage in therapy has diminished.

The service text reminder service is being used to assist in the reduction of DNAs. This gives the prompt to clients 24 hours before an appointment for those most likely to have forgotten.

In January a Contract Performance Notice was issued by the CCG relating to underperformance. The provider presented an action plan for review. A discrepancy was raised between the local data submitted to the CCG by the provider and the data the provider has submitted to the Health & Social Care Information Centre for the national data requirements. The gap in activity figures between the data sets has narrowed in the latest month.

Figure 18 Monthly Provider Summary including (National KPI s Recovery and Prevalence)

Performance Indicator			Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	TOTALS
Population (Paychiatric Morbidty Survey)			19079	19079	19079	19079	19079	19079	19079	19079	19079	19079	19079
National defininiton of those who have entered into treatment			103	96	130	164	104	123	128	165	191	218	1422
Prevelance Trajectory (%)			1.25%	1.25%	1.25% (q1=3.75%)	1.25%	1.25%	1.25% (q2=3.75%)	1.25%	1.25%	1.25% (q3=3.75%)	1.25%	**15.00%**
Prevelance Trajectory ACTUAL			0.54%	0.50%	0.68%	0.86%	0.55%	0.64%	0.67%	0.86%	1.00%	1.14%	7.45%
National definition of those who have completed treatment (KPI5)			95	85	78	99	83	93	79	115	86	101	
National definition of those who have entered Below Caseness (KPI6b)			7	8	6	9	8	6	3	8	12	8	
National definition of those who have moved to recovery (KPI6)			39	47	35	40	44	39	29	41	41	44	
Recovery - National Target			50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%	
Recovery ACTUAL			44.3%	61.0%	48.6%	44.4%	58.7%	44.8%	38.2%	38.3%	55.4%	47.3%	
Referrals Received			290	253	255	245	209	244	225	264	206	239	
Gp Referrals			192	138	108	107	87	101	89	81	57	107	
% GP Referrals			66%	55%	42%	44%	42%	41%	40%	31%	28%	45%	
Self referrals			64	81	126	117	110	138	109	163	134	111	
% Self referrals			22%	32%	49%	48%	53%	57%	48%	62%	65%	46%	
Other referrals	Other Referrals are 11 - Acute Care Team, 1 - Perinatal, 4 - Other, 2-Pyschiatrist, 2-SecondaryCare		34	34	21	21	12	5	27	20	15	21	
% Other referrals			12%	13%	8%	9%	6%	2%	12%	8%	7%	0	
Referral not suitable or returned to GP			0	0	0	0	0	0	0	0	0	0	
Referrals opting in			275	228	204	173	162	171	153	177	148	196	
Opt-in rate %			95%	90%	80%	71%	78%	70%	68%	67%	72%	82%	
Patients starting treatment by step (Local Definition)		Step 2	77	65	98	127	72	98	105	157	179	213	
		Step 3	26	31	32	36	32	25	23	8	12	3	
		Step 4				1							
		Total	103	96	130	164	104	123	128	165	191	216	
Percentage of patients entering in 28 days or less			47.0%	50.0%	44.0%	58.0%	41.0%	45.0%	21.0%	37.8%	22.9%	23.3%	
Completed Treatment Episodes by Step (Local Definition)		Step 2	141	90	116	145	91	166	186	236	166	233	
		Step 3	287	273	248	191	261	223	209	205	338	259	
		Step 4		1			1	1	1		7		
		Total	428	364	364	336	353	390	396	441	511	492	
Activity	Attendances	Step 2	267	314	429	541	387	479	463	492	403	482	
		Step 3	283	277	389	359	330	343	319	318	252	352	
		Step 4		4	1	2	3	11	14	14	8	6	
	DNA's	Step 2	42	62	108	117	55	84	88	65	51	66	
		Step 3	20	31	41	46	34	35	35	24	14	25	
		Step 4							1		0		
	Cancels	Step 2	37	61	117	127	93	83	113	101	110	98	
		Step 3	37	41	65	71	62	78	69	89	52	84	
		Step 4			3			2	2	2	1	0	
	Attendances	Total	550	595	819	902	720	833	796	824	663	840	
	DNAs	Total	62	93	149	163	89	119	124	89	65	91	
	Cancelled	Total	74	102	185	198	155	163	184	192	163	182	
	Number Cancelled by patient	Total	43	60	136	144	112	106	138	155	118	125	
	Number Cancelled by provider	Total	31	42	49	54	43	57	46	37	45	57	

Figure 19: IAPT Waiting Time KPIs

	Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Year To Date
EH.1_A1	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 treament in the reporting period	75% To be achieved by April 2016											
	Numerator		94	83	92	116	83	99	90	115	81	98	951
	Denominator		96	84	95	127	85	104	93	117	83	101	985
	%		97.92%	98.81%	96.84%	91.34%	97.65%	95.19%	96.77%	98.29%	97.59%	97.03%	96.5%
EH.2_A2	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	95% to be achieved by April 2016											
	Numerator		96	84	95	127	85	104	93	117	83	101	985
	Denominator		96	84	95	127	85	104	93	117	83	101	985
	%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

8. Community Health

8.1 Southport and Ormskirk Community Health

The Trust is still experiencing issues with reporting on CERT, Chronic Care Coordinators and Community Matrons after the migration to EMIS. These issues have been logged with EMIS and the Trust continues to work with the suppliers to resolve these issues.

Podiatry Non AQP-There has been a shift in activity between clinic based and community contacts.

Integrated Care- The trust has established a data collection process that utilises electronic proformas on Medway. It should be noted that this data collection does not support the production of a CIDS. The trust has now developed a monthly report based on the data captured on the electronic proforma of patient's discharges under section 2 and 5 (which indicates the type of care package required for each patient) by ward. This has been shared with the commissioner for a decision as to whether this will for fill the reporting needs. At the FIG it was suggested that looking at the eligible cohort of patients would be more meaningful and looking at how it could be linked to delayed discharge reasons. This work is on-going with a view to developing meaningful measures.

Continence: This service has experienced issues with staffing at currently have 39 long waiters and the longest wait in weeks is 43.

Pain Management- The refreshed data provided at month 9 year to date may still include activity that should be attributed to the acute part of the service. This was raised at the last FIG meeting and is still currently being investigated. This service has been affected also by staffing issues during the year and this had led to delays in the inputting of data in December due to staff sickness. The staff member has now returned to work and is addressing the backlog. The service has 8 long waiters and further feedback from the service is awaited.

Blue badge- longest waits have been increasing during the year and is now at 50 weeks. This is a small service.

Treatment Rooms-The trust are currently investigating the increase in activity related to wound care which would normally be dealt with in primary care. This may be related to practices that do not have access to a practice nurse. The trust are currently investigating this and a response is awaited .

Waiting Times
Work is still on-going but on hold to set appropriate wait targets by service as the national RTT targets are inappropriate for community services. The trust has agreed to provide thematic reasons on a monthly basis around breaches from now on.

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 is part of the work plan of the Finance and Information Group.

There are general implications this year as the trust move from the IPM community system to EMIS and Medway and so far this has manifested itself in the trust being unable to date to report on Community Nurses, CERT, Chronic Care Coordinators and Lymphodema which is still a manual data collection.

Any Qualified Provider

The locally agreed assessment tariff of £25 is being used from 1st April in the podiatry AQP dataset**.** The Podiatry AQP is budget is £566,000. At month 10 2015/16 the costs to date are £316,197 compared to the same time last year £507,60 and at March 2014/15 it came in at 8% over budget. Activity comparisons this year (Southport and Formby CCG activity only) (4596) to last year (3514) show activity is up however the application of the £25 tariff has reduced the possible costs.
The trust has been asked to provide the diagnostics within the data set and have said that they will work towards including this. The trust may still need to raise credit notes in relation to an earlier query raised in relation to patients discharged at first visit and for more recent queries raised. This needs to be checked with finance. The trust raised possible technical problems that they may face moving forward with Podiatry AQP moving to EMIS at the last FIG meeting. The trust have been asked to contact another local community trust that may have had the same issues to establish if there is any solutions that can be shared.

Adult Hearing Audiology costs are over the full year budget. The budget is £248,000 and at month 10 2015/16 the costs are £332,643 which is 34% over the annual budget. The costs at the same time last year were £202,961 at month 10 2014/15. Comparisons of activity between the two time periods shows that activity is up 15/16 (1062) compared to 14/15 (964) and demand has increased.
This is due to three year reviews being seen and the allocated budget not being uplifted to take this effect into account. At month 7 the trust were asked to provide the number of scheduled reviews between November and March to give a forecast of the likely final year costs and this has been provided and passed to the finance lead.

The MSK AQP is also likely to over perform 2015/16 as at month 10 only 9% of the budget is left for the rest of the financial year. Last year there was financial underperformance on this AQP. Last month a query was raised with the trust as to where the additional activity is coming from and a response to this is awaited. At month 9 further queries were raised as duplicate patients have been identified within the submitted data set, same patients discharged in the same month and patients with no outcome of attendance despite some of them having a diagnosis that would indicate that further treatment may be required. An initial response from the trust agrees with the identification of duplicate records and changes due to the corrections will filter through within the data sets received. Once the level of duplication has been established and rectified this will impact on the year to date spend and this may require the trust to issue credit notes. The data set also includes patients where a tariff is present and the outcome has been recorded as " NULL" and this has been raised with the trust also. This is being investigated with a view to the trust providing this information within the data set. This will continue to be monitored as part of the on-going data quality checks.

Quality Overview
The CCG is working with the Trust to develop a suite of Community specific KPIs, these will be incorporated into the Quality Schedule in 16/17. The Trust has been requested to deliver a presentation at the April CQPG regarding safer staffing and staff sickness particularly focusing on community services and district nursing.

Bridgewater Community Health

Paediatric Audiology: The Trust has assessed 90.15% of children's hearing within 6 weeks against a target of 99%. A total of 33 children have waited in excess of 6 weeks. In Southport performance remains challenging with only 58% of children seen within six weeks. 7 referrals were received 1 month late due to an interruption in facsimile functioning, back log of appointments due to reduced capacity within the team. A remedial action plan is in place which involves a full review of the Southport service A deep dive into Audiology performance was undertaken at the Operational and Performance meeting in December 2015 and the following actions are being undertaken to address performance:
The Wigan service is supporting the Southport service and staffing capacity is reduced by 66% due to sickness absence of clinical and management staff and an unsuccessful recruitment campaign to fill vacancies. Absence is being managed in line with HR policy. With regard to vacancies, one post has been upgraded in an attempt to attract interest and locum agencies are being contacted to secure staffing. The Clinical manager is in negotiation with a locum agency to secure the services of a newly identified locum to commence as soon as possible. Two locum posts have been approved and one is due to start 18/1/2016 and the second to commence 1/2/2016. The management post is being covered by a secondment to start 25/1/2016. The Trusts quality and safety committee received a full report at its October meeting and will continue to receive monthly updates.

Liverpool Community Health Trust

Exception reporting started to be provided from month 3 with Allied Health professional exceptions reported a month in arrears. This is a standing item on the FIG and is a standing agenda item as the trust has failed to consistently provide them.
Community Equipment: The increase in demand is attributed to a number of factors: Sefton MBC budget issues, staffing resources in the warehouse, availability of delivery slots, and operational issues within the CES. Additional funding has been agreed by the commissioners to be split proportionally across both CCGs and this is documented in the FIG work plan. NHS Southport & Formby CCG has agreed to fund £33,750 non-recurrently Qtr. 2 2015/16 for the provision of Community Equipment Store.

A number of actions have also been identified for this service:
• Trust to provide a detailed overview of current waiting list. This has not been received and is being chased by the CSU
• Trust to consider providing training on prescribing equipment and budget allocation

Paediatric Speech and Language (SALT)-The staff have not been able to meet the increased numbers of referrals and demand for SALT assessments and the trust is reviewing the current core offer. There are planned discussions with education regarding the service to special educational settings and resourced units. The service is asking if additional funding can be sought outside of the block contract to enable staff to manage the high numbers of children waiting for support and assessment. Improvements will be seen when the service review is completed. The trust submitted a business case for waiting list initiative funding and this has not been approved. The commissioner has asked for this to be reviewed to clearly demonstrate cost savings for the CCG.

Waiting times are reported for a small number of therapy services a month in arrears. Waiting times are not being recorded for Community Cardiac/Heart Failure, IV Therapy and Respiration. 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.

Paediatric SALT: Current waiting times of concern: at month 10 for Paediatric SALT is reported as in excess of 18 weeks at 26 weeks average wait for NHS Southport & Formby and this is a worsening on the position last month . It was reported at the LCH December Board that a full service review is currently being completed including waiting list validation. The Board was also informed that a decision was made to close the waiting list. It was reported that 260 patients are waiting for an appointment across the LCH catchment. It was confirmed that a locum has been commissioned in order to offer an appointment to patients on the waiting list.

The waiting times remain significantly above target in Sefton due to demand and capacity being significantly out of balance .A full validation of the waiting list is due to be completed in Sefton by January 2016.

The Capacity and demand model was expected by 18th December 2015 to inform the resources required to ensure waiting times are achieved. Additional therapists have been recruited and locums are due to start in January 2016. The waiting list remains closed and weekly meetings with commissioners will continue to monitor the impact. For this financial year 2015-16, CSU has asked (via email Tue 19/05/2015) LCH to give an indication of which waiting times will be reported during the current month, a month behind and not at all. Awaiting response.

Waiting time Information has been discussed at the Collaborative Commissioning Forum. The Trust advised that a Waiting List Management Task and Finish group has been established and trajectories are being developed to get waiting times back in target. The therapies paper prepared in April is being refreshed to go back to the board in November. Awaiting further feedback on progress.

Adult SALT: The Trust submitted a Business Case for waiting list initiative funding. This has been reviewed by the CCG and based upon the information provided the CCGs have not agreed to provide additional funding. The Trust has been advised to further develop the Business Case to demonstrate that for every £1 invested £3 of savings would result for NHS Southport & Formby CCG.

Patient Identifiable data

The Trusts Caldicott guardian had 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 update to this is that the approach now being implemented is a reversal of this approach and the trust are raising patient awareness around the use of patient identifiable data and have introduced an op out process. This means that patients can opt out from having identifiable electronic information flowed related to them. It was agreed that the trust would forward a copy of the letter prepared by the Caldicott guardian about what the trust plans to do at the last LCH finance and information group meeting . The letter that was sent out was in reference to the Liverpool CCG walk in centres. At present there is building work taking place at Litherland and it has not been possible to display the relevant information to patients in relation to information sharing. Once the refurbishment is complete and the literature is available this process will commence and patient identifiable WIC data will flow as part of the SUS submissions

Quality Overview

Liverpool Community Health is subject to enhanced surveillance. Work streams have been identified by the Collaborative Forum (CF) including Culture, Governance, Safety and Workforce, each area has an identified clinical and managerial lead from the CCG and the Trust, each work stream reports directly into the joint CQPG and CF. The CQC re-inspected the Trust w/c 1st February, initial feedback from the Trust at the joint CQPG meeting in March was positive, particularly regarding culture and staff feedback – it is anticipated the rating will remain 'Needs Improvement' with elements of 'Good'.

Delayed Transfers of Care

The Trust are working closely with the Local Authority to review delayed transfers of care, discussions are taking place through the SRG.

Serious Incidents / Pressure Ulcers

Key areas of risk identified continue to be pressure ulcers, where the collaborative workshop has taken place alongside the trust and Liverpool CCG. The workshop has developed a composite action plan to address the 8 identified themes. The trust alongside both Liverpool and South Sefton CCG have confirmed their attendance at the NHSE Pressure Ulcer action plan development session, where the composite action plan will be share. LCCG are leading on this piece of work with LCH although SS CCG are an active member of this group. This approach is in line with the RASCI model

SALT & Physiotherapy Waiting Times

The CCG continues to experience longs waits for both paediatric and adult SALT and Physiotherapy, this has been raised at CQPG and Contract meetings, the Trust has been asked to resubmit a business case regarding SALT and Physiotherapy this will be reviewed by the CCG clinical leads. The Trust has also been asked to provide monthly progress reports and recovery plans for CCG assurance regarding patient safety.

9. Third Sector Contracts

All Third Sector Contracts and Grant agreements are due to expire on 31st March 2016. Planning for the coming year is in progress and further meetings are to take place shortly to discuss commissioning intentions for 2016-17.

Full and detailed reports containing service outcomes for each provider have now been finalised, these are now with commissioners. A piece of work has been undertaken to establish commissioning priorities and funding for 2016-17, this is to be presented and discussed at the next full board meeting at the end of March. Letters requesting contract documentation are pending until a final decision has been made.

IG Toolkit compliancy assessments are underway and are expected to be finalised prior to 31st March 2016.

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 - January	31	32	↑	There was 6 new cases reported in January 2016, year to date there have been 35 cases against a year to date plan of 31. Of the 6 new cases 5 were reported by Southport and Ormskirk Hospital (3 apportioned to Acute, 2 apportioned to community) and 1 reported by Aintree (apportioned to Acute). All but 3 cases reported in year to date all have been aligned to Southport & Ormskirk Hospital (21 apportioned to acute trust and 14 apportioned to community). The remaining 2 cases was aligned to The Walton Centre in April and apportioned to the acute trust (1 case) and Aintree in July apportioned to community). Year-end plan is 38.	The majority of Southport & Formby CCG C.difficile cases are attributed to Southport & Ormskirk Hospitals. Please see below for the Trust narrative.
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Southport & Ormskirk)**	15/16 - January	30	32 (20 following appeal)	↑	There were 6 new cases reported in January 2016 (ytd 32), against a year to date plan of 30. Year-end plan is 36. To date 12 cases have been successfully appealed, taking the Trust's below the trajectory of 30 cases YTD.	To date the Trust has had 32 total cases (reported by PHE). 17 cases have been put forward for consideration by the CCG Appeals Panel and 12 have been upheld taking the number of YTD cases to 20. In reviewing our most recent C diff cases the Trust had zero in December, followed by 6 cases in January. The January cases were during a time period when there was extensive pressure on emergency admissions, however following RCAs of the 6 cases, 4 will be submitted for appeal. Learning points following the RCAs were there were considered to be lapses in care included: not isolating a patient promptly following symptoms of diarrhoea, not obtaining stool specimens promptly after symptoms of diarrhoea, obtaining microbiological evidence of infection from possible sites of infection and the appropriate use of antibiotics.

Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	15/16 - January	0	0	↔	No new cases reported in January 2016.	
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Southport & Ormskirk)**	15/16 - January	0	1	↔	No new cases have been reported in January 2016. 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 (West Lancs CCG patient) and are therefore over the annual trajectory of zero. A Post 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. Completeion of MRSA screening pathways is monitored at PNFs for each Clinical Business Unit. The Trust declared a second case on 29th February - further details will be included in the Month 11 report.
Mixed Sex Accommodation Breaches						
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(CCG)**	15/16 - January	0.00	1.30	↓	In January the CCG had 5 mixed sex accommodation breaches which is above the target and as such are reporting red for this indicator the sixth time in 2015-16.	The majority of the breaches occurred in Southport & Ormskirk Trust, see below for comments.
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(Southport & Ormskirk)**	15/16 - January	0.00	2.00	↑	In January the Trust had 10 mixed sex accommodation breaches which is above the target and as such are reporting red for this indicator the sixth time in 2015-16. Year to date there have been 48 breaches.	There were 10 breaches in January. They all related to ITU patients. A joint decision has been made by the Chief Executive and Chief Operating Officer to prioritise this area. The Director of Nursing and Quality Lead is capacity planning to prioritise the movement of patients within the ITU.
Enhancing quality of life for people with long term conditions						
Patient experience of primary care i) GP Services	Jan-Mar 15 and Jul-Sept 15		3.75%	↓		
Patient experience of primary care ii) GP Out of Hours services	Jul-Sept 15		15.70%	↑	Percentage of respondents reporting confidence and trust in person/people seen or spoken to at the GP Out of Hours Service. Due to slight to the question on out of hours, the results are based on Jul-Sept 15 only.	
Patient experience of primary care i) GP Services ii) GP Out of Hours services (Combined)	Jan-Mar 15 and Jul-Sept 15	6%	4.73%	↓		

Emergency Admissions Composite Indicator(Cumulative)	15/16 - January	1987.96	2,152.32	↑	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 over the monthly plan and had 277 less admissions than the same period last year.	Unplanned care leads continue to monitor these indicators closely. Pathway changes at Southport & Ormskirk Hospital have not have been reflected in the planned targets as the targets were set in 2013 when the 5 year strategic plans were set. S&O implemented pathway changes in October 2014 which has led to a higher number of admissions than originally planned for.
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s(Cumulative)	15/16 - January	499.74	303.26	↓	The agreed plans are based on activity for the same period last year. The CCG is under the monthly plan and the decrease in actual admissions is 46 below the same period last year.	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	15/16 - January	944.80	866.99	↓	The agreed plans are based on activity for the same period last year. The CCG is under the monthly plan the decrease in actual admissions is 95 lower the same period last year.	
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	15/16 - January	290.45	380.15	↑	The agreed plans are based on activity for the same period last year. (Numbers are generally very low for this indicator). The CCG is over plan for this indicator the increase in actual admissions is 21 more than the same period last year.	The CCG respiratory programme manager continues to monitor this indicator closely.
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	15/16 - January	1380.3	1,212.47	↓	The agreed plans are based on activity for the same period last year. This indicator is below plan, the decrease in actual admissions is 205 lower the same period last year.	
Emergency readmissions within 30 days of discharge from hospital (Cumulative)	15/16 - January	No Plan	14.90	↓	The emergency readmission rate for the CCG is lower than previous month (16.73) and lower than the same period last year (17.56).	

Helping people to recover from episodes of ill health or following injury						
Patient reported outcomes measures for elective procedures: Groin hernia	Apr 14 - Mar 15 (Prov data)	0.082	0.071	Provisional data (Published Feb 2016)	Provisonal data shows the CCG is higher than the years rate of 0.067 in 2013/14 but is lower than plan and the England average 0.084.	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	Apr 14 - Mar 15 (Prov data)	0.429	0.421	Provisional data (Published Feb 2016)	Provisional data for 2014-15 is scoring lower than the plan and England average. England average 0.437.	
Patient reported outcomes measures for elective procedures: Knee replacement	Apr 14 - Mar 15 (Prov data)	0.311	0.310	Provisional data (Published Feb 2016)	Provisonal data shows the CCG's rate is lower than the previous year (2013/14 - 0.340) and under the plan. England average 0.315.	
% who had a stroke & spend at least 90% of their time on a stroke unit **(CCG)**	15/16 - January	80%	52.90%	↓	The CCG failed the 80% target in January with only 9 out of 17 patients spending 90% of their time on a stroke unit.	The stroke target of 90% stay in acute stroke unit was underachieved at 55.6% in January. At the recent stroke operational group there was detailed discussion about the difficulties in hitting the targets despite moving as the RCP suggested to a smaller unit. Part of the reason is due to the current pressures that the whole trust and especially ED is experiencing. The move has been regarded as successful on the whole especially re the nursing morale Three main issues which if addressed would support improving achievement of the targets. 1. Agreeing the business case for an ESD service which has been in the system for a number of months without any feedback and is supported by the CCGs and would also demonstrate a commitment to community services and reducing length of stay within the ICO. 2. There is a realisation that although the 22 beds is the correct number one of our current issues is that the staff are struggling due to the sex mixes of the 3 bays and it would be really beneficial if one of the 6 bedded bays could be partitioned to give us the flexibility we need. This is being looked into 3. With the advent of Bluebell there is the opportunity to look at a discharge to assess model. The stroke unit have only rarely used Bluebell for MOFD and TOFD patients because there is still the prolonged bureaucracy of assessment to complete which means especially for those requiring long term care that they don't fulfil the criteria as they do not yet have a discharge address. The resolution of these would have a significant impact on our bed usage and improve both our targets and the patient experience.
% who had a stroke & spend at least 90% of their time on a stroke unit **(Southport & Ormskirk)**	15/16 - January	80%	55.60%	↑	The Trust failed the 80% target in January with only 15 out of out of 27 patients spending 90% of their time on a stroke unit.	
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(CCG)**	15/16 - January	60%	75.00%	↓		
% high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Southport & Ormskirk)**	15/16 - January	60%	62.50%	↑		

Mental health						
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative) **(CCG)**	15/16 - Qtr3	95%	100.00%	↔		
IAPT Access - Roll Out	15/16 - Qtr3	3.75%	2.54%	↑	The CCG are under plan for Q3 for IAPT Roll Out, this equates to 484 patients having entered into treatment out of a population of 19079 (Psychiatric Morbidty Survey).	See section 7 of main report for commentary
IAPT Access - Roll Out	15/16 - January	1.25%	1.10%	↑	The CCG are under plan in January for IAPT Roll Out, out of a population of 19079, 218 patients have entered into treatment. There has been a slight increase on previous month when the trust reported 1.0%.	See section 7 of main report for commentary
IAPT - Recovery Rate	15/16 - Qtr3	50.00%	43.19%	↓	The CCG are under plan for recovery rate reaching 43.19% in Q3. This equates to 111 patients who have moved to recovery out of 280 who have completed treatment.	See section 7 of main report for commentary
IAPT - Recovery Rate	15/16 - January	50.00%	47.31%	↓	The CCG are under plan for recovery rate in January This equates to 44 patients who have moved to recovery out of 93 who have completed treatment. There has been a dip in performance from the previous month when the trust reported 55.41%.	See section 7 of main report for commentary
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	Q3 15/16	75.00%	97.60%	↑	January data shows 97.0% a very slight decrease from December when 97.6% was recorded.	
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	Q3 15/16	95%	100.00%	↔	January data shows 100%.	

Preventing people from dying prematurely						
Under 75 mortality rate from cancer	2014		131.10	↑	Under75 mortality rate from Cancer has increased from 120.20 in 2013 to 131.10 in 2014.	
Under 75 mortality rate from cardiovascular disease	2014		66.00	↑	Under 75 mortality rate from cardiovascular disease has increased from 57.50 in 2013 to 66.00 in 2014.	
Under 75 mortality rate from liver disease	2014		20.40	↑	Under 75 mortality rate from liver disease has increased from 15.80 in 2013 to 20.40 in 2014.	
Under 75 mortality rate from respiratory disease	2014		22.10	↓	Under 75 mortality rate from respiratory has decreased very slightly from 22.30 in 2013 to 22.10 in 2014.	
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Person)	2014	2,464.40	2,120.40	↑		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 - January	93%	94.62%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Southport & Ormskirk)**	15/16 - January	93%	95.26%	↑		
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 - January	93%	89.74%	↑	Southport & Formby CCG achieved the target for January achieving 93.6% but are still failing year to date due to previous months breaches. Year to date out of 429, there have been 44 patient breaches.	A communication to GPs regarding the management of breast symptomatic patients went out mid February, so hoping to see an improvement from March. This should aid demand management and in reminding GP and patient that these patients will be seen in the 2/52 timeframe if they need to be referred.
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 - January	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 - January	96%	98.47%	↔		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Southport & Ormskirk)**	15/16 - January	96%	98.41%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	15/16 - January	94%	95.78%	↑		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Southport & Ormskirk)**	15/16 - January	94%	100.00%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	15/16 - January	94%	100.00%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Southport & Ormskirk)**	15/16 - January	94%	95.92%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	15/16 - January	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 - January	98%	100.00%	↔		

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 - January	85% (local target)	82.81%	↔	Southport & Formby CCG achieved the target for January but failed year to date partly due to previous month breaches. In January 2 patients out of a total of 17 were not upgraded (88.24%). Year to date there have been 128 patients and 22 patient breaches and are under the 85% local target set.	
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 - January		90.84%	↓		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	15/16 - January	90%	98.21%	↑		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(Southport & Ormskirk)**	15/16 - January	90%	79.17%	↑	Southport & Ormskirk Trust achieved the target in January reaching 100% but are failing and year to date due to previous months breaches. Year to date there have been the equivalent of 2.5 breaches out of a total of 12 patients.	
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	15/16 - January	85%	85.44%	↓		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Southport & Ormskirk)**	15/16 - January	85%	86.88%	↓		

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 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(Southport & Ormskirk)**	15/16 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(CCG)**	15/16 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(Southport & Ormskirk)**	15/16 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	15/16 - January	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Southport & Ormskirk)**	15/16 - January	0	0	↔		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(CCG)**	15/16 - January	90%	89.79%	↓	The CCG have failed the 90% target reaching 89.79%. This equates to 67 patients out of 656 not seen within 18 weeks.	No longer a national performance targets but continue to monitor locally.
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(Southport & Ormskirk)**	15/16 - January	90%	82.86%	↓	The Trust has failed the 90% target reaching 82.86% in January, this equates to 152 out of 887 not seen within 18 weeks.	
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(CCG)**	15/16 - January	95%	93.66%	↓	The CCG have failed the 95% target reaching 93.66%. This equates to 194 patients out of 3059 not seen within 18 weeks.	
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(Southport & Ormskirk)**	15/16 - January	95%	94.54%	↓	The Trust has failed the 95% target reaching 95.54% in January, this equates to 230 patients out of 4215 not seen within 18 weeks.	
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 - January	92%	95.90%	↔		
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 - January	92%	97.00%	↑		

A&E waits						
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) All Types**	15/16 - January	95.00%	92.36%	↓	Southport & Formby CCG failed the 95% target in January reaching 84.22% and are failing year to date reaching 92.36%. In January 469 attendances out of 2972 were not admitted, transferred or discharged within 4 hours.	NHSE have recently announced that any Trust which falls below 80% on the main A and E 4 hour wait target will have to monitor and report breaches via root cause analysis on a weekly basis. The Trust does not fall into that category though it is still falling short of the 95% compliance target at 92.9% year to date (83.4% in January). NHSE have made it clear that they expect all Trusts to achieve the 95% target by April 2017. The Trust considers that there are some quick wins to hit the 90% target by April 2016 and is developing a clinical service strategy. This will be produced in the business planning round for consideration by the senior management team. The strategy will aim to redesign all pathways taking account of previous advice from NHSE's Emergency Care Intensive Support Team. The strategy will be converted to an implementation plan which will be rolled out throughout the year with the objective to hit the 95% by early 2017 The TDA is coming to the Trust in April 2016 and the strategy and first cut of the plan will be presented to them by the service leads. Ambulance handover will form part of the plan and trajectories for this, along with the A and E targets, will be included within it. A and E remains the main concern. At the PMF it was recognised that 20% of staffing was via agency, there had been a small increase in incidents, morale is low and there had been an effect on patient experience reflected in the friends and family test figures. Activity was particularly high in January and the Management Team have escalated action to the urgent care team to meet weekly to consider supportive measures to improve matters.
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG) Type 1**	15/16 - January	95.00%	88.90%	↓	Southport & Formby CCG failed the 95% target in January reaching 74.10% and are failing year to date reaching 88.90%. In January 488 attendances out of 1884 were not admitted, transferred or discharged within 4 hours.	
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Southport & Ormskirk) All Types**	15/16 - January	95.00%	92.07%	↔	Southport & Ormskirk have failed the target in January reaching 84.0%, and are failing year to date reaching 92.07%. In January 1497 attendances out of 9339 were not admitted, transferred or discharged within 4 hours.	
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Southport & Ormskirk) Type 1**	15/16 - January	95.00%	86.82%	↓	Southport & Ormskirk have failed the target in January reaching 74.13%, and are failing year to date reaching 86.52%. In January 1557 attendances out of 6018 were not admitted, transferred or discharged within 4 hours.	

Diagnostic test waiting times						
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	15/16 - January	1.00%	2.65%	↔	The CCG has failed to achieve the target in January with 55 patients out of 2075 waiting over 6 weeks for their diagnostic tests, of the 55, 14 patients over 13 weeks. Of the 55 breaches 48 were for audiology assessments, 33 at Bridgewater.	Bridgewater Trust has assessed 90.15% of children's hearing within 6 weeks against a target of 99%. A total of 33 children have waited in excess of 6 weeks: • 33 in Southport where performance remains challenging with only 58% of children seen within six weeks. 7 referrals were received 1 month late due to an interruption in fax functioning, back log of appointments due to reduced capacity within the team • A remedial action plan is in place which involves a full review of the Southport service. A deep dive into Audiology performance was undertaken at the Operational and Performance meeting in December 2015 and the following actions are being undertaken to address performance: • The Wigan team is supporting the Southport service and staffing capacity is reduced by 66% due to sickness absence of clinical and management staff and an unsuccessful recruitment campaign to fill vacancies. Absence is being managed in line with HR policy. With regard to vacancies, one post has been upgraded in an attempt to attract interest and locum agencies are being contacted to secure staffing. The Clinical manager is in negotiation with a locum agency to secure services of a newly identified locum to commence as soon as possible. 2 locum posts have been approved , one due to start 18/1/2016 and the second to commence 1/2/2016. The management post is being covered by a secondment to start 25/1/2016. .
% of patients waiting 6 weeks or more for a Diagnostic Test **(Southport & Ormskirk)**	15/16 - January	1.00%	0.90%	↑		

Category A ambulance calls						
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	15/16 - January	75%	74.02%	↓	The CCG failed to achieve the 75% target year to date (74.02%), or in month (Jan) recording 61.70%.	The onset of winter has seen the whole of the urgent care system coming under pressure due to high levels of demand. The overall demand in January, for NWAS was 6.9% higher than planned for and 2.7% than plan for Southport & Formby CCG. For the most time critical response times (Red) was 9.0% higher than plan for NWAS as a whole and 1.1% higher than plan for Southport & Formby CCG. The average turnaround times at Southport & Ormskirk Hospital were the longest of any Cheshire & Merseyside in January at just over 56 minutes on average. Additional capacity has also been created due to extra ambulance available in the Southport area.
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	15/16 - January	75%	67.10%	↓	The CCG failed to achieve the 75% target year to date (67.10%), or in month (Jan) recording 55.5%.	
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	15/16 - January	95%	88.60%	↓	The CCG failed to achieve the 95% target year to date (88.60), or in month (Jan) recording 81.20%.	
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	15/16 - January	75%	76.10%	↔		
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	15/16 - January	75%	72.70%	↓	NWAS failed to achieve the 75% year to date or in month (Jan) recording 63.49%.	
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	15/16 - January	95%	93.70%	↓	NWAS failed to achieve the 95% year to date or in month (Jan) recording 89.85%.	
Local Indicator						
Access to community mental health services by people from Black and Minority Ethnic (BME) groups (Rate per 100,000 population)	2014/15	2200	2202.8	↑	The latest data shows access to community mental health services by people from BME groups is over the CCG plan. This is also improvement on the previous year when the CCG rate was 2118.0.	

10.2 Friends and Family – Southport and Ormskirk Hospital NHS Trust

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

Clinical Area	Response Rate (RR) Target	RR Actual (Jan 2016)	RR - Trajectory From Previous Month (Dec 15)	Percentage Recommended (England Average)	Percentage Recommended (Jan 2016)	PR Trajectory From Previous Month (Dec 15)	Percentage Not Recommended (England Average)	Percentage Not Recommended (Jan 2016)	PNR Trajectory From Previous Month (Dec 15)
Inpatients	25%	19.8%	↓	96.0%	94%	↔	1.0%	2.0%	↔
A&E	15%	0.7%	↔	86.0%	80%	↓	7%	13%	↓
Q1 - Antenatal Care	N/A	-	-	96%	100%	↑	1%	0%	↔
Q2 - Birth	N/A	12.1%	↑	97%	76%	↓	1%	5%	↑
Q3 - Postnatal Ward	N/A	-	-	94%	89%	↓	2%	6%	↑
Q4 - Postnatal Community Ward	N/A	-	-	98%	79%	↑	1%	0%	↓

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 bullet points for both inpatients and A&E. The trust have deteriorated in response rates for inpatients compared to the previous month. A&E response rates remain extremely low at 0.7%

The percentage of patients that would recommend the inpatient service in the trust has remained static compared to the previous month and is below the England average. The percentage of people who would not recommend the inpatient service has remained static since the previous month and is now in line with the England average.

In A&E the percentage of people who would recommend the service has declined from the previous month to 80%, but is lower than the England average. The percentage of people who would not recommend the A&E service has declined from the previous month and is lower than the England average. However given the extremely poor response rate the results cannot be viewed with any confidence.

For maternity services, recommendation of antenatal care is 100% and has increased on the previous month. Birth, postnatal ward and postnatal community ward have shown a decrease in percentage of people who would recommend the service compared to the previous month and fall below the England average. However there is no response rate recorded for 3 out of the 4 areas measured and therefore it is difficult to see how figures for % recommended or not recommend have been deduced.

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 bi-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) and Never Events

10.3.1 CCG level Serious Untoward Incidents

These are serious incidents involving Southport and Formby CCG patients irrespective of their location of care. This data relates to month 11, which is the latest data. There were 3 Serious Incidents in February involving Southport and Formby CCG patients.For the year 15/16 up to and including February there have been 47 Serious Incidents involving Southport and Formby CCG patients.

Figure 21 SUIs Reported at Southport & Formby CCG level

CCG SUIs Never Event

Type of Incident	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Allegation Against HC Professional			1									1
Attempted Suicide by Outpatient (in receipt)		1										1
Child abuse (institutional)										1		1
Failure to act upon test results									1			1
Maternity services - unexpected neonatal death.										1		1
Medication											1	1
Mental Health Act - Class A incident										1		1
Pressure Sore - (Grade 3 or 4)			1	1								2
Pressure ulcer - (Grade 3)	3	6	3	1	1			2				16
Pressure ulcer - (Grade 4)	2		3					1				6
Serious Self Inflicted Injury Inpatient					1							1
Serious Self Inflicted Injury Outpatient							1					1
Slips/Trips/Falls										1	1	2
Sub-optimal care of the deteriorating patient		2										2
Surgical Error	1	1			1					1		4
Treatment						1						1
Unexpected Death						1	1	1			1	4
Unexpected Death (general)	1											1
Grand Total	**7**	**10**	**8**	**2**	**3**	**2**	**2**	**4**	**1**	**5**	**3**	**47**

Figure 22 SUIs by Provider

Provider / Type of Incident	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Aintree University Hospital NHS Foundation Trust												
Treatment						1						1
Unexpected Death (general)	1											1
Central Manchester University Hospitals NHS Foundation Trust												
Surgical Error										1		1
Liverpool Women's NHS Foundation Trust												
Surgical Error		1										1
Mersey Care NHS Trust												
Attempted Suicide by Outpatient (in receipt)		1										1
Child abuse (institutional)										1		1
Mental Health Act - Class A incident										1		1
Serious Self Inflicted Injury Inpatient					1							1
Serious Self Inflicted Injury Outpatient							1					1
Slips/Trips/Falls										1	1	2
Unexpected Death								1			1	2
Royal Liverpool Broadgreen University												
Surgical Error									1			1
Southport and Ormskirk Hospital NHS Trust												
Allegation Against HC Professional			1									1
Failure to act upon test results									1			1
Maternity services - unexpected neonatal death.										1		1
Medication											1	1
Pressure Sore - (Grade 3 or 4)			1	1								2
Pressure ulcer - (Grade 3)	3	6	3	1	1			2				16
Pressure ulcer - (Grade 4)	2		3					1				6
Sub-optimal care of the deteriorating patient		2										2
Surgical Error					1							1
Unexpected Death						1	1					2
Grand Total	**7**	**10**	**8**	**2**	**3**	**2**	**2**	**4**	**1**	**5**	**3**	**47**

Number of Never Events reported in period

Number of Never Events reported in period for Southport and Formby CCG Patients

Two Never Events involved a Southport and Formby CCG patient. These Never Events happened in May 2015 at the Liverpool Women's NHS Foundation Trust, and in January 2016 at Central Manchester University Hospitals NHS Foundation Trust. Both Never Events were surgical errors

Number of Southport & Formby CCG Incidents reported by Provider

The majority of incidents have occurred in Southport & Ormskirk Hospital (33), with the other incidents occurring in each of the following providers:

- Aintree University Hospital NHS Foundation Trust - 2
- Liverpool Women's NHS Foundation Trust - 1
- Mersey Care NHS Trust – 9
- Royal Liverpool Broadgreen University Hospitals NHS Trust – 1
- Central Manchester University Hospitals NHS Foundation Trust – 1

Figure 23 SUIs Reported at Southport & Ormskirk Hospital

For the year 15/16 up to and including February, Southport & Ormskirk Hospital Integrated Care Organisation (ICO) reported 83 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.

Provider SUIs Never Event *only 1 never event in Febr

Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Adverse media coverage or public concern about the organisation or the wider NHS										1		1
Allegation Against HC Professional			1							1		2
Child abuse (institutional)			1									1
Confidential Information Leak				1								1
Failure to act upon test results				1					1			2
Maternity services - unexpected neonatal death.					1					2		3
Medication								1			*2	3
Pressure Sore - (Grade 3 or 4)		2	2	1								5
Pressure ulcer - (Grade 3)	14	7	6	2	2	4	1	5	1			42
Pressure ulcer - (Grade 4)	8	1	3			1		1				14
Sub-optimal care of the deteriorating patient	1	2		1								4
Surgical Error					1							1
Unexpected Death						1	2					3
Unexpected Death of Inpatient (in receipt)	1											1
Grand Total	**24**	**12**	**13**	**6**	**4**	**6**	**3**	**7**	**2**	**4**	**2**	**83**

Figure 24 SUIs Reported at Southport & Ormskirk Hospital split by CCG

CCG Name / Incident Type	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Sefton CCG												
Adverse media coverage or public concern about the organisation or the wider NHS										1		1
Allegation Against HC Professional										1		1
Maternity services - unexpected neonatal death					1							1
Pressure ulcer - (Grade 3)	1	1										2
Pressure ulcer - (Grade 4)	1											1
Southport & Formby CCG												
Allegation Against HC Professional			1									1
Failure to act upon test results									1			1
Maternity services - unexpected neonatal death										1		1
Medication											1	1
Pressure Sore - (Grade 3 or 4)			1	1								2
Pressure ulcer - (Grade 3)	3	6	3	1	1			2				16
Pressure ulcer - (Grade 4)	2		3					1				6
Sub-optimal care of the deteriorating patient		2										2
Surgical Error					1							1
Unexpected Death						1	1					2
West Lancashire CCG												
Child abuse (institutional)			1									1
Confidential Information Leak				1								1
Failure to act upon test results				1								1
Maternity services - unexpected neonatal death										1		1
Medication								1			1	2
Pressure Sore - (Grade 3 or 4)		2	1									3
Pressure ulcer - (Grade 3)	10		3	1	1	4	1	3	1			24
Pressure ulcer - (Grade 4)	5	1				1						7
Sub-optimal care of the deteriorating patient	1			1								2
Unexpected Death							1					1
Unexpected Death of Inpatient (in receipt)	1											1
Grand Total	**24**	**12**	**13**	**6**	**4**	**6**	**3**	**7**	**2**	**4**	**2**	**83**

NHS
Southport and Formby
Clinical Commissioning Group

Number of Never Events reported in period

Southport & Ormskirk Hospital Integrated Care Organisation (ICO) have reported two Never Events. One in November 2015 and one in February 2016, both relate to medication errors.

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.

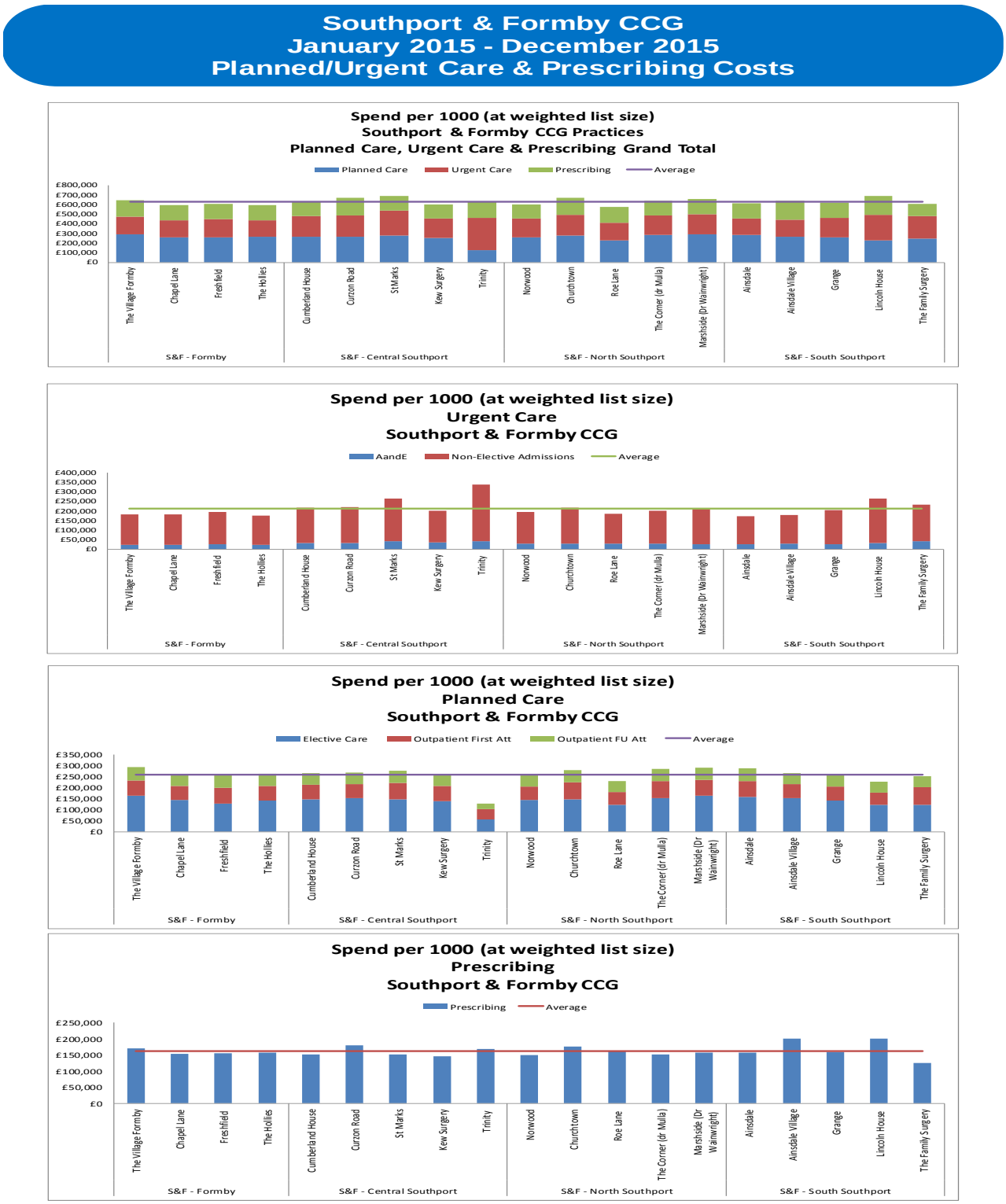
11.3 Format

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 Cheshire & Merseyside Intelligence Portal (CMiP).

11.4 Summary of performance

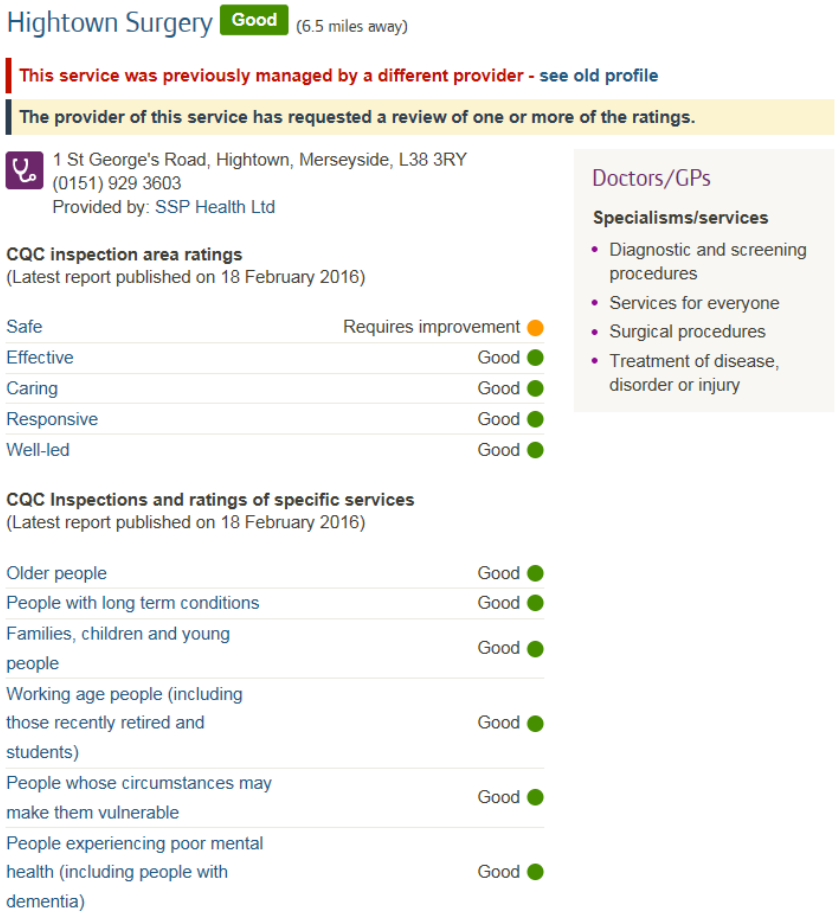
Colleagues from Finance and Business Intelligence teams within the CCG have been working closely with clinical leads to develop financial information. Colleagues have developed a chart to show weighted spend per head of weighted practice population which takes into account age, sex, deprivation, rurality, case mix, care and nursing home residents amongst others to standardise the data. The chart below is in draft format and is currently being shared with localities for feedback.

Figure 25 Summary of Primary Care Dashboard – Urgent Care Summary



11.5 CQC Inspections

A number of practices in Southport and Formby CCG have been visited by the Care Quality Commission in 2015/16. CQC publish all inspection reports on their website. There has been one further inspection result published in February, for Hightown Surgery, which although a practice in South Sefton, the practice services are being provided by a Formby practice:



Hightown Surgery **Good** (6.5 miles away)

This service was previously managed by a different provider - see old profile

The provider of this service has requested a review of one or more of the ratings.

1 St George's Road, Hightown, Merseyside, L38 3RY
(0151) 929 3603
Provided by: SSP Health Ltd

Doctors/GPs

Specialisms/services

- Diagnostic and screening procedures
- Services for everyone
- Surgical procedures
- Treatment of disease, disorder or injury

CQC inspection area ratings
(Latest report published on 18 February 2016)

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

CQC Inspections and ratings of specific services
(Latest report published on 18 February 2016)

Older people	Good
People with long term conditions	Good
Families, children and young people	Good
Working age people (including those recently retired and students)	Good
People whose circumstances may make them vulnerable	Good
People experiencing poor mental health (including people with dementia)	Good

12. Better Care Fund update

The payment for performance period of the 2015/16 Better Care Fund has now ended, as reported last month. Discussions are now underway for 2016/17 BCF planning.

13. NHS England Activity Monitoring

Figure 26 NHS England Activity Monitoring

Source	Referrals (G&A)	*Month 10 YTD PLAN*	*Month 10 YTD ACTUAL*	*Month 10 YTD Variance*	ACTIONS being Taken to Address Cumulative Variances GREATER than +/-3%
	Referrals (G&A)				
MAR	GP	23322	27016	15.8%	Please see previous report detailing the problems with the coding of referrals at Southport & Ormskirk Trust since the introduction of the new PAS back in October 14. Local referral data suggests an increase but at a lower rate but still above the 3% threshold.
MAR	Other	11922	15844	32.9%	As above. Updated figures using local referral data suggests a much lower increase but still outside the 3% threshold.
MAR	Total	35244	42860	21.6%	See above.
	Outpatient attendances (G&A)				
SUS	All 1st OP	31646	37453	18.3%	Issues between plans (based on MAR) and actuals (SUS monitored) noted in previous submission. Actual activity from April to January (SUS) against the same period last year shows a variance of less than 1% for first outpatient attendances. Follow up activity comparing last year to this year shows a slight increase of approx. 5.3%. Overall the increase is slightly above 3% for all attendances.
SUS	Follow-up	74367	97034	30.5%	
SUS	Total OP attends	106013	134487	26.9%	
SUS	Outpatient procedures (G&A) (included in attends)				
	Admitted Patient Care (G&A)				
SUS	Elective Day case spells	16546	15087	-8.8%	As stated in previous reports day case activity has increased against previous years. When comparing activity year to date to the same period in 14/15 the variance is approx. +8%.
SUS	Elective Ordinary spells	2544	2712	6.6%	Actual increase against previous years activity in line with pan v actual.
SUS	Total Elective spells	19090	17799	-6.8%	See above.
SUS	Non-elective spells complete	13351	13719	2.8%	
SUS	Total completed spells	32441	31518	-2.8%	
	Attendances at A&E				
SUS	Type 1				
SUS	All types	31874	34130	7.1%	Actual activity for 2015/16 compared with the same period last year shows a variance slightly above the 3% threshold at 3.3%.

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

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

Key Issue	Risk Identified	Mitigating Actions
• The CCG is unlikely to deliver its planned surplus of £1.8m during this financial year. The best case scenario suggests a small surplus will be delivered.	• Non-delivery of NHS England business rules. Potential failure to deliver its statutory duty to break-even	• Ongoing review of QIPP schemes to assess deliverability and remove any barriers to achieving this. Clinical leadership meetings. Engagement with Wider group. Meetings scheduled with individual practices

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

- Committee recommended a review of AQP focussing upon quality of clinical pathways, working with other interested commissioners to introduce revised arrangements by April 2016
- The Committee noted other key opportunities to explore further reductions in expenditure
- The Committee recommended that a review of pregabalin prescribing be undertaken as part of whole CCG PLT session
- The Committee noted that the QIPP requirement is £8.2m worth of savings before the end of March 2017 and the requirement to deliver as much as possible in the remainder of this financial year to bring the CCG back into a surplus position.
- The Committee recommended that a December meeting was necessary and suggested that it took place in the scheduled development session to enable input from all GB members. This meeting will focus upon the Month 8 financial position and QIPP delivery plan only.

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Wednesday 20th January 2016	Chair: Roger Pontefract

Key Issue	Risk Identified	Mitigating Actions
• CCG financial position is critical for 2015/16. Expenditure must be reduced in Q4 as a matter of urgency.	• Potential failure to deliver statutory financial duty.	• Ongoing continued review of all expenditure to identify areas that offer reductions in spend.

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

- It was agreed that the Top 10 areas which have opportunity to deliver savings would be presented to the Committee next month.

- Midlands and Lancashire CSU remain on course to take over provision of services to CSU on 1st March. The Transaction and Mobilisation groups have reported that all risks are being managed.

- Adopted Pan Mersey APC recommendations:
  - Tolvaptan tablets for the treatment of Autosomal Dominant Polycystic Kidney Disease;
  - Omalizumab 150mg solution for injection (Xolair®) for previously treated spontaneous chronic urticaria by specialists only.

- 2014/15 QP figure confirmed/reported as £44k despite CCG representation regarding evidence around key indicators.
- 2015/16 QP performance:
  - Anti-microbial prescribing is performing well;
  - Will need to deliver 2015/16 opening financial plan to trigger a payment for 2015/16. It is highly unlikely that the CCG will deliver this position.

- BCF
  - 2015/16 – Dwayne Johnson will provide an updated paper to Governing Body next week.
  - 2016/17 – Revised Policy Framework recently published.
    - The payment for performance element (ie achievement of non-elective activity reductions) has been removed for 2016/17.
    - More focus upon:
      - local targets for delayed transfers of care;
      - NHS commissioned out of hospital services, which may include a wide range of services including social care.

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Meeting held on Wednesday 17th February 2016	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions
• Deteriorating financial position for CCG.	• Non-delivery of statutory targets.	• Further review of expenditure/delivery of QIPP.

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

- HR performance report received. Further emails required to remind all staff members to update their mandatory training/IG training numbers.
- HR policies recommended subject to GP approval as meeting not quorate.
- An update was received in respect of BCF and the Committee noted further discussions required with NHSE.
- Prescribing Rebate Scheme update to Committee March 2017.
- QIPP – top 10 areas totalling £5.1m – need clinical, executive and operational leads to take ownership. Monthly meeting to take place to monitor delivery.

NHS
Southport and Formby
Clinical Commissioning Group

Key Issues Report to Governing Body

Quality Committee Meeting held on 16th December 2015	Chair: Dr Rob Caudwell

Key Issue	Risk Identified	Mitigating Actions
Domiciliary Care Provider – CQC Action Letter issued to Domiciliary care Provider in operation across the CCG area	• Patient Safety • Commissioning arrangement re: DCP	• Contingency plan in place • Communication process in place at CCG and LA • Meeting to be held early January 2016 to review current commissioning arrangements within the CCG

Information Points for Southport & Formby CCG Governing Body (for noting)
Professional Registration Policy – Policy approved **Draft CCG Personal health Budget Policy & Practice –** received and approved **Quality Committee Vice Chair –** Member of the Committee identified subject to agreement by the individual

NHS
Southport and Formby
Clinical Commissioning Group

Key Issues Report to Governing Body

Quality Committee Meeting held on 20th January 2016	Chair: Dr Rob Caudwell

Key Issue	Risk Identified	Mitigating Actions
Safeguarding level of assurance at Southport & Ormskirk	• As highlighted previously to Governing Body	• As highlighted previously to Governing Body • Additional action – formal letter written for consideration at CCF to be sent to the Trust • Chair of CCF/Quality Committee has discussed lack of assurance with Chair of Trust's Quality & Safety Committee

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

1. Southport & Ormskirk Medical Director and Director of Nursing attended to provide an update to the Committee on Management of Quality Concerns' highlighted in CQC Chief Inspector of Hospitals Visit and RCOG Report re Maternity Services. Trust offered to come back to Quality Committee to give further updates on this or other issues.

2. NHSE presented the Cold Chain Audit Action Plan. Lack of assurance expressed by Quality Committee as no evidence of progress against timelines. Requested that the action plan be reviewed and re-submitted in February 2016.

3. Provider Quality Performance reports received for the purposes of assurance by the Committee.

4. Southport & Ormskirk 12 hour Paediatric Breach discussed with SRG. BD to check to see if NWAS have reported this as a risk with Spec-Comm.

Committee:	Meeting Date	Chair:
Healthy Liverpool Realigning Hospital Based Care Committees in Common (CIC)	2nd March 2016	Dr Nadim Fazlani

Key issues:	Risks Identified:	Mitigating Actions:
1 Need to understand the role of the Committee in Common for the North Mersey Local System Delivery Plan (part of the overarching Cheshire & Mersey Sustainability and Transformation Plan).	• Lack of clarity regarding decision making thereby hindering progress on changes.	• Separate Steering Group for the North Mersey Local System Delivery Plan to be established. • Committee in Common to remain in place to ensure statutory duties are met by each commissioning body.
2 Need for clear process for future service reconfigurations which works across all Statutory Bodies in line with NHS England Guidance.	• That different statutory bodies have different processes which are not recognised/understood, thereby hindering progress on changes.	• CCG/Local Authority communication and engagement leads to work together across Liverpool to ensure both national and local processes are adhered to.
3 Delivery of single receiving site for Major Trauma.	• That public engagement requirements have not been met thus delaying the service change.	• Refreshed public consultation to be undertaken.

Recommendations to NHS Liverpool CCG Governing Body:
• To note the above issues, risks and mitigating actions.

Key Issues Log

Committee: Liverpool City Region NHS CCG Alliance	**Meeting Date**: 2nd March 2016	**Chair:** Dr Andrew Pryce

Key issues:	**Risks Identified:**	**Mitigating Actions:**
1 Misalignment between draft Terms of Reference for the Alliance and new planning arrangements.	• Confusion with partners regarding decision making.	• Liverpool City Region NHS CCG Alliance prime role to be the voice of NHS Commissioners in the development of devolution of health responsibilities. • Terms of Reference to be amended to reflect this and agreed by each CCG Governing Body.
2 Planning footprints.	• That existing plans (eg Healthy Liverpool) are slowed down given requirement to work across Cheshire & Mersey.	• Clear financial and governance between Local System Delivery Plans confirmed.

Recommendations to NHS Liverpool CCG Governing Body:
• To note the key issues and risks.

NHS
Southport and Formby
Clinical Commissioning Group

NHS England

Key Issues
Joint Commissioning Committee

Meeting Date	**10 February 2016**
Chair	**Jan Leonard**

Key Issues	Risks Identified	Mitigating Actions
1. Trinity	• End of contract 31 March	• The group endorsed the decision to award the interim provider contract to Dr Maassarani & Partners and approved the procurement process going forward.

Recommendations to the Governing Body
1. To note.

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Audit Committee Meeting held on Wednesday, 7th October 2015	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions

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

- Review of CCG responsibilities with respect to potential frauds undertaken by members, following adoption of co-commissioning status with NHSE.
- Internal Audit plan on target. Significant assurance levels reported for safeguarding/outcome based commissioning reviews.
- HMRC investigation complete. CCG to make small payment in respect of NI employer's contributions to ensure compliance for 2013/14 and 2014/15.
- GBAF/CRR reviewed – agreed by Committee.
- Clarity required on Conflicts of Interest Policy to ensure that CCG up-to-date in terms of its responsibilities/reporting requirements.

Key Issues Report to Governing Body

NHS
Southport and Formby
Clinical Commissioning Group

Audit Committee Meeting held on Wednesday, 13th January 2016	Chair: Helen Nichols

Key Issue	Risk Identified	Mitigating Actions

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

- Note requirement to convene panel to reappoint External Audit providers with effect from 1st April 2017. Decision required by December 2016.
- Internal Audit report – further understanding of CCG rate of return measure included in QIPP business case reviews.
- LCFS report – paper received; no issues to report.
- External Audit report:
  - Summary of financial /Value for Money areas of focus for 2015/16.
  - New Value for Money Approach (focus on co-commissioning/QIPP).
  - NHS briefing – appointing your external auditor (see point above).
- Report on Macpherson review – estimation techniques applied in key areas:
  - Continuing Care/FNC
  - Prescribing
- IG Toolkit review; delegated authority given to MMcD/HN in order to meet submission deadline of 31st March 2016.
- Annual Audit – proposed sign-off meeting on the morning of Wednesday 25th May
  - Invite all Governing Body members to attend.

NHS
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Key Issues
North

Meeting Date	**17th March 2016**
Chair	**Dr R Caudwell covering for Dr I Scott**

Key Issues	Risks Identified	Mitigating Actions
1. Frail Elderly scheme within Local Quality Contract	• High conversion rates to assessment and achievability of Scheme	• Threshold based models being worked up

Information Points for Governing Body to Note:
North Locality has discussed practice boundaries and location of residential and nursing homes across the Locality as a starting point to plan for the future.

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Key Issues
Ainsdale and Birkdale

Meeting Date	**10th March 2016**
Chair	**Dr K Naidoo**

Key Issues	Risks Identified	Mitigating Actions
1. Process for collection of histopathology specimens from practices	• Samples are not signed for upon collection and could not be effectively tracked or responsibility assigned in the event of missing specimens.	• To be raised at contracts meetings with Southport and Ormskirk Hospital NHST

Information Points for Governing Body to Note:
The Governing Body is asked to note the work done by Ainsdale and Birkdale Locality in relation to case finding for Atrial Fibrillation patients and appropriate anti-coagulation prescribing. Early results in relation to the impact on the incidence of stroke look very positive. It is intended to present this work at a future Wider Constituent Forum. Ainsdale and Birkdale Locality has discussed practice boundaries and location of residential and nursing homes across the Locality as a starting point to plan for the future.

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Southport and Formby
Clinical Commissioning Group

Key Issues
Central locality

Meeting Date	**22 March 2016**
Chair	**Dr Tim Irvine**

Key Issues	Risks Identified	Mitigating Actions
1. Safeguarding	• The Locality group discussed concerns around process for referrals and acknowledgements.	• This has been fed back to Dr Wendy Hewitt who is reporting these concerns to the MASH team.

Information Points for Governing Body to Note:

NHS
Southport and Formby
Clinical Commissioning Group

Key Issues
Formby locality

Meeting Date	**10 March 2016**
Chair	**Dr Chris Bolton**

Key Issues	Risks Identified	Mitigating Actions
1. Pathology Labs	• Delay in results/ patient safety	• Dr Callow is following both of these issues up through the Quality Committee.
2. Discharge letters	• Delay in results / Patient safety.	

Information Points for Governing Body to Note:

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Minutes

Wednesday 18th November 2015, 9.30am to 11.30am

Family Life Centre, Southport

Attendees		
Helen Nichols	Lay Member (Chair)	HN
Roger Pontefract	Lay Member	RP
Dr Martin Evans	GP Governing Body Member	ME
Colette Riley	Practice Manager	CR
Martin McDowell	Chief Finance Officer	MMcD
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Debbie Fagan	Chief Nurse & Quality Officer	DF
Susanne Lynch	CCG Lead for Medicines Management	SL
David Smith	Deputy Chief Finance Officer	DS
James Bradley	Head of Strategic Finance Planning	JB
Adam Burgess	HR Business Partner	AB
Dr Hilal Mulla	GP Governing Body Member	HM
Ex-officio Member*		
Fiona Taylor	Chief Officer	FLT
Apologies		
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Karl McCluskey	Chief Strategy & Outcomes Officer	KMcC
Minutes		
Vicky Taylor	Quality Team Business Support Officer	VT

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	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	
Dr Hilal Mulla	GP Governing Body Member	A	A	✓	A	✓	A	✓	A	A	✓	
Roger Pontefract	Lay Member	✓	A	✓	A	✓	A	✓	A	✓	✓	
Colette Riley	Practice Manager	✓	✓	✓	A	✓	✓	✓	✓	✓	N	
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	✓	A	✓	✓	✓	✓	✓	✓	
Jan Leonard	Chief Redesign & Commissioning Officer	✓	✓	A	A	A	✓	✓	✓	✓	✓	
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A	A	A	A	A	A	✓	A	A	A	
Fiona Taylor	Chief Officer	*	*	*	*	*	*	*	*	*	*	
David Smith	Deputy Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
James Bradley	Head of Strategic Finance Planning	✓	✓	✓	A	N	✓	✓	✓	✓	✓	
Susanne Lynch	CCG Lead for Medicines Management	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	
Malcolm Cunningham	Head of Primary Care & Contracting	A	✓	✓	✓	A	A	✓	A	A	N	

No	Item	Action
FR15/130	**Apologies for absence** Apologies for absence were received from Fiona Taylor, Karl McCluskey and Tracy Jeffes.	
FR15/131	**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.	
FR15/132	**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.	
FR15/133	**Action points from the previous meeting** ***NW Frame-work*** – Committee noted original timescale of 1st November had slipped. Revised launch date of Framework to be requested. DF believes announcement imminent. ***Mersey Care/LMC Shared Care Review:*** SL reported that meeting was positive. LMC highlighted issues relating to discharge of patients on dangerous medications and further work is required to receive assurance around public safety. HM noted that additional resources will be required to enable Primary Care to take on this work and is linked into existing work being undertaken around re-design of mental health services. He noted that this could lead to more efficient use of resources. SL explained the differences between the three amber categories for drugs. MMcD advised that several Trusts were reviewing amber drugs, with a view to increasing shared care arrangements in Primary Care.	
FR15/134	**Month 7 Finance Report** JB noted that management action is required to deliver a best case scenario of £0.1million. Pressures during the month include: • Increased A&E activity in S&O. The Committee discussed the performance of the 111 service in relation to this issue. • Back-dated invoices relating to MH OATS patients. The pathway relating to these invoices is being reviewed to understand why the CCG's main provider did not provide care. **Action -** JL to request details regarding 'discharge/onward direction' of NHS calls. HL noted the 25% increase in Audiology AQP services. JL reported that this is likely to be due to previous patients returning for a three-yearly follow-up. The Committee held a general discussion in respect of AQP principles, noting that cost had increased by c. £1m since its introduction. **Action –** JL/MMcD will speak with other local commissioners (LCCG/WCCG) to determine a potential joint approach. MMcD asked for revised commissioning arrangements to be in place by April 2016. MMcD noted that management actions required strengthening to deliver the current best case scenario position. In respect to specific questions, MMcD noted that given the age of debt relating to 'Breast Care Services', he would write to S&O advising of CCG concerns.	JL JL/MMcD

No	Item	Action
	The Committee had a long discussion in respect of prescribing waste. MMcD reported that the CCG had asked the LMC to support the principles in the 'Waste Campaign' in their discussions with the LPC. The discussion also covered the 'Care at the Chemist' scheme operated by the CCG. MMcD noted that the CCG should not be prescribing low-cost medicines (e.g. paracetamol, ibuprofen) unless in line with NICE guidance. A review of the CATC scheme was agreed to narrow the scope of provision. **Southport & Ormskirk Trust** MMcD reported that he had been involved in a facilitated meeting since the finance report was published. The CCG reverted to its pre-arbitration (August) offer to the Trust of £1.0m for non-PbR services. This has led to an additional pressure of £250k to the CCG. After discussion, HN noted that the scenario modelling undertaken by the CCG should be clearly explained to NHS England when the CCG submits to the Month 7 Financial Report. HN outlined that in particular, it should be made clear that the current forecast represents the best case not most likely scenario. MMcD noted that GP governing body members have been assigned to 18 of the CCG practices to help support review of clinical activity and to offer different perspectives upon referral management and prescribing within each practice. Further targeted work is being undertaken with practices to review clinical coding and tariff payment. Three practices are initially involved in this work which will determine whether systematic issue exist which will be reported back to the Trust.	
	Action taken by the Committee: **The Committee received the report**	
FR15/135	**Prescribing Performance Report** SL reported an overspend of £0.096m declared at month 5 (August 2015) SL highlighted the significant increase in Pregabalin expenditure as a main cause. After a discussion, the Committee recommended that the CCG undertakes a review of pain relief prescribing practice. HM noted that some of the issues came from prescribing being instigated in secondary care. As recommended at Finance & Resource Committee, SL to suggest to PLT that a Pain Management session is undertaken to address some of the prescribing issues. SL expressed concerns regarding capacity within the medicines management team noting that demand for the team's services continues to rise. She highlighted that it was difficult to recruit appropriately skilled staff. She confirmed that support to practices was linked to relative risks and engagement from practices to ensure that the work undertaken will deliver positive results. SL informed the committee that she will be speaking to Business Services Authority in relation to our Waste Campaign later this week following their interest. HN asked how likely the CCG was to achieve the Waste Target given the prescribing issues. SL believed the position would improve.	
	Action taken by the Committee: **The Committee noted the contents of the report**	

No	Item	Action
FR15/136	**External Updates / Benchmarking and VFM reports** DS noted that no reports were required this month	
FR15/137	QIPP Update MMcD reported that the QIPP Committee met last week. A review of low value clinical procedures is being undertaken with all clinical governing body members involved. MMcD re-affirmed that the CCG needs to deliver £8.2m worth of QIPP savings by March 2017 to deliver a continued break-even position. He further stressed the need that it was vital to deliver these savings as early as possible in order to support delivery of the CCG's target position for 2015/16.	
	Action taken by the Committee: **The Committee noted the verbal update**	
FR15/138	**Individual Exception Funding Request Quarterly Report** JL presented the report to the committee outlining the key issues.	
	Action taken by the Committee: **The Committee noted the contents of the report**	
FR15/139	**Better Care Fund** The CCG is in process of returning Quarter 2 (to end September). Current projections suggested that reduction in NEL activity relating to the pay for performance element of the BCF is unlikely to be met. Further discussions are taking place with the Council regarding this issue.	
	Action taken by the Committee **The Committee noted the verbal report**	
FR15/140	**Any Other Business** **HR Recruitment and Selection Policy** HN reported receipt of the above policy which was forwarded to the Committee yesterday. TJ had advised that the policy was in effect but had never been formally accepted. The Committee agreed to adopt the policy.	
	Action taken by the Committee **The Committee approved the policy**	
FR15/141	**Key Issues review** MMcD summarised the key issues of this meeting, and these will be presented to the Governing Body.	
FR15/142	**December Meeting** MMcD noted that the Committee is not scheduled to meet in December and suggested that an extra meeting was necessary given the CCG's financial position. He agreed to ask TJ if this could be accommodated within the scheduled GB development session. The two items for discussion would be monthly finance report and QIPP update.	
	Date of next meeting Wednesday 20th January 2016 9.30am to 11.30am Family Life Centre, Southport	

NHS
Southport and Formby
Clinical Commissioning Group

Finance and Resource Committee Minutes

Wednesday 20th January 2016, 9.30am to 11.30am

Family Life Centre, Southport

Attendees		
Roger Pontefract	Lay Member (Deputy Chair)	RP
Dr Martin Evans	GP Governing Body Member	ME
Dr Hilal Mulla	GP Governing Body Member	HM
Martin McDowell	Chief Finance Officer	MMcD
Jan Leonard	Chief Redesign & Commissioning Officer	JL
Debbie Fagan	Chief Nurse & Quality Officer	DF
Susanne Lynch	CCG Lead for Medicines Management	SL
David Smith	Deputy Chief Finance Officer	DS
James Bradley	Head of Strategic Finance Planning	JB
Rebecca McCullough	Head of Financial Management and Planning	RMcC
Ex-officio Member*		
Fiona Taylor	Chief Officer	FLT
Apologies		
Helen Nichols	Lay Member (Chair)	HN
Colette Riley	Practice Manager	CR
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
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	Jan 16	Feb 16	Mar 16	May 16	June 16	July 16	Sept 16	Oct 16	Nov 16	Jan 17
Helen Nichols	Lay Member (Chair)	A									
Dr Martin Evans	GP Governing Body Member	✓									
Dr Hilal Mulla	GP Governing Body Member	✓									
Roger Pontefract	Lay Member	✓									
Colette Riley	Practice Manager	A									
Martin McDowell	Chief Finance Officer	✓									
Debbie Fagan	Chief Nurse & Quality Officer	✓									
Jan Leonard	Chief Redesign & Commissioning Officer	✓									
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	A									
Fiona Taylor	Chief Officer	*									
David Smith	Deputy Chief Finance Officer	✓									
James Bradley	Head of Strategic Finance Planning	✓									
Susanne Lynch	CCG Lead for Medicines Management	✓									
Malcolm Cunningham	Head of Primary Care & Contracting	A									

No	Item	Action
FR16/01	**Apologies for Absence** Apologies for absence were received from Helen Nichols, Fiona Taylor, Colette Riley, Tracy Jeffes and Malcolm Cunningham.	
FR16/02	**Declarations of interest regarding agenda items** CCG officers holding dual roles in both Southport and Formby and South Sefton CCGs declared their potential conflicts of interest.	
FR16/03	**Minutes of the previous meeting and key issues** The minutes of the previous meeting were approved as a true and accurate record and signed-off by the Chair. The key issues log was approved as an accurate reflection of the main issues from the previous meeting.	
FR16/04	**Action points from the previous meeting** **FR15/134 Month 7 Finance Report:** • *JL to request details regarding "discharge/onward direction" of NHS calls* – JL obtained a monthly report from 111 which showed the following figures: 53.6% advised to contact primary and community care, 11.4% advised to attend A&E, 19.4% closed with advice only and 15.6% transferred to ambulance service. The Committee noted the figures were broadly in line with other CCGs with no apparent increase in trend. Terry Hill will continue to monitor the situation and the Committee is to receive a report every six months. • *JL/MMcD to speak with other local commissioners (LCCG/WCCCG) to determine potential joint approach* - MMcD/JL highlighted AQP as an issue, and although the need to put some delay in the system was agreed, eg relating to hearing loss, this was acknowledged as being difficult to measure. MMcD/JL to review AQP position before start of April 2016 and JB to look at audiology block.	MMcD/JL JB
FR16/05	**Month 9 Finance Report** JB presented this paper which provided an overview of the financial position for the CCG as at 31 December 2015, and informed the Committee that both Prescribing and CHC forecasts showed an improvement for this month. MMcD asked the Committee to note that with regard to penalty issues following guidelines from TDA England, he will be writing to NHSE to explain that the CCG had included forecast Q4 penalties within its Month 9 return. RP emphasised the importance and urgency of taking strong action to ensure the CCG delivered on its ideas, and it was agreed to put together a top 10 list of key saving areas. JB/DS are to work with Fiona Doherty to produce this list and will bring to the next meeting. The Committee noted a typing error in *Section 9. Recommendations (second bullet point)* – figure of £4.343m should read £3.643m. **Action by the Committee** The Committee received this report by way of assurance and approved the recommendations therein.	JB/DS/FD

No	Item	Action
FR16/06	**Financial Strategy Update** MMcD gave a verbal update informing the Committee that the CCG had received its 3 year allocations. The CCG uplift for 2016/17 is 3.05% compared with an average increase of 3.5% for CCGs. He noted that this uplift would have to fund extra pressures in areas including mental health investment, NHS pension reforms and other areas where funding responsibilities have transferred to the CCG (eg GP IT funding). MMcD is to present a report at the next meeting which will also go to the next Governing Body Development Session. **Action by the Committee** The Committee noted this update	
FR16/07	**Prescribing Performance Report** SL presented the following reports to the Committee: (a) Quarter 2 Report (b) Month 7 Report (c) APC Recommendations November 2015 (d) APC Recommendations December 2015 **Action by the Committee** The Committee noted these reports and approved the APC recommendations therein, noting that MMcD has already approved the use of Omalizumab utilising his delegated authority.	
FR16/08	**NWCSU Performance Report** MMcD gave a verbal update regarding closure of the CSU and informed the Committee that everything was on track. However the closedown of the unit itself is likely to run beyond the transfer date, as it will be necessary to ensure all residual issues are addressed and any legacy issues transferred back to NHSE. **Action by the Committee** The Committee noted this update.	
FR16/09	**Sefton Property Estate Partnership Group (SPEP)** MMcD informed the Committee that the initial draft strategy was submitted in November, and it was now necessary to flesh this out. The next SPEP meeting is on 3rd February and further discussions will take place around this. He also raised the possibility of a workshop, and potentially working towards a number of hubs that serve the population and take control of delivery services around the hospital. MMcD is to bring a timeline for the coming year to the March meeting for discussion, and this will be added to the agenda accordingly. **Action by the Committee** The Committee noted this update.	MMcD
FR16/10	**External Updates/Benchmarking and VFM Reports** No update was given at this meeting.	
FR16/11	**CCG Assurance** MMcD informed the Committee that clarity over the Q2 assurance meeting dates is still required. Regarding the framework, he advised that a dashboard/ league table type approach has been suggested. MMcD is to bring a paper back to the March meeting with plans for this framework. **Action by the Committee** The Committee noted this update.	MMcD
FR16/12	**QIPP Update** No further update was given.	

No	Item	Action
FR16/13	**Quality Premium Dashboard** JL presented this report to the Committee who noted that although the CCG is unlikely to receive an additional payment in 2015/16, the importance of quality must be maintained. **Action by the Committee** The Committee received this report by way of assurance.	
FR16/14	**Better Care Fund Update** MMcD gave a verbal update and advised the Committee that discussions were ongoing with Sefton Council regarding BCF contributions for 2015/16. A separate paper will be presented to the Governing Body (Part 2) outlining the position and recommendations. Dwayne Johnson, Sefton Council, is to take a paper to the next Governing Body Part 2 meeting for review and discussion regarding an additional payment to the BCF. **Action by the Committee** The Committee noted this update and recognised the importance of maintaining good relationships with Sefton Council.	
FR16/15	**Committee Work Schedule 2016/17** The Committee noted this schedule and agreed the content therein.	
FR16/16	**Committee Meeting Dates 2016/17** The Committee agreed these meeting dates, and noted that dates for February and March 2017 will be scheduled and added to this list in order to complete the 2016/17 financial year.	RM
FR16/17	**Any Other Business** No further business was discussed.	
FR16/18	**Key Issues Review** MMcD highlighted the key issues from the meeting and these will be presented as a Key Issues Report to Governing Body.	
	Date of Next Meeting Wednesday 17th February 2016 9.30am to 11.30am Family Life Centre, Southport	

Chair: _____ Date: _____

NHS
Southport and Formby
Clinical Commissioning Group

Quality Committee Minutes

Date: **Wednesday 16th December 2015, 11.30 am – 12.30 pm**
Venue: **Studio 3, Lakeside Christian Centre, Fairway, Southport, Merseyside, PR9 0LA**

Membership		
Dr Rob Caudwell	Chair & GP Governing Body Member	RC
Paul Ashby	Practice Manager, Ainsdale Medical Centre	PA
Dr Doug Callow	GP Quality Lead S&F	DC
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Billie Dodd	Head of CCG Development	BD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
Helen Nichols	Lay Member	HN
Ex Officio Member		
Fiona Taylor	Chief Officer	FT
In Attendance		
James Hester	Programme Manager Quality & Safety	JH
Brendan Prescott	Deputy Chief Nurse / Head of Quality	HR
Helen Roberts	Senior Pharmacist	BP
Apologies		
Billie Dodd	Head of CCG Development	BD
Fiona Taylor	Chief Officer	FT
Minutes		
Vicky Taylor	Quality Team Business Support Officer	VT

Membership Attendance Tracker

Name	Membership	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 Rob Caudwell	GP Governing Body Member (Chair as of Jun 2014)	√	√			√	√	A	L	√			
Paul Ashby	Practice Manager, Ainsdale Medical Centre	A	√			√	√	√	√	A			
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	√	A			√	√	√	√	√			
Malcolm Cunningham	CCG Head of Primary Care & Contracting	A	A			A	A	A	A	√			
Billie Dodd	Head of CCG Development	A	√			√	√	L	A	√			
Debbie Fagan	Chief Nurse & Quality Officer	√	√			L	√	√	√	√			
Martin McDowell	Chief Finance Officer	√	√			√	√	√	√	√			
Helen Nichols	Governing Body and Lay Member	√	√			A	L	√	√	√			
Roger Pontefract	Lay Member					A	A	√	A	√			

✓ Present
A Apologies
L Late or left early

No.	Item	Action
15/141	**Apologies for Absence** Apologies for absence were received from PA.	
15/142	**Declarations of interest regarding Agenda items** CCG Officers holding dual roles in both Southport & Formby and South Sefton CCGs declared their potential conflict of interest.	
15/143	**Minutes of the previous meeting and Key Issues Log** The minutes of the previous meeting were agreed as an accurate reflection subject to DC's request to amend 15/136 to read 'DC highlighted an issue that had arisen within S&O regarding the 2 week wait referral / fax numbers in operation for urology depending upon haematuria / non-haematuria presentation and – if incorrect fax number used then the Trust were returning referrals back to GPs. Dc stated that this had been raised with the Trust and the issue was now reportedly resolved.	
15/144	**Matters Arising / Action Tracker** **15/088 EPEG Annual Report 2014/15 and development of the group** – The Committee noted that no response had been received and that the matter had now become protracted. JH to follow up with JHer. **Action: The Committee agreed to extend for a further month.** **15/109 Apologies for Absence (Appointment of Vice Chair)** - This action is on the agenda for completion. **Action: Action completed – remove from the tracker.** **15/128 Minutes of the previous meeting and Key Issues Log** - Correct version of Key Issues log emailed to all members on 18th November 2015 by VT. **Action: Action completed – remove from the tracker.** **15/129 (Originates from 15/082)** - **S&O Maternity Services Presentation** – DF sent an initial email to the Trust inviting them to attend the Committee to present on Maternity Services at Southport & Ormskirk Hospital Trust on 18th November 2015, followed up by a letter of confirmation on 8th December 2015. **Action: Action completed – remove from the tracker.** **15/130(i) S&O Safeguarding Performance (Contract Query)** – RC has not had the opportunity to meet with the Chair of S&O Quality & Safety Committee and requested the action be extended for one month. **Action: The Committee agreed to extend for a further month.** **15/130(ii) S&O Safeguarding Performance (Contract Query) –** DF confirmed that this action had now been completed with the S&O safeguarding information for Q2 to be given priority for review by the CCG Safeguarding service. **Action: Action completed – remove from the tracker.** **15/131 CCG Safeguarding Policy** – The Governing Body approved and ratified the changes to this policy at their meeting held on 25th November 2015. **Action: Action completed – remove from the tracker.** **15/133 Professional Registration Policy** - The policy is on today's agenda for approval by the S&F Quality Committee. **Action: Action completed – remove from the tracker.** **15/135(i) Serious Incident Reports / RCAs** – Due to the cancellation of the S&O CCF meeting, this action was extended for one month to enable a response to be obtained.	

	Action: The Committee agreed to extend for a further month. **15/140 Details of Change of Time and Venue for Next Meeting** – Details of the revised timing and venue for the December meeting of the S&F Quality Committee were sent out on 20th November 2015. **Action: Action completed – remove from the tracker.** **15/134(ii) Provider Quality Report –** DF confirmed that this action had now been completed. **Action: Action completed – remove from the tracker.**	
15/145	**Section 11 Compliance Outcomes (Safeguarding)** BP presented this paper to the Quality Committee which provided the current position against the Section 11 Audit Standards. An action plan has been developed to support the progression against standards where full compliance has not been evidenced. BP confirmed that the Audit had been carried out by Karen Garside of the CCGs Safeguarding Team, with recommended changes to the HR Induction process to ensure new starters are directed to appropriate policies and have undergone appropriate training from the outset of their employment. The Safeguarding Team is to inform what such training will comprise in liaison with Adam Burgess. Whilst recognising that policies and training would be made available to staff, RC sought assurance that the CCG took steps to ensure staff were complying. DF requested that an update be presented to the Quality Committee by the CCG Safeguarding Service at the next internal meeting. **Action: DF to ask the CCG Safeguarding Service to provide an update on the action plan at the next internal meeting.**	**DF**
	The Committee received the report and action plan	
15/146	**Chief Nurse Report** All relevant issues conveyed within the verbal update were reported to the Governing Body including: DF advised the Committee of a recent communication from the CQC which highlighted concerns about a domiciliary care agency providing care across the Sefton area and the steps taken by the CCG as part of the local required response. The Committee noted the constraints on the CCG due to the tight timescale given by the CQC and noted the positive response and management by the CCG and CSU teams. DF confirmed that the CCG had liaised with Southport & Ormskirk Hospital Trust and Liverpool Community Health Trust to reinforce the need for their staff to undertake any outstanding CQC reviews on patients. It was recognised that there is a need for the work on contracts with domiciliary care agencies to be expedited in order to improve the performance management of such providers. BP to progress this issue with a further whilst DF is on annual leave with an update to be provided in January 2016. **Action: BP to progress this issue with a further whilst DF is on annual leave with an update to be provided in January 2016.**	**BP**

	The committee received the report	
15/147	**Draft Personal Health Budget** BP presented this paper on behalf of Tracey Forshaw, Programme Manager – Vulnerable People, explaining that S&F CCG is legally required to have policies and procedures in place to support the expansion of the implementation of Personal Health Budgets from April 2016. The Committee were asked to receive and approve the draft policy whilst noting that further work is due to be carried out before it is submitted for final approval. BP asked the Committee to recognise that although the policy has been presented through the Quality Committee, successful PHB delivery will also require the involvement of the Finance and Contracts Teams. BP recommended this support be formalised. It is expected that implementation of PHBs should effectively prove cost neutral for the CCG with the new Provider for management of the Continuing Health Care contract to provide administrative support for this service and management of applications. BP confirmed that the CCG are meeting their mandate to ensure the policy can be put in place for April 2016. **Action: Date in policy to be amended to April 2016.**	**TF**
	The Committee received and approved the draft policy	
15/148	**Professional Registration Policy** The Committee approved the policy following discussions held at the October 2015 meeting.	
	The Committee approved the policy	
15/149	**Appointment of Vice Chair for the Committee** The Committee identified and approved the appointment of a Committee member as Vice Chair for the Southport & Formby Quality Committee subject to their acceptance.	
	The Committee approved the appointment of a Committee member as Vice Chair	
15/150	**Key Issues Log** The following were highlighted to be included in the key issues log from the Committee to the Governing Body: • Domiciliary Care provider and CQC actions • Approval of Professional Registration policy • Approval of Draft PHB policy • Approval of Vice Chair subject to the individual's acceptance	
15/151	**Any Other Business** 1. DF advised the Committee of a Never Event at Southport & Ormskirk Hospital Trust. Preliminary investigations have taken place with a follow up meeting to take place the week commencing 21st December. Assurances have been received from the Trust that steps have been taken to address the issues leading to the event. The patient concerned has now been discharged. **Action: Checks undertaken when recruiting overseas nurses to ensure patient safety to be discussed at S&F Clinical Quality Performance Group.** 2. DF stated that a previous Serious Incident that had been reported raised an issue regarding the regular monitoring of vital signs (this Serious Incident was part of the contract query). With regard to the Never event discussed in	**DF**

	15/152(1) there may also be an issue with regarding to the monitoring of vital signs. JH advised that a new practice had been put in place to address. DF asked if the Quality Team could review the previous Trust action plan with initial information coming from the never event meetings that were taking place. **Action: JH and Quality Team to review action plan from Serious Incident**	**JH**
15/152	**Date of Next Meeting** Wednesday 20th January 2016, 11.30 am – 13.30 pm at The Family Life Centre, Ash Street, Southport	

Chair : _____ _____

PRINT NAME **SIGNATURE**

Date : _____

NHS
Southport and Formby
Clinical Commissioning Group

Quality Committee - External Minutes

Date: **Wednesday 20th January 2016, 11.30 am – 1.30 pm**
Venue: **Family Life Centre, Ash Street, Southport**

Membership		
Dr Rob Caudwell	Chair & GP Governing Body Member	RC
Paul Ashby	Practice Manager, Ainsdale Medical Centre	PA
Dr Doug Callow ***until 1.10 pm**	GP Quality Lead S&F	DC
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Billie Dodd ***from 11.49 am**	Head of CCG Development	BD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
Helen Nichols	Lay Member	HN
Ex Officio Member		
Fiona Taylor	Chief Officer	FT
In attendance		
Dr John Caine ***until 12.05 pm**	Chair, West Lancashire CCG	Dr JC
Julie Cummins	Clinical Quality & Performance Co-ordinator	JC
Simon Featherstone	Director of Nursing & Quality, Southport & Ormskirk Hospital NHS Trust	SF
Dr Rob Gillies	Executive Medical Director, Southport & Ormskirk Hospital NHS Trust	RG
James Hester	Programme Manager – Quality	JH
Pauline Jones	NHSE	PJ
Roger Pontefract	Lay Member	RP
Helen Roberts	Senior Pharmacist	HR
Jo Simpson	Quality & Performance Manager	JS
Helen Smith	Head of Safeguarding Adults	HS
Wendy Storey	Screening & Immunisation Co-ordinator Merseyside for Public Health England (PHE)	WS
Apologies		
Helen Nichols	Lay Member	HN
Minutes		
Vicky Taylor	Quality Team Business Support Officer	VT

Membership Attendance Tracker

Name	Membership	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 Rob Caudwell	GP Governing Body Member (Chair as of Jun 2014)	√	√			√	√	A	L	√	√		
Paul Ashby	Practice Manager, Ainsdale Medical Centre	A	√			√	√	√	√	A	√		
Dr Doug Callow	GP Governing Body Member /Clinical Quality Lead	√	A			√	√	√	√	√	√		
Malcolm Cunningham	CCG Head of Primary Care & Contracting	A	A			A	A	A	A	√	A		
Billie Dodd	Head of CCG Development	A	√			√	√	L	A	√	√		
Debbie Fagan	Chief Nurse & Quality Officer	√	√			L	√	√	√	√	√		
Martin McDowell	Chief Finance Officer	√	√			√	√	√	√	√	√		
Helen Nichols	Governing Body and Lay Member	√	√			A	L	√	√	√	A		
Roger Pontefract	Lay Member					A	A	√	A	√	√		

✓ Present
A Apologies
L Late or left early

No.	Item	Action
16/001	**Apologies for Absence** Apologies for absence were received from HM, MC and FT. DC had notified the Committee prior to the meeting that he was required to leave at 1 p.m.	
16/002	**Declarations of interest regarding Agenda items** CCG Officers holding dual roles in both Southport & Formby and South Sefton CCGs declared their potential conflict of interest.	
16/003	**Minutes of the previous meeting and Key Issues Log** The minutes of the previous meeting were agreed as an accurate reflection.	
16/004	**Matters Arising / Action Tracker** **15/088 EPEG Annual Report 2014/15 and development of the group** - JH confirmed discussions had now taken place involving the Local Authority and CCG on the issue of encouraging patients to take responsibility for their health. **Action: Action completed – remove from the tracker** **15/098 Audit of Cold Chain Management in GP Practices** - Report included on today's agenda. **Action: Action completed – remove from the tracker** **15/130(i) S&O Safeguarding Performance (Contract Query)** – RC will provide an update to the Committee under agenda item 16/005. **Action: Action completed – remove from the tracker** **15/134(i) Provider Quality Report** – Draft reports are now being developed by the BI Team to improve reporting and will be shared with Committee members when they become available. New style reports should be in place by April / May 2016 for 16/17 reporting and will be more in line with Governing Body Report. **Action: Action completed – remove from the tracker** **15/134(iii) Provider Quality Report** – JS provided the Committee with the following responses and confirmed this action could now be closed. *Psychotherapy* Waiting times were raised at the Mersey Care CQPG on 11/12/2015. Dr Andrew Sedgewick, Local Division Medical Director will be presenting a paper on psychotherapy waiting times at February CQPG which will also outline a proposed business case to be considered by commissioners. *Eating Disorders* The Trust has not formally identified Eating Disorders as an underfunded service, but it is acknowledged that the service is experiencing high levels of demand. **Action: Action completed – remove from the tracker** **15/135(i) Serious Incident Reports / RCAs** – As the meeting of the S&O Collaborative Commissioning Forum (CCF) has not yet taken place, the Committee agreed to extend the action to March 2016. **Action: Action extended until Committee meet in March 2016.** **15/135(ii) Serious Incident Reports / RCAs** – DF advised that this issue would be discussed at CCF next week. A formal letter has been drafted to send to the Trust regarding certain Serious Incidents on Pressure Ulcers. JH raised issue of representation of West Lancs CCG at Serious Incident Review meetings.	**JH**

	Action: Action completed – remove from the tracker **15/146 Chief Nurse Report (Domiciliary Care Providers)** – DF confirmed an internal meeting has been held to discuss the governance arrangements and put a mechanism in place around performance management. A report is to be taken to Leadership Team next week. **Action: Action completed – remove from the tracker** **15/147 Draft Personal Health Budget** – DF confirmed the date in the policy had been amended. **Action: Action completed – remove from the tracker** **15/151(i) Any Other Business (Never Event)** – This item has been added to the agenda of the Contracts meeting due to be held at the beginning of February 2016. **Action: Action completed – remove from the tracker**	
16/005	**CCG Safeguarding Service Quarterly Report** HS presented the report and the assurance level of providers was discussed. • S&O – The Committee noted the Trust remained on 'limited assurance' in relation to both adults and children. HS advised that a lack of assurance had been provided against the training standards for adults evidenced by a downward trajectory evident in relation to MCA/ DoLS training together with a lack of provision of Level 3 training and limited assurance against the progress and scrutiny of Level 2 training. The Committee also noted that there were no apparent plans in place or trajectory submitted as to how safeguarding children training will be achieved in spite of being requested previously. • LCH – The Trust remains on 'reasonable assurance' overall and with confirmation of safeguarding adults training at level 3 awaited this standard remains as red. 'Reasonable assurance' has also been provided for safeguarding children, however a lack of support on early assessments was noted. • Alder Hey Children's NHS Foundation Trust – 'Limited assurance' in relation to safeguarding adults is currently provided by the Trust with a number of meetings planned involving LCCG to review the action plan. Concerns around limited assurance of training at level 2. Big training initiative in place this week when improvements should be seen. • Liverpool Women's NHS Foundation Trust – The Trust remains on 'reasonable assurance' with no significant improvement seen in Q2. • Merseycare - The Trust has provided reasonable assurance in relation to both safeguarding adults and safeguarding children. Gaps in data submission and the decrease in safeguarding training for adults is responsible for the rating of 'reasonable assurance' applied this quarter. • Aintree University Hospital - Reasonable assurance has been provided with the Committee noting that there has been no movement in training figures since Q1.	

	Child Sexual Exploitation Update HS asked that any questions on the appendix with the report which provided an update on Child Sexual Exploitation are forwarded to Karen Garside, Designated Nurse Safeguarding Children, who was unable to attend the meeting. ***Safeguarding Service Update*** The Committee were advised of the recent successful recruitment within the Safeguarding Service of two secondments, with the staff expected to be in post towards the end of January. The Committee noted the updates with regards to Domestic Homicide Reviews and Care Homes The Committee noted that there had been an open contract query AT Southport & Ormskirk Hospital Trust on safeguarding since 4th March 2015. Approval was awaited regarding a draft letter signed by the Chief Officers of Southport & Formby and West Lancashire CCGs for sharing with the CCF next week which was due to be sent to Trust. RC was aware of the imminent appointment at the Trust which may start to address some of the safeguarding issues.	
	The Committee noted and received the report	
16/006	**CSU Care Home Q2 Quality Report** JC presented the report which highlighted performance and quality monitoring information for Nursing Homes in SFCCG. JC confirmed that a clinical quality assessment would be carried out on a new care home opening in the Southport area. The Committee discussed the responsibilities of the Local Authority and the CCG and processes used to monitor quality standards within care homes together with a move towards considering the feasibility of the expectation of joint assessments taking place with the LA as part of the CSU team role.	
	The Committee received the report.	
16/007	**Maternity Services presentation** The Committee received a presentation from Mr Rob Gillies, Executive Medical Director and Simon Featherstone, Director of Nursing & Quality Southport & Ormskirk Hospital NHS Trust. The Committee learned that following the undertaking of a staffing review, midwifery staff numbers were now compliant and in line with NICE guidelines and Birthrate Plus. Whilst the skill-mix of staff is being considered, a temporary Band 7 has been appointed to provide additional support to junior midwives together with an element of over recruitment to mitigate absence of midwifery staff due to sickness and maternity leave. The Trust confirmed that the recommendations from the CQC Report and the RCOG review had largely been addressed. Further actions undertaken at the Trust include: • Dedicated scrub nurses recruited to cover scrub procedures previously undertaken by Midwives until a longer term solution is identified, taking into account issues presented due to theatres located on different sites • Structures for maternity theatres are now in place	

	• CQC issues around peri natal/post-partum haemorrhages concerns have been addressed • Concept of supportive measures drawn up to deal with maternity service issues • High risk pregnant ladies are offered the opportunity to transfer to other units (5 ladies out of annual workload of 2,700 patients involved to date); however, no patients wished to be transferred • Recruitment to substantive posts in maternity • IT maternity support went live recently which has the potential to improve efficiency within the midwifery service • A review has been commissioned with the Trust Development Authority (TDA) and Maternity Hospital Warwick to look at 22 cases of haemorrhage patients to establish whether there was a quantum of avoidable harm • Internal and external groups are being set up to look at the Review with the CCG to be invited to participate • High level meetings at Ormskirk site take place every Thursday morning which look at revised governance structure of the unit and matters arising from weekly HARM reviews • Liaison taking place with other Trusts to look at their lessons learned, including tertiary centres DF sought assurance that the maternity review would be thoroughly covered within the Trust's overarching Action Plan. SF confirmed that a separate maternity plan would be maintained. RG confirmed that the Trust were happy to attend Quality Committee meetings on a regular basis to share other areas of good practice and change within the Trust. DF thanked the Trust for attending and giving the Committee the opportunity to discuss their concerns.	
	The Committee received the presenting noting the improvements made following the review of maternity services at Southport & Ormskirk hospital NHS Trust	
16/008	**NHS ENGLAND Action Plan for Cold Chain Management in GP Practices** WS attended today's meeting to answer any questions the Committee might have arising from NHSE's report and action plan in response to the SFCCG's request for an audit to be carried out following a number of Cold Chain Audit issues. Whilst DC felt some progress had been made, he thought the report demonstrated that management of the cold chain process was not undertaken at the correct level. WS advised that she was not aware of any additional cold chain incidents occurring in Sefton, issues continued with Data Loggers as practices without this device were still suffering vaccine losses. This piece of equipment costs approximately £30. In addition, it was considered effective transport systems were not in place at all practices, with practices required to evidence they are transporting vaccines in an appropriate way. The Committee considered how they could be assured that the actions within the plan were completed by those they were assigned to and asked that the plan be adapted to maintain a record of status of actions to show when completed. **Action: Revised Action Plan to include record of completion of actions to come back to the Committee in March.**	**WS**

	The Committee received the report	
16/009	**Provider Quality Performance Reports** JS presented the report which was discussed by the Committee. *Southport & Ormskirk* Stroke performance – At the last internal Committee meeting held in November, DF stated that confirmation had been received from the provider at the CRM/CQPG that ring-fenced stroke beds would be in place in December 2015 however it was not clear whether this had happened. **Action: DF to seek confirmation that the ring-fenced stroke beds are in place as should have been the case since 12th December 2015.** Patient Reported Outcome Measures (PROMs) – Some issues in obtaining figures have been experienced by the Business Intelligence (BI) team with work underway to address. A&E - Pressures on the health economy were explained within the narrative of the report with ambulance handover training underway to support. BD noted the rise from 26% to 28% of patients waiting more than 75 minutes for an ambulance. Ambulance handover times will be monitored via the CQPG. Mixed Sex Accommodation Breaches (MSA) - Breaches in ITU and Critical care are to be discussed at CCF and CQPG meetings. DF commented on the importance of sanctions being implemented when breaches occur. Maternity - Expect performance issues are expected to improve now BI systems have gone live Infections (CDifficile) – Performance is just below trajectory for month 8 with the next Appeals panel meeting due to be held in February 2016. *MerseyCare NHS Trust* Every Contact Counts – Issues remain with same narrative recorded for past 3 months. Smoking Status Recorded for Patients on CPA - JS spoke to the Trust who believed they have seen an improvement to take them above target by Month 10 - therefore target should be achieved. JS advised that 'Keeping nourished' and 'Falls causing harm' were quarterly measures which needed to be reflected in the narrative as only monitored on a quarterly basis. The recording of single or multiple falls is to be looked at with LCH. *Liverpool Community Health NHS Trust* AHP Waiting Times - Increasing waiting times evident. The Trust presented a paper to CQPG last week which has been circulated internally for comment. This states there are no changes in the referral pathways. JS will ensure all are copied in to report. MC aware as contract lead. **Action: JS to ensure all Committee members are sent a copy of the LCH report on AHP Waiting times presented to the CQPG meeting in January 2016.** *NWAS* JS presented a snapshot of information with a more comprehensive overview to	**DF** **JS**

	be provided in future. *NHS111* JH, RC and Andy Mimnagh have sited issues in respect of NHS111 which would be highlighted to the Committee. Terry Hill offered to attend QC on quarterly basis to present on performance.	
	The Committee received the report	
16/010	**Serious Incident Report** JH presented the report to the Committee stating that Southport & Formby Hospital NHS Trust appear to have made some headway in addressing Serious Incidents (SIs) with added support from West Lancashire CCG. JH expected the make-up of group members to address some issues raised without the need for escalation. Trust representatives will also attend the meetings for the final half hour to answer direct questions in relation to the reports presented. JH anticipated seeing a reduction in the number of incidents reported in March. The Committee noted that more than half of the incidents detailed within this month's report have been closed since its circulation. The CCF will receive a formal response from Simon Featherstone next week which is expected to lead to the removal of up to 70 SIs from STEIS. Two SIs on maternity have been reported which will be monitored through the STEIS process with a further two currently under discussion with the Trust expected to be raised through STEIS by NHS England.	
	The Committee received the report	
16/011	**Proposed Meeting Schedule for Quality Committee 2016/17** JH presented the report which followed a review of the existing meeting schedule for the Quality Committee and proposed a new schedule for 2016/17. The reasons for recommending the changes were presented with internal meetings proposed to take place jointly with South Sefton CCG. Issues in achieving a quorum were also being addressed through a review of the Terms of Reference. Provided the changes were in line with governance and the effectiveness of the Quality Committee was not affected, DF was supportive of the proposal and thanked the members of the team involved for taking account of benefits and QIPP savings. The Chair supported the proposal but acknowledged that the SSCCG would also need to agree to accept the proposal at their meeting on 21st January 2016.	
	The Committee received and approved the proposal within the report.	
16/012	**EPEG Key Issues Report** RP was unable to attend the last meeting of EPEG but advised the Committee that the following issues had been shared: • Discussions had taken place with the Local Authority re their equivalent group to look at joint and wider issues • Grants to voluntary community, health & wellbeing and Safe Sector • Looking for better engagement with children and young people – future EPEG meeting to address • Dementia friends training to be rolled out within CCGs	
	The Committee received the verbal update	
16/013	**GP Quality Lead Update** RC provided an update advising that some CQC inspections of GP Practices had been determined 'good' overall with two 'outstanding'	

	A local quality scheme is up and running with no major issues although some concerns re availability of pharmacy staff to undertake duties. PA shared details of issue with the handling of NOP letters involving the S&F Hospital Trust and NHS England. **Action: BD to discuss with Sharon Bradburn.**	**BD**
	The Committee received the verbal update	
16/014	**Key Issues Log** The following were highlighted to be included in the key issues log from the Committee to the Governing Body: • Safeguarding level of assurance at S&O • Southport & Ormskirk Medical Director and Director of Nursing attended to provide an update to the Committee on Management of Quality Concerns' highlighted in CQC Chief Inspector of Hospitals Visit and RCOG Report re Maternity Services • NHSE presented the Cold Chain Audit Action Plan. Lack of assurance expressed by Quality Committee as no evidence of progress against timelines. Requested that the action plan be reviewed and re-submitted in February 2016	
16/015	**Any Other Business** Southport & Ormskirk 12 hour Paediatric Breach discussed with SRG. **Action: BD to check to see if NWAS have reported this as a risk with Spec-Comm.**	**BD**
16/016	**Date of Next Meeting** Wednesday 17th February 2016 11.30 am – 13.30 pm at The Family Life Centre, Ash Street, Southport	

Chair : _____ _____

PRINT NAME **SIGNATURE**

Date : _____