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NHS
Liverpool
Clinical Commissioning Group

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
GOVERNING BODY
TUESDAY 11th JULY 2017 AT 2PM
HALL 1, LACE CONFERENCE CENTRE

AGENDA

Part 1: Introductions and Apologies

1.1	Declarations of Interest	***All***
1.2	Minutes and action points from the meeting on 13th June 2017	***Attached*** ***All***
1.3	Matters Arising	***All***

Part 2: Updates

2.1	Feedback from Committees:	**Report no: GB 46-17**
	➢ Committees in Common – 9th June 2017	**Katherine Sheerin**
	➢ Primary Care Commissioning Committee – 20th June 2017	**Dave Antrobus**
	➢ Finance Procurement & Contracting Committee - 27th June 2017	**Dr Nadim Fazlani**
	➢ Healthy Liverpool Programme Board – 28th June 2017	**Tom Jackson**
	➢ Quality Safety & Outcomes Committee – 4th July 2017	**Dave Antrobus**
2.2	Chief Officer's Update	**Verbal** **Katherine Sheerin**
2.3	Feedback from the Liverpool Safeguarding Children Board 21st June 2017	**Report no: GB 47-17** **Kerry Lloyd**
2.4	Public Health Update	**Verbal** **Dr Sandra Davies**
2.5	Feedback from Health & Wellbeing Board 22nd June 2017	**Verbal** **Dr Sandra Davies**

Part 3: Performance

3.1	Finance Update May 2017 – Month 2 17/18	**Report no: GB 48-17** **Tom Jackson**
3.2	CCG Corporate Performance Report July 2017	**Report no: GB 49-17** **Stephen Hendry**
3.3	Health Care Associated Infection Annual report 2016-17	**Report no: GB 50-17** **Jane Lunt/Alison Thompson**

Part 4: Strategy and Commissioning

No items

Part 5: Governance

5.1	Corporate Risk Register Update (July 2017)	**Report no: GB 51-17** **Ian Davies**
5.2	Establishing a Joint Committee across Liverpool, South Sefton and Knowsley CCGs to Agree Agree Options And Take Forward Decision Making On The Future Configuration Of Hospital Services In North Mersey	**Report no: GB 52-17** **Katherine Sheerin**
5.3	Healthwatch Liverpool Annual Report 2016/17	**Report no: GB 53-17** **Dave Antrobus/** **Sarah Thwaites**

6. Date and time of next meetings:
Tuesday 8th August 2017 in the Boardroom, Liverpool CCG, The Department, 2 Renshaw Street, Liverpool L1 2SA

For Noting:

- Committees in Common – 7th December 2016
- Primary Care Commissioning Committee – 18th April 2017
- Finance Procurement & Contracting Committee – 30th May 2017
- Healthy Liverpool Programme Board – 31st May 2017
- Quality Safety & Outcomes Committee – 6th June 2017
- NHS Liverpool CCG Remuneration Review Report

NHS
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Clinical Commissioning Group

Report no: GB 46-17

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
GOVERNING BODY

TUESDAY 11TH JULY 2017

Title of Report	Feedback from Committees
Lead Governor	Dr Nadim Fazlani, Dr Rosie Kaur, Dave Antrobus, Prof, Maureen Williams
Senior Management Team Lead	Cheryl Mould, Primary Care Programme Director, Tom Jackson, Chief Finance Officer, Jane Lunt, Head of Quality/Chief Nurse, Katherine Sheerin, Chief Officer
Report Author(s)	Cheryl Mould, Primary Care Programme Director, Tom Jackson, Chief Finance Officer, Jane Lunt, Head of Quality/Chief Nurse
Summary	The purpose of this paper is to present the key issues discussed, risks identified and mitigating actions agreed at the following committees: ➢ Committees in Common – 9th June 2017 ➢ Primary Care Commissioning Committee – 20th June 2017 ➢ Finance Procurement & Contracting Committee - 27th June 2017 ➢ Healthy Liverpool Programme Board – 28th June 2017 ➢ Quality Safety & Outcomes Committee – 4th July 2017 This will ensure that the Governing Body is fully engaged with the work of committees, and reflects sound governance and decision making arrangements for the CCG.
Recommendation	That Liverpool CCG Governing Body: ➢ Considers the report and recommendations from the committees
Relevant Standards or targets	

NHS Knowsley Clinical Commissioning Group | NHS Liverpool Clinical Commissioning Group | NHS South Sefton Clinical Commissioning Group | NHS Southport and Formby Clinical Commissioning Group

HEALTHY LIVERPOOL PROGRAMME
RE-ALIGNING HOSPITAL BASED CARE

COMMITTEE(S) IN COMMON (CIC)
KNOWSLEY, LIVERPOOL, SOUTH SEFTON AND SOUTHPORT & FORMBY CCGS

FRIDAY 9TH JUNE 2017
Boardroom, Liverpool CCG
The Department, Lewis's Building, 2 Renshaw Street, L1 2SA

Time 12.00pm – 2.00pm
AGENDA

1.	Welcome, Introductions and Apologies	Dr Nadim Fazlani
2.	Declarations of interest	ALL
3.	Minutes and actions from the 7th December 2016 meeting	ALL
4.	Establishing a joint committee - discussion paper and draft Terms of Reference	Katherine Sheerin Report No: CIC 01-17
5.	Orthopaedics review - update on progress	Dr Fiona Lemmens/Dr Chris Grant Verbal
6.	Review of Women's and Neonatal services - update on progress	Dr Fiona Lemmens/Dr Chris Grant Verbal
7.	Population Based Needs Review of in-Hospital Services for Southport & Formby and West Lancashire	Fiona Taylor Report No: CIC 02-17
8.	North Mersey Stroke Review	Fiona Taylor Report No: CIC 03-17
9.	Any other business	
10.	Date and time of next meeting: Friday, 11 August 2017,12pm to 2pm, Boardroom, Liverpool CCG	

Committee: Committee(s) In Common	**Meeting Date**: 9th June 2017	**Chair:** Dr Nadim Fazlani

Key issues:	**Risks Identified:**	**Mitigating Actions:**
1. Establishing a joint committee across Liverpool, Knowsley, South Sefton and Southport & Formby CCGs	• That decisions regarding hospital services redesign are not aligned/ slowed down.	• To establish a Joint Committee Draft Terms of Reference to go to each Governing Body for debate and approval.
2. Orthopaedics/ENT Review	• Opportunities for optimal patient services not maximised	• Joint Overview & Scrutiny Committee set up for 26th June 2017. • Public Committee to commence.
3. North Mersey Stroke Review	• That services change is not effectively managed in line with requirements.	• North Mersey Stroke Review Group – Liverpool CCG service input to be identified.

Recommendations to NHS Liverpool CCG Governing Body:
1. To note the key issues and risks.

PRIMARY CARE COMMISSIONING COMMITTEE
TUESDAY 20TH JUNE 2017 AT 10AM to 12PM
BOARDROOM THE DEPARTMENT

A G E N D A

Part 1: Introductions and Apologies

1.1	Declarations of Interest	***All***
1.2	Minutes and actions from previous meeting on 18th April 2017	**All**
1.3	Matters Arising:	
1.3.1	Framework for Discretionary Payment for Locum Cover	**PCCC 12-17** **Scott Aldridge**

Part 2: Updates

2.1	Primary Care Support Services	**Verbal** **Tom Knight**
2.2	Feedback from Sub-Committees:	**PCCC 13-17**
	• Medicines Optimisation Sub-Committee -	**PCCC 13a-17** **Peter Johnstone**
	• Locality Workshops – April	**PCCC 13b-17** **Jacqui Waterhouse**
	• Primary Care Programme Group - May 2017	**PCCC 13c-17** **Rosie Kaur**
	• Transformation of Primary Care (Response to General Practice Forward View)	**PCCC 12d-17** **Colette Morris**

Part 3: Strategy & Commissioning

3.1	Direct Patient Ordering	**PCCC 14-17** **Peter Johnstone**

Part 4: Performance

4.1	Primary Care Commissioning Committee Performance Report	**PCCC 15-17** **Rosie Kaur/** **Cheryl Mould**

Part 5: Governance

5.1	Primary Care Commissioning Committee Risk Register	**PCCC 16-17** **Cheryl Mould**

6.	Any Other Business	**ALL**

7. Date and time of next meeting:

Tuesday 15th August 2017
Formal Meeting
Boardroom, The Department

LIVERPOOL CCG CORPORATE GOVERNANCE TEMPLATE – COMMITTEE MINUTES

Committee: Primary Care Commissioning Committee	**Meeting Date:** 20th June 2017	**Chair**: Dave Antrobus **Vice Chair:** Katherine Sheerin

Key issues:	**Risks Identified:**	**Mitigating Actions:**
1. Primary Care Support Services.	• That the issues relating to medical records will impact on clinical care to patients.	• To request performance against local indicators. • To continue to raise concerns at national level.
2. Direct Patient Ordering of prescriptions.	• That the risks identified are not appropriately mitigated.	• Commence a small scale pilot in one neighbourhood. • Implement an effective communication strategy. • Identify vulnerable patients and ensure pharmacist contacts them to agree a system to manage their ordering.

Recommendations to NHS Liverpool CCG Governing Body:

1. To note the issues, risks and mitigating actions.
2. To highlight to the Governing Body end of year performance of GP Specification 2017, there has been significant improvement and it was noted how hard practices had worked. The baseline position for 2017/18 was also positive

FINANCE, PROCUREMENT AND CONTRACTING COMMITTEE
TUESDAY 27TH JUNE 2017 AT 10AM
ROOM 2, THE DEPARTMENT, LEWIS'S BUILDING
RENSHAW STREET L1 2SA

Part 1:	**Introductions and Apologies**	
1.1	Declarations of Interest	***All***
1.2	Minutes and action points from the meeting on 30th May 2017	***Attached*** ***All***
1.3	Matters Arising	***All***
Part 2:	**Updates**	
No items		
Part 3:	**Performance**	
3.1	Finance Update May 2017 – Month 2 17/18	**Report no: FPCC 33-17** **Tom Jackson**
3.2	Cash Releasing Efficiency Savings (CRES) 2017/18	**Report no: FPCC 34-17** **Tom Jackson**
3.2	Financial Reporting – Moving to in-year surplus reporting.	**Report no: FPCC 35-17** **Tom Jackson**
Part 4:	**Strategy and Commissioning**	
4.1	Continuing Healthcare Retrospective Claims for period 2012-2016– Options Paper	**Report no: FPCC 36-17** **Kerry Lloyd**
4.2	Transforming Care for Care Home Residents using Telemedicine	**Report no: FPCC 37-17** **Dr Fiona Ogden-Forde/ Jacqui Campbell**

4.3	Procurement of Catheter and Stoma Appliance Management Services (Pilots)	**Report no: FPCC 38-17** **Derek Rothwell/** **Tom Fairclough**
4.4	Procurement Of Telehealth Technology Services (ITT)	**Report no: FPCC 39-17** **Derek Rothwell/** **Tom Fairclough**
4.5	Commercial Sponsorship Of Prescribing Projects	**Report no: FPCC 40-17** **Peter Johnstone**

Part 5: Governance

No items

6. **Date and time of next meeting**:
Tuesday 25th July 2017 Room 2 at 10am to 12.30pm The Department, Lewis's Building, L1 2SA.

Committee: Finance Procurement & Contracting Committee	**Meeting Date**:27th June 2017	**Chair: Dr Nadim Fazlani**

Key issues:	**Risks Identified:**	**Mitigating Actions:**
1. Financial Monitoring of Year to Date / Forecast Expenditure update as per M2 reporting (May) with regards to delivery of NHS England Business Rules including progress report on Cash Releasing Efficiency Saving (CRES) measures.	• Number of risks as identified within the papers – potential impact of variation away from planned expenditure levels and required delivery of Cash Releasing Efficiency Saving (CRES) measures.	• Continued monitoring of forecast outturn assumptions on monthly basis until the end of the financial year in order to ensure delivery.
2. Continuing Healthcare Retrospective Claims Update	• Potential for claims outside of time period of review in line with Previously Unassessed Periods of Care (PuPoC) guidance. • Resulting additional financial cost.	• Liverpool CCG is currently not mandated to undertake these reviews and will review approach upon updates to national policy and formal guidance .
3. Procurement Waiver for extension of Telemedicine project into remainder of Care Homes	• Delays to the progress of the care home model and related demand management plans	• Waiver supported to help progress plans and achieve key outcomes.
4. Pilot Catheter and Stoma Appliance Management Services Procurement Update	• Potential for challenge. • Achieving timelines outlined as part of procurement process.	• Rigorous adherence to procurement guidance and processes. • Liverpool CCG requirements for providers to have clear mobilisation plans.
5. Telehealth Technology Procurement Update.	• Potential for challenge . • Achieving timelines outlined as part of procurement process.	• Rigorous adherence to procurement guidance and processes. • Liverpool CCG requirements for providers to have clear mobilisation plans.

Recommendations to NHS Liverpool CCG Governing Body:
1. To note the key issues and risks.

Healthy Liverpool Programme Board

Wednesday 28 June 2017
3pm to 5pm

Board Room

AGENDA

1.0	**Welcome and Introductions**	T Jackson		3.00-3.10
2.0	**Minutes of the last meeting**	T Jackson		
3.0	**Matters Arising**	All		
4.0	**Governance**			
4.1	Risk Register	S Lavell	For discussion	3.10-3.40
5.0	**Performance**			
5.1	Programme Highlight reports (attached)	Clinical Directors	For discussion	3.40-4.10
5.2	Performance and Outcomes Reporting	H McManus	For discussion	4.10-4.30
6.0	**Strategy & Commissioning**			
6.1	Road Map for Programme End and Transition	S Lavell	For discussion	4.30-4.50
7.0	**Any Other Business**	All		4.50-5.00
8.0	**Communication/messages from this meeting**	All		
9.0	Date and time of next meeting: Wednesday 26 July 2017 from 3pm to 5pm, Board Room.			

Committee: Healthy Liverpool	**Meeting Date**: 28 June 2017	Chair: Dave Antrobus (deputising for Tom Jackson)

Key issues:	Risks Identified:	Mitigating Actions:
1. Risk Register	• Ensuring risks are identified and managed effectively.	• The refreshed risk register has been updated with mitigating actions and responsibility assigned.
2. Roadmap for Healthy Liverpool programme End and Transition	• Ensuring a planned end to the Healthy Liverpool programme, including a process for benefits realisation and transition of longer term workstreams into other portfolios/programmes	• A review of programme delivery in terms of both service change and improved outcomes has started. Progress will be reported to HLP Programme board monthly.
3. Performance Management	• Ensuring robust performance management is in place for the Healthy Liverpool programme.	• The board received a presentation on outcomes improvement progress to date. This is linked to the Programme reviews as part of the Healthy Liverpool Roadmap for programme end.

Recommendations to NHS Liverpool CCG Governing Body:
1. To note the key issues and risks identified by the HLP Board.

QUALITY SAFETY AND OUTCOMES COMMITTEE
TUESDAY 4TH JULY 2017 3PM TO 5PM
BOARDROOM THE DEPARTMENT

A G E N D A

Part 1: Introduction & Apologies

1.1	Welcome & Introductions	**ALL**
1.2	Declaration of Interests	**ALL**
1.3	Minutes and Actions from 6th June 2017	**Chair**
1.4	Matters Arising	

Part 2: Updates

2.1	Update on safeguarding lead generic nhs.net email accounts	**Verbal Margaret Goddard**
2.2	CCG Safeguarding Quarterly Report Quarter 4	**QSOC 38-17 Helen Smith/ Esther Golby**

Part 3: Strategy & Commissioning

3.1	Engagement Plan: Getting your treatment right	**QSOC 39-17 Kelly Jones**

Part 4: Performance

4.1	Serious Incident Overview 2017/18 Quarter 1	**QSOC 40-17 Kerry Lloyd**
4.2	Early Warning Dashboard	**QSOC 41-17 Kerry Lloyd**

Part 5: Governance

5.1 Risk Register **QSOC 42-17**
Kerry Lloyd

6. Any Other Business

Date & Time of next meeting
Tuesday 1st August 2017 3pm to 5pm Boardroom, The Department

Committee: Quality, Safety & Outcomes C'tee	**Meeting Date:** 4th July 2017	**Chair:** Dave Antrobus

Key issues:	**Risks Identified:**	**Mitigating Actions:**
1. The quality of care provided in care homes.	• The impact of quality related issues as identified in the safeguarding report presented. • The impact on residents and families.. • The impact of home closures due to quality of provision on the wider system	• Liverpool CCG is fully involved in the monthly Care Home Quality Assurance Group meetings held with partners including Liverpool City Council, CQC and Healthwatch - working together to identify and improve quality. • Liverpool CCG is working in partnership with Liverpool City Council and the sector itself in developing and delivering a Care Home improvement strategy. • A 'deep dive' paper will be presented to QSOC in September; outlining the current local challenges and the partnership approach to quality improvement.
2. Engagement plan re 'Getting Your Treatment Right'	• Adverse public response to proposals.	• Targeted consultation plan with key stakeholders to inform and work towards implementation
3. Serious incident management following the transfer of South Sefton CCG community Services provision to Mersey Care NHS Trust.	• Ability of LCCG to retain organisational oversight of Mersey Care Serious Incident management.	• Development of Standard Operating Procedure with South Sefton CCG, Liverpool CCG and NHS England which will outline defined process to allow continued Liverpool CCG oversight of Merseycare Serious Incident management.

Recommendations to NHS Liverpool CCG Governing Body:
1. Note the issues and the actions to mitigate risks.

Report no: GB 47-17

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP GOVERNING BODY

TUESDAY 11TH JULY 2017

Title of Report	Feedback from the Liverpool Safeguarding Children Board – 21st June 2017
Lead Governor	Jane Lunt, Head of Quality/Chief Nurse
Senior Management Team Lead	Jane Lunt, Head of Quality/Chief Nurse
Report Author	Hayley McCulloch, Designated Nurse Safeguarding Children
Summary	The purpose of this paper is to present the key issues discussed, risks identified and mitigating actions agreed at the Liverpool Safeguarding Children Board 21st June 2017. This will ensure that the Governing Body is fully engaged with the work of the Safeguarding Boards and reflects sound governance and decision making arrangements for the CCG.
Recommendation	That Liverpool CCG Governing Body: ➢ Considers the reports and recommendations from the Liverpool Safeguarding Children Board
Relevant Standards or targets	The Assurance & Accountability Framework 2015 – NHS England.

Committee: Liverpool Safeguarding Children Board	**Meeting Date:** 21st June 2017	**Chair:** Audrey Williamson

Key issues:	**Risks Identified:**	**Mitigating Actions:**
1. Neglect	• Neglect is an area of concern within Liverpool. A high proportion of cases demonstrate high levels of Neglect. • There have been a number of high risk cases where Neglect has been identified but not acknowledged. • There is an absence of a Multi-Agency tool to assess Neglect to enable partners to decipher/assess the level of Neglect in families.	• The LSCB agreed that a Tool is needed across the partnership to measure Neglect. The graded care profile was discussed and agreed at the LSCB. The Partnership also agreed to support the implementation of this tool. The CCG and Public Health agreed to support implementation for the Health Economy in Liverpool. • The Neglect Task and Finish Group of the LSCB will continue to meet. • The LSCB have identified Neglect as a priority area for the Board.
2. Child Exploitation	• Child Exploitation is an ever increasing area of work within Liverpool. • Child Sexual Exploitation is well recognised however additional forms of Child Exploitation are increasing and emerging. • Criminal Exploitation processes are newly developed and evolving. • The numbers of cases referred due to Criminal exploitation have exceeded those referred with CSE	• The Strategic Multi Agency Child Exploitation (MACE) Group includes representation from the CCG. • The Strategic MACE group and work plan includes all forms of Child Exploitation. • Work is underway to develop processes, risk assessments and a partnership response to Child Exploitation supported by the CCG. • The LSCB have identified Child Exploitation as a priority area for the

	concerns within a short time.	Board.

Recommendations to NHS Liverpool CCG Governing Body: 1**.** To note the issues, risks and mitigation.

NHS
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Report no: GB 48-17

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
GOVERNING BODY

TUESDAY 11th July 2017

Title of Report	Finance Update May 2017 – Month 2 17/18
Lead Governor	Tom Jackson Chief Finance Officer
Senior Management Team Lead	Tom Jackson Chief Finance Officer
Report Author	Mark Bakewell Deputy Chief Finance Officer Peter Quayle Head of Financial Management
Summary	This paper summarises the CCG's financial performance for the month of May 2017 (Month 2) for the Governing Body and contains details regarding a) Financial Performance in respect of delivery of NHS England Business Planning Rules particularly regarding in-year surplus position and treatment of non-recurrent headroom b) Assessment of risk to the delivery of forecast surplus position given current / required mitigating actions as identified within Financial Recovery Plan as shared with NHS England
Recommendation	That Liverpool CCG Governing Body: ➢ Notes the current financial position and risks associated with delivery of the forecast outturn position.

	➢ Notes the stated assumptions regarding proposed recovery solutions to deliver the required business rules based on current forecast outturn assumptions
Relevant standards/targets	Financial Duties NHS England Business Rules

FINANCIAL PERFORMANCE UPDATE – MONTH 2 (MAY) 2017/18

1. PURPOSE

The purpose of this report is to provide the Governing Body with an update on the CCG's financial performance within the 2017-18 financial year.

2. RECOMMENDATIONS

That the Liverpool CCG Governing Body:

- Notes the current financial position and risks associated with delivery of the forecast outturn position.

- Notes the stated assumptions regarding savings assumptions required to deliver the required business rules based on current forecast outturn assumptions.

3. REPORTING REQUIREMENTS

NHS England has advised that CCGs should move away from reporting financial performance on a "cumulative basis", to "in-year surplus" reporting.

The below table summarises the CCG Financial Performance against planning assumptions on both of these basis with a minor 'in-year' surplus (*a) required to maintain a relative 2% cumulative surplus position (*b) (given an increase in CCG resources compared to 16/17 due to additional allocation growth)

	2017/18 Financial Year £ 000's
'In –year' CCG Resource Limit	(867,988)
Expenditure Requirements	867,902
In Year Position Surplus / (Deficit)	86 (*a)
Prior Year (carry forward) Surplus	16,377
2017/18 Planned Surplus position	16,463 (*b)

The focus of future 'external' reporting in accordance with NHSE requirements will be the delivery of the £86k surplus (*a) for 2017/18, with the CCG ensuring that the 0.5% National Headroom reserve (as described below) remains available for national direction. The CCG will continue to report on both values for the 2017/18 financial year given the

change in reporting focus and to ensure awareness of its cumulative surplus position is maintained.

4. FINANCIAL POSITION SUMMARY AT MONTH 2

Elements of financial reporting remain indicative at this stage of the financial year due to the availability of in-year supporting information. This is due to the time lag of information in specific areas (such as prescribing, continuing healthcare etc) and month on month trend analysis to make a comprehensive assessment.

However, indicative information suggests that the CCG financial performance remains consistent with its planning assumptions and subject to delivery of its savings plan should remain on course to deliver required NHS England Business Planning Rules, albeit subject to a number of risks as outlined within this document and as per the financial plan agreed by the CCG Governing Body in March 2017

Financial Performance Indicators

The CCG's Financial Performance is assessed on the basis of the following indicators, as detailed by the relevant sections of the table below. Relevant Financial Values are 'RAG' rated on a self-assessment basis by the CCG Finance team, using the information available, and as described within this reporting period.

Financial Performance Indicators	2017/18 Plan £000	Month 1 (April) FOT £000	Month 2 (May) FOT £000
a) Business Rules			
'In year' Surplus / (Deficit) (*1)	86	86	86
2017/18 'Cumulative' Surplus Position	16,463	16,463	16,463
b) National Planning Rules			
0.5% Local Headroom NR 'Reserve' (*2)	4,275	4,275	4,275
0.5% National Headroom NR 'Reserve' (*2)	4,275	4,275	4,275
0.5% Contingency 'Reserve' (*2)	4,525	4,525	4,525
Running Costs Expenditure (*3)	10,562	10,047	10,047
c) **Effectiveness Indicators**	Target		
Month –End Cash Balance (*4)	< 1.25%	405	15
Better Payment Practice Code		M01 YTD	M02 YTD
Performance by Volume – NHS (*4)	95%	100%	100%
Performance by Volume - Non-NHS (*4)	95%	100%	95%
Performance by Value – NHS (*4)	95%	100%	100%
Performance by Value - Non-NHS (*4)	95%	100%	99%

**Notes*
1 – Delivery of NHS England Business Rules re minimum of in-year break position for '2.0% surplus' CCG's
2 – Earmarked Funds to be 'reserved' for Headroom and Contingency as per NHS England Planning Guidance (NB calculation methodology differs for respective 0.5% calculations)

5. DETAILED FINANCIAL PERFORMANCE INFORMATION

The below sections summarise the key information regarding Month 02 (May) 2017/18 reporting position for NHS Liverpool Clinical Commissioning Group.

a) Revenue Resource Limit

The resources available to the CCG within the 2017/18 financial year are described within the table below; these include the CCG's programme (recurrent and non-recurrent) and running cost allocations and also the amount delegated by NHS England for CCG commissioning of Primary Care (GP practices)

	£000
Notified Programme Allocation	782,388
Non-Recurrent Allocation	2,491
Primary Care Co Commissioning	72,547
Revenue Resource Limit (Programme)	857,426
Running Costs Allocation	10,562
Total In-Year Allocation	867,988
Prior Year (carried forward) Surplus	16,377
Total CCG Allocation	884,365

A breakdown of the CCG's non-recurrent resources within the 2017/18 financial allocations can be found below

	£000
NPfIT IT funding	4,000
Identification Rule Changes (Specialised)	(2,941)
HRG4+ changes	1,432
Total Non-Recurrent Allocation	2,491

b) 2017/18 Year to Date Expenditure Position as at Month 2 (May)

The CCG is reporting a year to date over performance of £0.29m against budgeted expenditure as at May 2017 as set out in the Table below.

	Annual Budget £'000	Year to date Budget £'000	Year to date Actual £'000	Year to date Variance £'000
ALLOCATION Total	**(884,365)**	**(147,394)**	**(147,394)**	**0**
ACUTE TOTAL	419,236	69,873	70,519	646
COMMUNITY HEALTH SERVICES TOTAL	88,830	14,822	14,874	53
CONTINUING CARE TOTAL	31,969	5,328	5,501	173
MENTAL HEALTH TOTAL	84,097	14,258	14,398	139
OTHER TOTAL	52,047	6,962	6,376	(585)
PRIMARY CARE TOTAL	181,687	31,662	31,710	47
PROGRAMME TOTAL	**857,867**	**142,905**	**143,378**	**473**
RUNNING COSTS TOTAL	**10,035**	**1,746**	**1,562**	**(184)**
EXPENDITURE TOTAL	**867,902**	**144,650**	**144,939**	**289**
TOTAL	**(16,463)**	**(2,744)**	**(2,455)**	**289**

The Month 02 reported financial positon is largely due to:

- The adverse impact of the 2016/17 outturn position compared to forecast totalling £0.77m; where final performance data (e.g. M12 SLAM and QoF (Quality and Outcome Framework)) was not available when finalising the 2016/17 accounts.

- Net cost pressures in year of £0.08m in respect of demand led expenditure and known changes to packages of care in the first two months of the year.

- Offset by two months of contingency reserve -£0.56m (net of unidentified CRES schemes).

i. Acute Expenditure

The overall Acute contracts expenditure position is currently £0.65m over plan as at May 2017, as per the table below.

	Category	Cost Centre	Annual Budget £'000	Year to date Budget £'000	Year to date Actual £'000	Variance £'000
PROGRAMME	ACUTE	ACUTE COMMISSIONING	415,731	69,288	69,934	646
PROGRAMME	ACUTE	COLLABORATIVE COMMISSIONING	0	0	(0)	(0)
PROGRAMME	ACUTE	END OF LIFE	0	0	0	0
PROGRAMME	ACUTE	HIGH COST DRUGS	264	44	44	0
PROGRAMME	ACUTE	NCAS/OATS	3,199	533	533	(0)
PROGRAMME	ACUTE	Winter Resilience	43	7	7	(0)
	ACUTE TOTAL		**419,236**	**69,873**	**70,519**	**646**

This is due to 2016/17 outturn costs being greater than accrued expenditure forecasts reflected in the 2016/17 annual financial accounts. Outturn contract and performance data (eg. M12 SLAM data) which was not available when finalising the 2016/17 accounts.

2017/18 financial performance is aligned to the Acting As One contracts. Non-Contract Activity (NCA) and Out of Area Treatments (OATs) are accrued in line with plan at Month 2 due to the lack of in-year supporting information at this time.

ii. Community Expenditure

Community Health Services expenditure is currently over planned levels by £0.05m. A detailed review of Hospices expenditure in the first two months of the year compared to plan is being undertaken during June and the outcome of this review will be fully reflected in the Month 03 financial position.

	Category	Cost Centre	Annual Budget £'000	Year to date Budget £'000	Year to date Actual £'000	Variance £'000
PROGRAMME	COMMUNITY HEALTH SERVICES	COMMUNITY SERVICES	70,350	11,725	11,731	6
PROGRAMME	COMMUNITY HEALTH SERVICES	CARERS	302	50	50	0
PROGRAMME	COMMUNITY HEALTH SERVICES	HOSPICES	4,169	577	624	47
PROGRAMME	COMMUNITY HEALTH SERVICES	INTERMEDIATE CARE	10,911	1,934	1,934	0
PROGRAMME	COMMUNITY HEALTH SERVICES	LONG TERM CONDITIONS	3,001	500	499	(1)
PROGRAMME	COMMUNITY HEALTH SERVICES	PALLIATIVE CARE	97	35	36	1
PROGRAMME	COMMUNITY HEALTH SERVICES	WHEELCHAIR SERVICE	0	0	0	0
	COMMUNITY HEALTH SERVICES TOTAL		**88,830**	**14,822**	**14,874**	**53**

iii. Continuing Care

Continuing care is over budget by £0.17m at Month 02 with demand led increases in costs in both CHC Children's services and Adult Fully Funded Personal Health Budgets.

	Category	Cost Centre	Annual Budget £'000	Year to date Budget £'000	Year to date Actual £'000	Variance £'000
PROGRAMME	CONTINUING CARE	CHC ADULT FULLY FUNDED	19,312	3,219	3,219	0
PROGRAMME	CONTINUING CARE	CHC ADULT JOINT FUNDED	3,127	521	521	(0)
PROGRAMME	CONTINUING CARE	CHC AD FULL FUND PERS HLTH BUD	988	165	207	42
PROGRAMME	CONTINUING CARE	CONTINUING HEALTHCARE ASSESSMENT	366	61	60	(1)
PROGRAMME	CONTINUING CARE	CHC CHILDREN	2,922	487	667	180
PROGRAMME	CONTINUING CARE	FUNDED NURSING CARE	5,254	876	827	(48)
	CONTINUING CARE TOTAL		**31,969**	**5,328**	**5,501**	**173**

It is recognised that demand led packages of care continue to present a financial risk to the CCG and a more in depth analysis of continuing care

costs and associated risks is being developed for periodic inclusion in future finance reports.

iv. Mental Health

Mental Health year to date expenditure exceeds budget by £0.14m as detailed in the table below.

	Category	Cost Centre	Annual Budget £'000	Year to date Budget £'000	Year to date Actual £'000	Variance £'000
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH CONTRACTS	66,202	11,034	11,045	12
PROGRAMME	MENTAL HEALTH	CHILD AND ADOLESCENT MENTAL HEALTH	1,366	368	368	0
PROGRAMME	MENTAL HEALTH	DEMENTIA	75	43	44	0
PROGRAMME	MENTAL HEALTH	LEARNING DIFFICULTIES	4,713	785	884	99
PROGRAMME	MENTAL HEALTH	MENTAL CAPACITY ACT	116	19	19	0
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - ADULTS	6,152	1,045	1,045	0
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - ADVOCACY	91	30	30	(0)
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - COLLABORATIVE COMMISSIONING	21	14	14	(0)
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - NOT CONTRACTED ACTIVITY	202	34	39	5
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - OLDER PEOPLE	4,105	684	724	40
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - OTHER	1,054	202	184	(18)
	MENTAL HEALTH TOTAL		**84,097**	**14,258**	**14,398**	**139**

Older People services reflects a 2016/17 outturn cost pressure, whilst Learning Difficulties includes an additional high cost placement in 2017/18.

v. Other Programme (including Reserves)

Other Programme costs are £0.59m favourable to budget, largely due to recognition of two months of the CCG's uncommitted budget reserve £0.75m (full year £4.525m), offset by year to date unidentified CRES target of £0.19m.

	Category	Cost Centre	Annual Budget £'000	Year to date Budget £'000	Year to date Actual £'000	Variance £'000
PROGRAMME	OTHER	COMMISSIONING - NON ACUTE	10,883	1,814	1,814	0
PROGRAMME	OTHER	COMMISSIONING RESERVE	26,266	3,305	2,740	(565)
PROGRAMME	OTHER	COUNSELLING SERVICES	200	33	33	0
PROGRAMME	OTHER	NON RECURRENT PROGRAMMES	298	50	51	2
PROGRAMME	OTHER	NON RECURRENT RESERVE	3,912	0	0	0
PROGRAMME	OTHER	PATIENT TRANSPORT	10	2	6	4
PROGRAMME	OTHER	PROGRAMME PROJECTS	1,069	178	178	0
PROGRAMME	OTHER	REABLEMENT	0	0	0	0
PROGRAMME	OTHER	RECHARGES NHS PROPERTY SERVICES	5,795	966	966	0
PROGRAMME	OTHER	EXCEPTIONS & PRIOR APPROVALS	(38)	8	(11)	(18)
PROGRAMME	OTHER	SAFEGUARDING	1,056	176	176	(0)
PROGRAMME	OTHER	NHS 111	1,384	228	228	(1)
PROGRAMME	OTHER	QUALITY PREMIUM PROGRAMME	0	0	0	0
PROGRAMME	OTHER	CLINICAL LEADS	1,211	202	195	(7)
	OTHER TOTAL		**52,047**	**6,962**	**6,376**	**(585)**

All other earmarked Commissioning reserves have been accrued in full in line with Plan utilisation.

vi. Primary Care

Primary Care costs exceed year to date budget by £0.05m as detailed below.

	Category	Cost Centre	Annual Budget £'000	Year to date Budget £'000	Year to date Actual £'000	Variance £'000
PROGRAMME	PRIMARY CARE	CENTRAL DRUGS	65	11	11	(0)
PROGRAMME	PRIMARY CARE	COMMISSIONING SCHEMES	1,139	193	174	(19)
PROGRAMME	PRIMARY CARE	LOCAL ENHANCED SERVICES	13,974	3,017	3,017	0
PROGRAMME	PRIMARY CARE	OUT OF HOURS	4,663	777	778	0
PROGRAMME	PRIMARY CARE	RTF REVENUE	0	0	0	0
PROGRAMME	PRIMARY CARE	OXYGEN	870	145	145	0
PROGRAMME	PRIMARY CARE	PRESCRIBING	86,382	15,144	15,150	6
PROGRAMME	PRIMARY CARE	PRIMARY CARE IT	2,048	341	290	(51)
PROGRAMME	PRIMARY CARE	PRC DELEGATED CO-COMMISSIONING	72,547	12,033	12,145	112
	PRIMARY CARE TOTAL		**181,687**	**31,662**	**31,710**	**47**

Delegated co-commissioning reflects 2016/17 net outturn QoF pressures of £0.09m, together with increased Community Health Partnership rent increases of 3.2% for the year.

Primary Care IT reflects the full year recovery of VAT on the GP EMIS system. Commissioning Schemes staffing levels are currently below funded establishment. Prescribing reflects a small outturn pressure from 2016/17, with expenditure for 2017/18 accrued in line with plan pending the availability of current year data.

vii. Running Costs

Running costs are £0.18m favourable to plan at May, with staff in post below funded establishment. £0.5m full year efficiency has been built into the Corporate budget, profiled from Month 4 onwards.

	Category	Cost Centre	Annual Budget £'000	Year to date Budget £'000	Year to date Actual £'000	Variance £'000
ADMINISTRATION	CORPORATE	ADMINISTRATION & BUSINESS SUPPORT	1,028	175	161	(14)
ADMINISTRATION	CORPORATE	BUSINESS INFORMATICS	1,155	189	152	(37)
ADMINISTRATION	CORPORATE	CEO/ BOARD OFFICE	2,198	366	350	(17)
ADMINISTRATION	CORPORATE	COMMISSIONING	678	116	81	(35)
ADMINISTRATION	CORPORATE	COMMUNICATIONS & PR	250	36	30	(6)
ADMINISTRATION	CORPORATE	CONTRACT MANAGEMENT	1,644	266	249	(17)
ADMINISTRATION	CORPORATE	ESTATES AND FACILITIES	497	83	84	1
ADMINISTRATION	CORPORATE	FINANCE	1,018	169	155	(14)
ADMINISTRATION	CORPORATE	HUMAN RESOURCES	0	0	0	0
ADMINISTRATION	CORPORATE	INNOVATION FUND	0	0	0	0
ADMINISTRATION	CORPORATE	OPERATIONS MANAGEMENT	376	65	54	(11)
ADMINISTRATION	CORPORATE	STRATEGY & DEVELOPMENT	808	133	116	(17)
ADMINISTRATION	CORPORATE	CORPORATE COSTS & SERVICES	882	147	129	(18)
ADMINISTRATION	CORPORATE	GENERAL RESERVE - ADMIN	(500)	0	0	0
	RUNNING COSTS TOTAL		**10,035**	**1,746**	**1,562**	**(184)**

c) Forecast Outturn Position as at Month 2 (May)

The CCG is reporting an outturn position compliant with the 2017/18 Plan reflecting the delivery of business rules for the year.

The forecast outturn in the Table below reflects known 2016/17 outturn pressures, together with the full year impact of demand led pressures at the end of Month 02.

Financial outturn is contingent on delivery of the CCG's Cash Releasing Efficiency Savings (CRES) as set out in a supporting Month 02 CRES Committee paper.

2016/17 outturn cost pressures, together with 2017/18 demand led pressures are mitigated in the forecast outturn position through a £1.9m call on the £4.525m contingency reserve.

All other reserves are forecast to be utilised in accordance with planning assumptions.

	Annual Budget £000's	2017/18 Forecast Outturn £000's	Forecast Variance £000's
RESOURCE ALLOCATION	**(884,365)**	**(884,365)**	**0**
ACUTE	**419,236**	**419,882**	**646**
COMMUNITY HEALTH SERVICES	**88,830**	**88,918**	**88**
CONTINUING CARE	**31,969**	**32,396**	**427**
MENTAL HEALTH	**84,097**	**84,620**	**523**
OTHER PROGRAMME (INC RESERVES)	**52,047**	**50,152**	**(1,896)**
PRIMARY CARE	**181,687**	**181,886**	**199**
TOTAL PROGRAMME COSTS	**857,867**	**857,855**	**(12)**
TOTAL RUNNING COSTS	**10,035**	**10,047**	**12**
TOTAL EXPENDITURE	**867,902**	**867,902**	**0**
TOTAL	**(16,463)**	**(16,463)**	**0**

Key Variances and Exceptional Items

i. Acute Contracts

Acute contracts for 2017/18 are forecast in accordance with Acting As One. The £0.65m forecast variance reflects 2016/17 outturn pressures following receipt of performance data (eg. M12 SLAM data) which was not available when finalising the 2016/17 accounts.

Category	Cost centre	Annual Budget £'000	Forecast £'000	Forecast Variance £'000
ACUTE	ACUTE COMMISSIONING	415,731	416,377	646
ACUTE	COLLABORATIVE COMMISSIONING	0	0	0
ACUTE	END OF LIFE	0	0	0
ACUTE	HIGH COST DRUGS	264	264	0
ACUTE	NCAS/OATS	3,199	3,199	0
ACUTE	WINTER RESILIANCE	43	43	0
ACUTE TOTAL		**419,236**	**419,882**	**646**

Non-Contract Activity (NCA) and Out of Area Treatments (OATs) are forecast in line with plan due to the lack of in-year supporting information at Month 02.

ii. Community Health Contracts

Community Services outturn includes increased Podiatry AQP activity forecast for Wirral Community FT. Palliative Care reflects the costs of the Healthy Lung evaluation not incorporated in baseline planning assumptions.

Category	Cost centre	Annual Budget £'000	Forecast £'000	Forecast Variance £'000
COMMUNITY HEALTH SERVICES	COMMUNITY SERVICES	70,350	70,412	62
COMMUNITY HEALTH SERVICES	CARERS	302	302	0
COMMUNITY HEALTH SERVICES	HOSPICES	4,169	4,166	(3)
COMMUNITY HEALTH SERVICES	INTERMEDIATE CARE	10,911	10,911	0
COMMUNITY HEALTH SERVICES	LONG TERM CONDITIONS	3,001	3,001	0
COMMUNITY HEALTH SERVICES	PALLIATIVE CARE	97	126	29
COMMUNITY HEALTH SERVICES	WHEELCHAIR SERVICE	0	0	0
COMMUNITY HEALTH SERVICES TOTAL		**88,830**	**88,918**	**88**

iii. Continuing Care

Continuing Care forecast reflects an increase in demand led packages of care. A more in depth analysis of continuing care costs and associated risks is being developed for periodic inclusion in future finance reports.

Category	Cost centre	Annual Budget £'000	Forecast £'000	Forecast Variance £'000
CONTINUING CARE	CHC ADULT FULLY FUNDED	19,312	19,312	0
CONTINUING CARE	CHC ADULT JOINT FUNDED	3,127	3,127	0
CONTINUING CARE	CHC AD FULL FUND PERS HLTH BUD	988	1,243	254
CONTINUING CARE	CHC CHILDREN	2,922	3,102	180
CONTINUING CARE	CONTINUING HEALTHCARE ASSESSMENT & SUPPORT	366	358	(8)
CONTINUING CARE	FUNDED NURSING CARE	5,254	5,254	0
CONTINUING CARE TOTAL		**31,969**	**32,396**	**427**

iv. Mental Health Contracts

Learning Difficulties includes the full year effect of a new high cost placement in 2017/18. Commissioning staff are currently exploring an optimal solution that will also represent best value for money.

Mental Health Services – Other is forecasting a favourable variance against the MH Investment Standard.

Category	Cost centre	Annual Budget £'000	Forecast £'000	Forecast Variance £'000
MENTAL HEALTH	MENTAL HEALTH CONTRACTS	66,202	66,242	40
MENTAL HEALTH	CHILD AND ADOLESCENT MENTAL HEALTH	1,366	1,366	0
MENTAL HEALTH	DEMENTIA	75	76	0
MENTAL HEALTH	LEARNING DIFFICULTIES	4,713	5,259	546
MENTAL HEALTH	MENTAL CAPACITY ACT	116	116	0
MENTAL HEALTH	MENTAL HEALTH SERVICES - ADULTS	6,152	6,152	(0)
MENTAL HEALTH	MENTAL HEALTH SERVICES - ADVOCACY	91	91	0
MENTAL HEALTH	MENTAL HEALTH SERVICES - COLLABORATIVE COMMISSIONING	21	21	0
MENTAL HEALTH	MENTAL HEALTH SERVICES - NOT CONTRACTED ACTIVITY	202	207	5
MENTAL HEALTH	MENTAL HEALTH SERVICES - OLDER PEOPLE	4,105	4,143	38
MENTAL HEALTH	MENTAL HEALTH SERVICES - OTHER	1,054	947	(107)
MENTAL HEALTH TOTAL		**84,097**	**84,620**	**523**

v. Other Programme (including Reserves)

Other Programme costs are forecast in line with Plan. The favourable Commissioning Reserve forecast reflects that £1.9m of the CCG's full year £4.275m contingency, will need to be released to mitigate cost pressures identified at Month 2. All other reserves are forecast to be utilised as per plan.

Category	Cost centre	Annual Budget £'000	Forecast £'000	Forecast Variance £'000
OTHER	COMMISSIONING - NON ACUTE	10,883	10,883	0
OTHER	COMMISSIONING RESERVE	26,266	24,364	(1,902)
OTHER	COUNSELLING SERVICES	200	200	0
OTHER	NON RECURRENT PROGRAMMES	298	300	2
OTHER	NON RECURRENT RESERVE	3,912	3,912	0
OTHER	PATIENT TRANSPORT	10	15	5
OTHER	PROGRAMME PROJECTS	1,069	1,069	0
OTHER	REABLEMENT	0	0	0
OTHER	RECHARGES NHS PROPERTY SERVICES LTD	5,795	5,795	0
OTHER	EXCEPTIONS & PRIOR APPROVALS	(38)	(38)	0
OTHER	SAFEGUARDING	1,056	1,055	(0)
OTHER	NHS 111	1,384	1,384	0
OTHER	QUALITY PREMIUM PROGRAMME	0	0	0
OTHER	CLINICAL LEADS	1,211	1,211	0
OTHER TOTAL		**52,047**	**50,152**	**(1,896)**

vi. Primary Care

Primary Care is forecasting expenditure £0.20m above budget which includes Co-Commissioning 2016/17 net outturn QoF pressures of

£0.09m and additional 2017/18 rent costs of £0.15m following a 3.2% rent increase for Community Health Partnership premises.

Category	Cost centre	Annual Budget £'000	Forecast £'000	Forecast Variance £'000
PRIMARY CARE	CENTRAL DRUGS	65	65	0
PRIMARY CARE	COMMISSIONING SCHEMES	1,139	1,100	(39)
PRIMARY CARE	LOCAL ENHANCED SERVICES	13,974	13,974	0
PRIMARY CARE	OUT OF HOURS	4,663	4,722	59
PRIMARY CARE	PCTF REVENUE	0	0	0
PRIMARY CARE	OXYGEN	870	870	0
PRIMARY CARE	PRESCRIBING	86,382	86,382	0
PRIMARY CARE	PRIMARY CARE IT	2,048	1,986	(62)
PRIMARY CARE	PRC DELEGATED CO-COMMISSIONING	72,547	72,787	240
PRIMARY CARE TOTAL		**181,687**	**181,886**	**199**

vii. Running Costs

Individual costs centres are forecast to underspend against baseline staffing establishment. Further efficiency savings of £0.247m are required in year to deliver the full £0.5m cash releasing efficiency savings (CRES) as reflected in the Admin General Reserve. Delivery against planned savings will be reported through a separate detailed CRES paper.

Category	Cost centre	Annual Budget £'000	Forecast £'000	Forecast Variance £'000
RUNNING COSTS	ADMINISTRATION & BUSINESS SUPPORT	1,028	1,009	(19)
RUNNING COSTS	BUSINESS INFORMATICS	1,155	1,028	(127)
RUNNING COSTS	CEO/ BOARD OFFICE	2,198	2,152	(46)
RUNNING COSTS	COMMISSIONING	678	663	(16)
RUNNING COSTS	COMMUNICATIONS & PR	250	240	(10)
RUNNING COSTS	CONTRACT MANAGEMENT	1,644	1,643	(0)
RUNNING COSTS	ESTATES AND FACILITIES	497	497	
RUNNING COSTS	FINANCE	1,018	1,015	(3)
RUNNING COSTS	OPERATIONS MANAGEMENT	376	373	(3)
RUNNING COSTS	STRATEGY & DEVELOPMENT	808	798	(10)
RUNNING COSTS	CORPORATE COSTS & SERVICES	882	876	(5)
RUNNING COSTS	GENERAL RESERVE - ADMIN	(500)	(247)	253
RUNNING COSTS TOTAL		**10,035**	**10,047**	**12**

d) RISKS

Delivery of the CCG's planned outturn position and achievement of Business Rules is subject to the appropriate proactive management of risks, including:

i. Demand Led Expenditure, which is subject to fluctuation, including CCG responsibilities regarding Section 117, Complex Needs and Mental Health Rehabilitation costs. An agreed approach to risk sharing for joint packages of care is required as part of the revised Section 75 agreement with Liverpool City Council.

ii. Cash Releasing Efficiency Savings (CRES)

- CRES of £25.2m was assumed in the CCG's Financial Planning assumptions in order to deliver NHS England Business Planning Rules for the 2017-18 financial year.

- The financial plan approved by the governing body in April 2017 identified a programme of cash releasing efficiency savings totalling £23.6m leaving an unidentified gap of £1.55m.

- Further amendments made to planning assumptions resulted in a revised CRES target of £26.18m for the 2017/18 financial year, supported by the development of a CRES Tracking tool in order to monitor both financial and non-financial aspects of implementation.

- Given that CRES realisation is critical to the delivery of Business Planning Rules, monitoring arrangements will continue to be enhanced during quarter one.

- Monthly meetings will take place with SMT leads and Programme leads in order to ensure accurate and up to date information is included in CRES reports.

- Reporting of CRES performance will take place through the Finance, Procurement and Contracting Committee with oversight from the Financial Recovery and Oversight Group.

A high level summary of risks and oversight of CRES performance will be incorporated in the monthly Finance Update reports.

6. STATEMENT OF FINANCIAL POSITION

A statement of financial position (e.g. Balance Sheet) for the CCG will be included within the quarter one update to the CCG Governing Body. The two key elements alongside respective payables / recievables below are as per below.

Cash Target

The target for the month of May 2017 was achieved with a cashbook balance of £15,294 at the end of the month. The target for the CCG is a cash holding of less than 1.25% of the monthly drawdown which for May equates to £793,750.

Better Payment Practice Code

Under the Better Payments Practice Code (BPPC), CCG's are expected to pay 95% of all creditors within 30 days of the receipt of valid invoices.

BPPC - April 2017 to May 2017						
	Total Number of Invoice Paid	Total Paid within Target	%age	Total Value of Invoices Paid £'000	Value Paid Within Target £'000	%age
NHS	460	458	100%	94,164,782	94,150,395	100%
NON NHS	2,024	1,923	95%	44,340,047	43,999,324	99%

The May 2017 year to date figures show that the CCG is currently compliant with all BPPC targets.

It should be noted that the volume of Non-NHS invoices processed in compliance with the BPPC code during May totalled 92.5% which was below target for the month. This was as a consequence of the introduction by CSU of the new ADAM system, which is now being used for the authorisation of Continuing Health Care invoices. The introduction of ADAM and downtime whilst records were migrated across to the new system has resulted in a backlog of invoices which Finance are looking to clear through focused resources during June. It is probable that June's Non-NHS BPPC performance by volume will also fall below target as the backlog of invoices are processed, before returning to normal performance levels in July.

The CCG continues to forecast compliance with the 95% BPPC target in the full year.

7. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers)

7.1 Does this require public engagement or has public engagement been carried out?

Not Applicable

7.2 Does the public sector equality duty apply?

Not Applicable

7.3 Explain how you have/will maximise social value in the proposal: describe the impact on each of the following areas showing how this is constructed to achieve the most:
Economic /Social / Environmental wellbeing

Not Applicable

7.4 Taking the above into account, describe the impact on improving health outcomes and reducing inequalities

Not Applicable

8. DESCRIBE HOW THIS PROMOTES FINANCIAL SUSTAINABILITY

Supports the achievement of Statutory Financial Duties.

9. CONCLUSION

The purpose of this report is to provide the Governing Body with an update on the CCG's financial performance against its planned surplus and elements of business planning rules for 2017/18.

Tom Jackson
Chief Finance Officer
4th July 2017

Appendix One – Year to Date Budget Performance as at May 2017

Type	Category	Description	Annual Budget (£)	Year to Date (£)			Forecast (£)	
				Budget	Actual	Variance	Outturn	Variance
ALLOCATIONS	CONFIRMED	CONFIRMED	-884,365,000	-147,394,165	-147,394,165	0	-884,365,000	0
ALLOCATIONS	POTENTIAL	POTENTIAL	0	0	0	0	0	0
ALLOCATIONS	**ALLOCATIONS**		**-884,365,000**	**-147,394,165**	**-147,394,165**	**0**	**-884,365,000**	**0**
PROGRAMME	ACUTE	ACUTE COMMISSIONING	415,730,806	69,288,452	69,934,354	645,902	416,376,908	646,102
PROGRAMME	ACUTE	NCAS/OATS	3,199,446	533,240	533,240	0	3,199,446	0
PROGRAMME	ACUTE	END OF LIFE	0	0	0	0	0	0
PROGRAMME	ACUTE	COLLABORATIVE COMMISSIONING	0	0	0	0	0	0
PROGRAMME	ACUTE	HIGH COST DRUGS	263,544	43,906	43,908	2	263,544	0
PROGRAMME	ACUTE	Winter Resilience	42,500	7,082	7,082	0	42,500	0
	ACUTE TOTAL		**419,236,296**	**69,872,680**	**70,518,584**	**645,904**	**419,882,398**	**646,102**
PROGRAMME	COMMUNITY HEALTH SERVICES	COMMUNITY SERVICES	70,349,922	11,724,981	11,730,618	5,637	70,412,166	62,244
PROGRAMME	COMMUNITY HEALTH SERVICES	INTERMEDIATE CARE	10,910,638	1,934,007	1,934,352	345	10,910,980	342
PROGRAMME	COMMUNITY HEALTH SERVICES	PALLIATIVE CARE	96,736	35,420	36,455	1,035	125,745	29,009
PROGRAMME	COMMUNITY HEALTH SERVICES	CARERS	302,051	50,340	50,342	2	302,051	0
PROGRAMME	COMMUNITY HEALTH SERVICES	HOSPICES	4,169,467	577,068	623,588	46,520	4,165,985	-3,482
PROGRAMME	COMMUNITY HEALTH SERVICES	LONG TERM CONDITIONS	3,001,144	499,762	499,046	-716	3,001,144	0
	COMMUNITY HEALTH SERVICES TOTAL		**88,829,958**	**14,821,578**	**14,874,401**	**52,823**	**88,918,071**	**88,113**
PROGRAMME	CONTINUING CARE	FUNDED NURSING CARE	5,254,482	875,744	827,321	-48,423	5,254,482	0
PROGRAMME	CONTINUING CARE	CHC ADULT FULLY FUNDED	19,311,895	3,218,646	3,218,649	3	19,311,895	0
PROGRAMME	CONTINUING CARE	CHC CHILDREN	0	0	0	0	0	0
PROGRAMME	CONTINUING CARE	Children's Continuing Care	2,922,187	487,016	667,274	180,258	3,102,430	180,243
PROGRAMME	CONTINUING CARE	CHC AD FULL FUND PERS HLTH BUD	988,450	164,741	207,095	42,354	1,242,571	254,121
PROGRAMME	CONTINUING CARE	CONTINUING HEALTHCARE ASSESSMENT & SUPPORT	365,514	60,918	59,666	-1,252	357,990	-7,524
PROGRAMME	CONTINUING CARE	ADULT JOINT FUNDED CONTINUING CARE	3,126,833	521,132	521,132	0	3,126,833	0
PROGRAMME	CONTINUING CARE	CHC ADULT JOINT FUNDED	0	0	0	0	0	0
	CONTINUING CARE TOTAL		**31,969,361**	**5,328,197**	**5,501,137**	**172,940**	**32,396,201**	**426,840**
PROGRAMME	MENTAL HEALTH	CHILD AND ADOLESCENT MENTAL HEALTH	1,365,900	367,808	368,103	295	1,365,900	0

PROGRAMME	MENTAL HEALTH	LEARNING DIFFICULTIES	4,712,670	785,427	884,351	98,924	5,258,545	545,875
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - OTHER	1,053,894	201,624	183,839	-17,785	947,167	-106,727
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH CONTRACTS	66,202,120	11,033,682	11,045,402	11,720	66,242,120	40,000
PROGRAMME	MENTAL HEALTH	DEMENTIA	75,398	43,497	43,810	313	75,711	313
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - ADVOCACY	90,686	30,228	30,199	-29	90,686	0
PROGRAMME	MENTAL HEALTH	MENTAL CAPACITY ACT	116,000	19,332	19,333	1	116,000	0
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - COLLABORATIVE COMMISSIONING	21,250	14,209	14,167	-42	21,250	0
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - NOT CONTRACTED ACTIVITY	201,640	33,600	39,099	5,499	207,135	5,495
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - ADULTS	6,152,426	1,044,846	1,044,900	54	6,152,320	-106
PROGRAMME	MENTAL HEALTH	MENTAL HEALTH SERVICES - OLDER PEOPLE	4,105,243	684,202	724,350	40,148	4,143,478	38,235
	MENTAL HEALTH TOTAL		**84,097,227**	**14,258,455**	**14,397,552**	**139,097**	**84,620,312**	**523,085**
PROGRAMME	OTHER	EXCEPTIONS & PRIOR APPROVALS	-37,692	7,802	-10,610	-18,412	-37,692	0
PROGRAMME	OTHER	COMMISSIONING - NON ACUTE	10,883,411	1,813,894	1,813,899	5	10,883,411	0
PROGRAMME	OTHER	REABLEMENT	0	0	0	0	0	0
PROGRAMME	OTHER	NHS 111	1,384,191	228,496	227,903	-593	1,384,191	0
PROGRAMME	OTHER	PATIENT TRANSPORT	10,000	1,666	5,658	3,992	14,971	4,971
PROGRAMME	OTHER	RECHARGES NHS PROPERTY SERVICES LTD	5,795,000	965,832	965,832	0	5,795,000	0
PROGRAMME	OTHER	QUALITY PREMIUM PROGRAMME	0	0	0	0	0	0
PROGRAMME	OTHER	SAFEGUARDING	1,055,520	175,912	175,888	-24	1,055,118	-402
PROGRAMME	OTHER	CLINICAL LEADS	1,211,322	201,884	194,636	-7,248	1,211,322	0
PROGRAMME	OTHER	PROGRAMME PROJECTS	1,069,407	178,232	178,235	3	1,069,407	0
PROGRAMME	OTHER	COUNSELLING SERVICES	200,000	33,332	33,332	0	200,000	0
PROGRAMME	OTHER	NON RECURRENT PROGRAMMES	297,790	49,628	51,486	1,858	299,644	1,854
		NON RECURRENT RESERVE	3,912,000	0	0	0	3,912,000	0
PROGRAMME	OTHER	COMMISSIONING RESERVE	26,266,372	3,304,840	2,740,231	-564,609	24,364,380	-1,901,992
	OTHER TOTAL		**52,047,321**	**6,961,518**	**6,376,489**	**-585,029**	**50,151,753**	**-1,895,568**
PROGRAMME	PRIMARY CARE	PRC DELEGATED CO-COMMISSIONING	72,547,000	12,032,874	12,144,539	111,665	72,787,320	240,320
PROGRAMME	PRIMARY CARE	PRESCRIBING	86,381,974	15,144,162	15,149,864	5,702	86,381,974	0
PROGRAMME	PRIMARY CARE	OUT OF HOURS	4,663,305	777,212	777,578	366	4,722,452	59,147
PROGRAMME	PRIMARY CARE	OXYGEN	869,716	144,950	145,033	83	869,716	0

PROGRAMME	PRIMARY CARE	CENTRAL DRUGS	64,632	10,772	10,715	-57	64,632	0
PROGRAMME	PRIMARY CARE	PRIMARY CARE IT	2,047,960	341,316	290,254	-51,062	1,986,274	-61,686
PROGRAMME	PRIMARY CARE	COMMISSIONING SCHEMES	1,138,916	193,454	174,227	-19,227	1,100,163	-38,753
PROGRAMME	PRIMARY CARE	LOCAL ENHANCED SERVICES	13,973,540	3,017,485	3,017,486	1	13,973,540	0
	PRIMARY CARE TOTAL		**181,687,043**	**31,662,225**	**31,709,696**	**47,471**	**181,886,071**	**199,028**
ADMIN	CORPORATE	ESTATES AND FACILITIES	496,900	82,816	83,749	933	496,900	0
ADMIN	CORPORATE	INNOVATION FUND	0	0	0	0	0	0
ADMIN	CORPORATE	OPERATIONS MANAGEMENT	376,254	65,288	54,026	-11,262	372,920	-3,334
ADMIN	CORPORATE	COMMISSIONING	678,366	115,788	81,094	-34,694	662,551	-15,815
ADMIN	CORPORATE	COMMUNICATIONS & PR	250,269	36,322	29,943	-6,379	239,867	-10,402
ADMIN	CORPORATE	STRATEGY & DEVELOPMENT	807,965	133,476	116,481	-16,995	797,525	-10,440
ADMIN	CORPORATE	FINANCE	1,017,955	168,988	154,886	-14,102	1,015,231	-2,724
ADMIN	CORPORATE	ADMINISTRATION & BUSINESS SUPPORT	1,028,360	174,890	161,327	-13,563	1,009,404	-18,956
ADMIN	CORPORATE	CEO/ BOARD OFFICE	2,197,970	366,311	349,548	-16,763	2,151,851	-46,119
ADMIN	CORPORATE	CONTRACT MANAGEMENT	1,643,740	265,994	249,450	-16,544	1,643,395	-345
ADMIN	CORPORATE	BUSINESS INFORMATICS	1,155,425	188,894	152,175	-36,719	1,028,458	-126,967
ADMIN	CORPORATE	CORPORATE COSTS & SERVICES	881,590	146,912	128,868	-18,044	876,498	-5,092
ADMIN	CORPORATE	GENERAL RESERVE - ADMIN	-500,000	0	0	0	-247,406	252,594
	CORPORATE TOTAL		**10,034,794**	**1,745,679**	**1,561,547**	**-184,132**	**10,047,194**	**12,400**
I+E Position			**867,902,000**	**144,650,332**	**144,939,406**	**289,074**	**867,902,000**	**0**
		Month 2 position	**-16,463,000**	**-2,743,833**	**-2,454,759**	**289,074**	**-16,463,000**	**0**

NHS
Liverpool
Clinical Commissioning Group

Report no: GB 49-17

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
GOVERNING BODY

TUESDAY 11th JULY 2017

Title of Report	CCG Corporate Performance Report July 2017
Lead Governor	Dr Nadim Fazlani
Senior Management Team Lead	Ian Davies, Chief Operating Officer
Report Author	Stephen Hendry, Senior Operations and Governance Manager
Summary	The purpose of this paper is to report to the Governing Body the areas of the CCG's performance in terms of its delivery of key NHS Constitutional measures, quality standards/performance and financial targets for April 2017 and May 2017.
Recommendation	That Liverpool CCG Governing Body: ➢ Notes the performance of the CCG in the delivery of key national performance indicators for the period and the recovery actions taken to improve performance; ➢ Determines if the levels of assurances given are adequate in terms of mitigating actions, particularly where risks to CCG strategic objectives are highlighted.
Relevant standards/targets	The NHS Constitution; CCG Improvement and Assessment Framework 2017/18; Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21; NHS England/NHS Improvement "Strengthening Financial Performance & Accountability in 2016/17"

CCG CORPORATE PERFORMANCE REPORT (JULY 2017)

1. PURPOSE

The purpose of this paper is to report to the Governing Body the areas of the CCG's performance in terms of its delivery against key NHS Constitutional measures, NHS Planning Guidance, quality standards/performance and targets for May 2017 and June 2017.

2. RECOMMENDATIONS

That Liverpool CCG Governing Body:

- Notes the performance of the CCG in the delivery of key national performance indicators for the period and the recovery actions taken to improve performance;
- Determines if the levels of assurances given are adequate in terms of mitigating actions, particularly where risks to CCG strategic objectives are highlighted.

3. BACKGROUND

The CCG is held to account by NHS England for performance against delivery of key indicators as defined in the CCG Improvement and Assessment Framework (CCG IAF), which requires the CCG to focus on maintaining and improving performance against the measures in the four domains of:

- **Better Health** (how the CCG is contributing towards improving the health and wellbeing of its population and 'bending' the demand curve);
- **Better Care** (care redesign, performance of constitutional standards and outcomes);
- **Sustainability** (how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends);
- **Leadership** (assesses the quality of the CCG's leadership, the quality of its plans, how the CCG works with its partners and the governance arrangements in place to ensure it acts with probity).

Ultimately, the CCG has to be assured that the services we commission are delivering the required NHS Constitutional and quality standards and

meeting local system priorities. This is largely achieved through the now well established governance frameworks and committee structures in place which monitor performance and provide assurances to the Governing Body that key risks to strategic objectives and operational delivery continue to be effectively managed.

The Corporate Performance Report will continue to evolve in both format and content during 2017/18 with the aim of aligning reporting requirements and measurements with the Local Delivery System (LDS) footprint and providing critical benchmarking data against our 'Core City' and 'NHS RightCare' peers.

Headline commentary is provided below to draw the Governing Body's attention to specific areas of performance, some of which represent risks to delivery, and to the relevant assurances on internal control measures in place to mitigate those risks. Due to the timing of certain data schedules this report updates the Governing Body with a combination of performance data from April 2017 (month 1) and May 2017.

4. BETTER CARE DOMAIN - NHS CONSTITUTIONAL MEASURES

NHS Liverpool CCG is committed to ensuring that performance against constitutional measures and outcomes is consistently and rigorously maintained. It should be noted that not all of the indicators within the 'Better Care domain' are reflected in the Corporate Performance Report.

4.1 Elective Access & Waiting Times

Achievement of 'recovery milestones' for access standards remains a priority for 2017/18. Standards relating to A&E and ambulance waits, referral to treatment, 62-day cancer waits (including securing adequate diagnostic capacity) along with mental health access standards account for four of the nine National 'must dos' which every local system is expected to achieve for the financial year.

4.1.1 Good Performance – 52 week waits

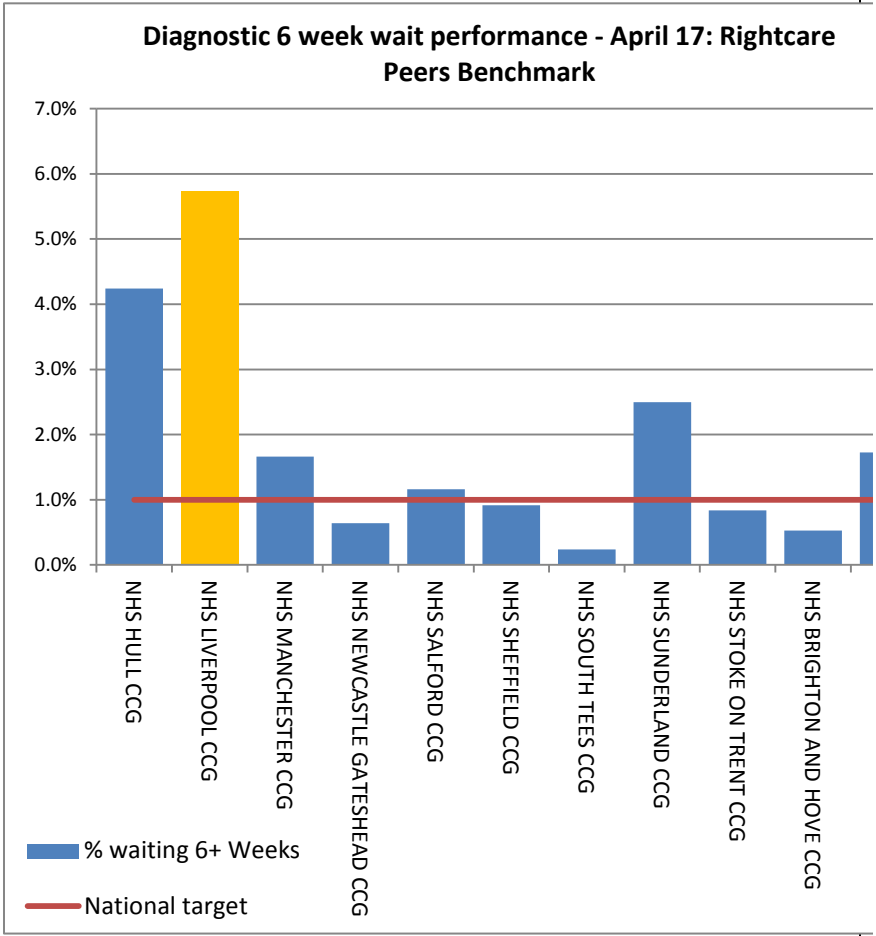
Indicator	Narrative
Referral to Treatment Incomplete pathway (52 Weeks) ***GREEN***  ***TREND*** 	**Number of 52-week Referral to Treatment Pathways** ***Mandate: no-one waits more than 52 weeks to receive treatment from the date of referral*** There were **0 (zero)** Liverpool CCG patients reported to be waiting over 52 weeks in May 2017. At provider catchment data, the latest published data available is for April 2017. There were 0 (zero) 52 week waiters reported at Liverpool providers during April 2017

4.1.2 Areas for Improvement – Diagnostic 6 week waits

Indicator	Narrative
Diagnostics - % patients waiting 6 weeks or more for a diagnostic test ***RED***  ***TREND*** 	***Mandate: no-one waits more than 6 weeks for a diagnostic test from the date of referral*** Liverpool CCG failed the 1% standard for May 2017 with performance at **7.89%.** This is a further decline in performance on the April 2017 position of **5.73%** As at May 2017, there were 707 patients **waiting over 6 weeks** (**65** of this cohort were waiting in excess of **13 weeks**). Analysis of the provider level performance against the standard for May 2017 show that the majority of breaches are again at the **Royal Liverpool Hospital** (the Trust reported 642 out of the Liverpool CCG overall total of 707). Issues continue to be predominantly in endoscopy, with 575 patients currently waiting over 6 weeks (59 patients waiting over 13 weeks). An increasing number of breaches (67) are now also occurring in MRI and CT due to an increased demand for imaging. Breaches of the standard also occurred at Aintree, with 59 Liverpool CCG patients waiting over 6 weeks in May 2017 (the Trust is also experiencing similar issues with endoscopy). Liverpool CCG's year-to-date performance for 2017/18

currently stands at 6.86%, significantly in excess of the 1% target.
Comparing April 2017 diagnostic performance (5.7%) against our RightCare peers**,** Liverpool CCG was ranked 11th out of 11 similar CCGs. The 'peer median' performance was 1.2% with the best performing CCG achieving 0.2% and the worst 5.7%.

Nationally the performance for April 2017 was reported to be 1.8%



The latest published data for provider catchment level is for April 2017 and can be summarised as follows:

- **The Royal Liverpool Hospital** failed to achieve 1% standard in April 2017 with performance at **10.9%.** This is a further decline in performance on the previous month. In total, **568** patients waited longer than the standard (**20** of these patients were waiting over 13 weeks). Capacity issues in endoscopy (particularly relating to colonoscopies and gastroscopies) are the main challenges in terms of the Trust's sustained achievement of the diagnostics target.

	• **Aintree** also failed to achieve the 1% standard in April 2017 with performance at **1.6%**. In total there were 79 patients who waited longer than the 6-week standard with all breaches occurring in endoscopy and imaging. All other Liverpool Providers achieved the standard in April 2017

Assurance on CCG Control Measures

The capacity and demand modelling report commissioned by the Royal Liverpool is yet be shared, although 'specialty specific' actions plans have been developed from this and the CCG will be supporting the Royal Liverpool to deliver. A performance oversight group has been established internally at the Royal to oversee the action plans, the CCG has requested representation on this group to inform ongoing collaborative projects. Specific actions for recovery include:

- **Gastro**- the dyspepsia pathway was launched across Liverpool general practices and a Gastro consultant is attending each of the locality meetings. Further work is ongoing to redesign pathways to influence referrals and endoscopy rates. The specialty has been identified as an early implementer for Advice and Guidance.

The CCG is undertaking a thorough review of diagnostic and RTT 18 weeks performance to assess the underlying performance issues and to explore what further action can be taken in 2017/18 to improve service delivery to patients and reduce both the numbers waiting and waiting times. Updates from this work will be provided in future performance reports.

4.1.3 Areas for Improvement - Referral to Treatment Incomplete pathway (18 Weeks)

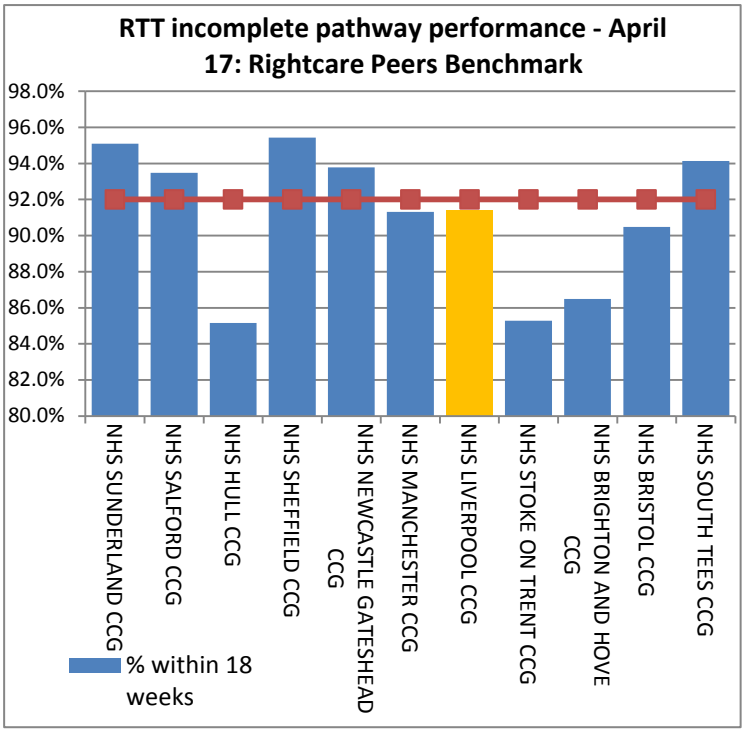
Indicator	Narrative
Referral to Treatment Incomplete pathway (18 Weeks) ***RED***  ***TREND*** 	The 2017/18 Planning Guidance includes a commitment to improve on and maintain the NHS Constitutional Standard which stipulates that over 92% of patients on non-emergency pathways do not wait in excess of 18 weeks from referral to treatment (including patient choice). Performance as at May 2017 remains below the 92 % standard at **91.2**% and as such gives the CCG an overall 'red' rating against this key constitutional measure. This is a slight decline in performance on April's position of 91.4%. As at May 2017 there were **29,896** 'active' waiters, **2,619** patients waiting **over 18 weeks** with **151** of this cohort waiting over **36 weeks.** Specialties with the

largest volumes of long waiters (+18 weeks) were **General Surgery (483), T&O (436) and Ophthalmology (354)**
Data for May 2017 shows that the total waiting list has increased on April 2017 going from 29,465 to 29,896. However, it is remains substantially lower than May 2016 which reported a total of 32,142 "active waiters"

Comparing April 2017 incomplete pathway performance (91.4%) against our RightCare peers, Liverpool CCG was ranked 6th out of 11 similar CCGs. The peer median performance was 91.4% (matching Liverpool CCG's performance). The best performing CCG achieved 95.4% with the worst performing at 85.2%.

Nationally the performance for April 2017 was reported to be 89.9%.

The chart below provides a breakdown of RTT incomplete pathway performance (April 2017) against "RightCare" peers.



The latest published data for provider catchment level is for April 2017 and can be summarised as follows:

The Royal Liverpool Hospital failed to achieve 92% standard in April 2017 with performance at **88.8**% which is a slight improvement on March 2017

	performance of 88.4%. This equates to 3040 patients waiting over 18 weeks for treatment. There are currently 6 specialties that are failing the standard. The poorest performing specialties are Urology (85.4%), General Surgery (83.6%) and T&O, (81.9%) The Royal Liverpool is currently one of two providers across Cheshire and Merseyside who are failing this standard. The issues affecting the provider's performance are as reported in the last six months. The provider has also reported a significant decline in performance in Dermatology and Allergy. Dermatology is particularly pressured due to neighbouring providers closing or significantly reducing their service. All other Liverpool Providers achieved the 92% standard in April 2017.

Assurance on CCG Control Measures

Capacity and demand report commissioned by the Royal Liverpool is due to be shared with CCG colleagues. Specialty specific actions plans have been developed from this report and the CCG will be supporting the Trust to deliver. Advice & Guidance is expected to be implemented in some specialties ahead of national targets to assist demand management.

The Referral Assessment Service (RAS) functionality to improve triage processes for complex areas has unfortunately been delayed from an anticipated launch in September 2017 to February 2018. This will inevitably impact on the transformation programme.

- **Dermatology** – alternative IT solutions have been explored as a result of the on-going functionality issues within EMIS. A demonstration of this to the Trust's clinical team is scheduled and timescales for 'go live' will then be confirmed. Referral rates into 2ww clinics remain a challenge due to neighbouring providers' capacity reduction. Communication has been sent to primary care to assist referral management and the same information has been communicated to neighbouring CCGs for dissemination;
- **Ophthalmology**- development of an SLA is well underway with the Royal Liverpool to move post-operative cataract follow ups into the community. A provisional start date of 1st September 2017 has been identified.
- **Trauma & Orthopaedics**- limb reconstruction services remains challenged due to a reduction in consultant capacity, with work being covered by additional PA sessions internally. A contract to outsource non-complex orthopaedics to Spire is currently being signed off.

The CCG is undertaking a thorough review of diagnostic and RTT 18 weeks performance to assess the underlying performance issues and to explore what further action can be taken in 2017/18 to improve service delivery to patients and reduce both the numbers waiting and waiting times. Updates from this work will be provided in future performance reports.

4.1.2 Areas for Improvement – NHS e-Referral Service

Indicator	Narrative
NHS e-Referral Service (e-RS): Utilisation Coverage % of referrals for a 1st Outpatient appointment that are made using the NHS e-RS RED  TREND 	The national ambition is that E-referral utilisation coverage should be 80% by the end of Quarter 2 2017/18 and 100% by the end of Q2 2018/19. Liverpool CCG's trajectory is to achieve 80% by the end of Q4 2017/18 as this is considered more realistic based on current performance levels. This has been signed off by NHSE as part of the 2017-19 operational plans The latest published e-referral utilisation data for Liverpool CCG is for **April 2017** and reports performance to be **56.5%.** Utilisation has consistently been reported at this level throughout 2016/17 with little improvement in performance being demonstrated. Performance for Liverpool CCG is now slightly lower than the national position which for April 2017 was reported to be 57%. Previously, the CCG has consistently been above the national average throughout 2015/16 and for the most part of 2016/17.
Assurance on CCG control measures As previously reported there are capacity issues within local trusts which have caused an increase in ASIs (appointment slot issues) and negatively impacting on the CCG's utilisation figures. Despite providers reviewing DOS (Directory of Services), demand management hasn't been carried out effectively across the system and capacity is an ongoing issue. As long as providers continue to book ASIs (Appointment Slot Issues) outside of the e-RS system the CCG's position will remain the same. However, national CQUINs have been introduced which will form the basis of closer collaboration between the CCG's Quality team, CCG commissioning leads, NHS Digital and local providers to resolve this long-standing issue. Providers were required to submit their trajectory plans at the end of June 2017 for inclusion in contracts beginning of July 2017. Although there is a significant amount of work to be done in terms of mapping services to e-RS and implementing Advice & Guidance, there are reasonable expectations that this collaborative working will yield a vast improvement over the coming months.	

4.2 Cancer Waiting Times

4.2.1 Good Performance – 8 out the 9 Cancer Waiting Time Standards

Indicator	Narrative
Cancer Waiting Times GREEN  TREND 	In April 2017, the CCG achieved 8 out of the 9 of cancer standards and performance remains positive, with achievement in month and YTD  **% Patients seen within two weeks for an urgent GP referral for suspected cancer** - Liverpool CCG

	achieved 95.7% against a target of 93%  **% of patients receiving definitive treatment within 1 month of a cancer diagnosis** - Liverpool CCG achieved 97.7% against a target of 96%  **% of patients receiving subsequent treatment for cancer within 31 days (Surgery)** - Liverpool CCG achieved 100% against a target of 94%  **% of patients receiving subsequent treatment for cancer within 31 days (drug treatment)** - Liverpool CCG achieved 98.6% against a target of 98%.  **% of patients receiving subsequent treatment for cancer within 31 days (radiotherapy treatment)** - Liverpool CCG achieved 98.4% against a target of 94%.  **% of patients receiving 1st definitive treatment for cancer within 62 days** - Liverpool CCG achieved 88.6% against a target of 85%. At provider catchment level, a number of providers failed to meet the standard in April 2017: • **Aintree** failed to meet the standard again in April 2017 with performance at **82.5%**. Trust performance against the measure continues to be affected by the urology biopsy equipment failure which occurred in December 2016 (and failed again following repair). Although this has now been resolved The trust is exploring how it might share capacity e.g. with the Royal to mitigate against future issues. Liverpool CCG continue to engage with South Sefton CCG colleagues to establish a recovery date; • **Clatterbridge Centre for Oncology** also failed to meet the standard with performance at 67.91% in April 2017.  **% of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service** - Liverpool CCG achieved 92.9% against a target of 90%. At provider catchment level, **Aintree** and **Clatterbridge** both failed the standard in April 2017 with performance at 83.3% and 66.7% respectively.

	% of patients receiving treatment for cancer within 62 days upgrade their priority - Liverpool CCG achieved 100% against a local target of 85%. At provider catchment level, **Liverpool Heart and Chest** and **Clatterbridge** failed the local standard with performance at 75% and 78.9% respectively.

Assurance on CCG control measures

Cancer 62 day waiting times performance is a high priority, as a 'must do' for the NHS. Liverpool CCG works directly with providers (including primary care) and partners (NHS England teams, Cheshire & Merseyside Cancer Alliance) to identify and tackle issues which impact on cancer performance, specifically:

- A CQUIN focussed on 62-day performance during 2016/17 has resulted in improved breach analysis and understanding of the issues in specific Trusts and pathways;
- Trust plans are in place in all areas which experience breach issues. Plans are regularly discussed with Trusts via established contract and cancer meetings;
- Region wide plans are in place to deliver short term improvements in areas amenable. These are monitored on a regular basis;
- Liverpool CCG is part of a Cheshire & Merseyside wide transformation plan for the early diagnosis of cancer, aiming to improve patient pathways, and deliver long term improvements in 62-day performance.

4.2.2 Areas for Improvement – Cancer Waiting Times (One Standard)

Indicator	Narrative
Cancer Waiting Times ***RED***  ***TREND*** 	**% of patients seen within 2 weeks for an urgent referral for breast symptoms** Liverpool CCG achieved 92.7%, marginally missing the target of 93%. This equates to one patient breach. All Merseyside providers met this target during April 2017, and Liverpool CCG's performance is regarded as a 'statistical anomaly' due to the small numbers involved.

Assurance on CCG control measures

Performance against this indicator will be monitored to determine if there is any risk of a deteriorating trend.

4.3 Urgent & Emergency Care

4.3.1 Areas for Improvement: Ambulance response times

Indicator	Narrative
Ambulance Response Times ***AMBER***  ***TREND*** 	Response performance in May 2017 has shown some deterioration, reflecting the increased demand seen with red activity +3.7% above plan (although overall activity overall was -2.1% against plan). Although performance still remains challenged in Liverpool, it was significantly better than the overall NWAS north west position **MAY 2017:** • **Red 1: 8-minute response** 72.49% against 75% target (remains above North West performance of 65.92%); • **Red 2: 8-minute response** 71.19% against 75% target (remains above North West performance of 64.43%); • **All Reds: 19-minute response** 91.56% against 95% target (remains above North West performance of 90.08%) The service continues to make progress in reducing conveyance to hospital, with the following May performance seen in Liverpool: • 'Hear & Treat' is at 12.31%; • 'See & Treat' at 22.08% and • 'See & Convey' at 65.61% of incidents
Assurance on CCG control measures The start of 2017/18 has shown volatility in performance in the city across all three national response targets, although it is too early to assess if this trend will continue. Demand across the North West for the emergency ambulance service continues to fluctuate, with May seeing a reduction in overall incidents, although Red activity overall was up 1.9%. The actual distance from the national targets for performance in the city, i.e. the time after the national targets at which they are met is as follows. In May 2017 we saw the following performance 'tails' (April 2017 comparative figures in brackets) Red 1 in May was met at 8mins 15secs (8mins 15secs); Red 2 at 8mins 50secs (7mins 35secs); and all Reds A19 at 29mins (20mins 15secs). The length of these performance 'tails' are closely monitored to assess the impact of any worsening performance, which in May reflected the increased Red demand.	

4.3.2 Areas for Improvement: Percentage of patients admitted, transferred or discharged from A&E within 4 hours

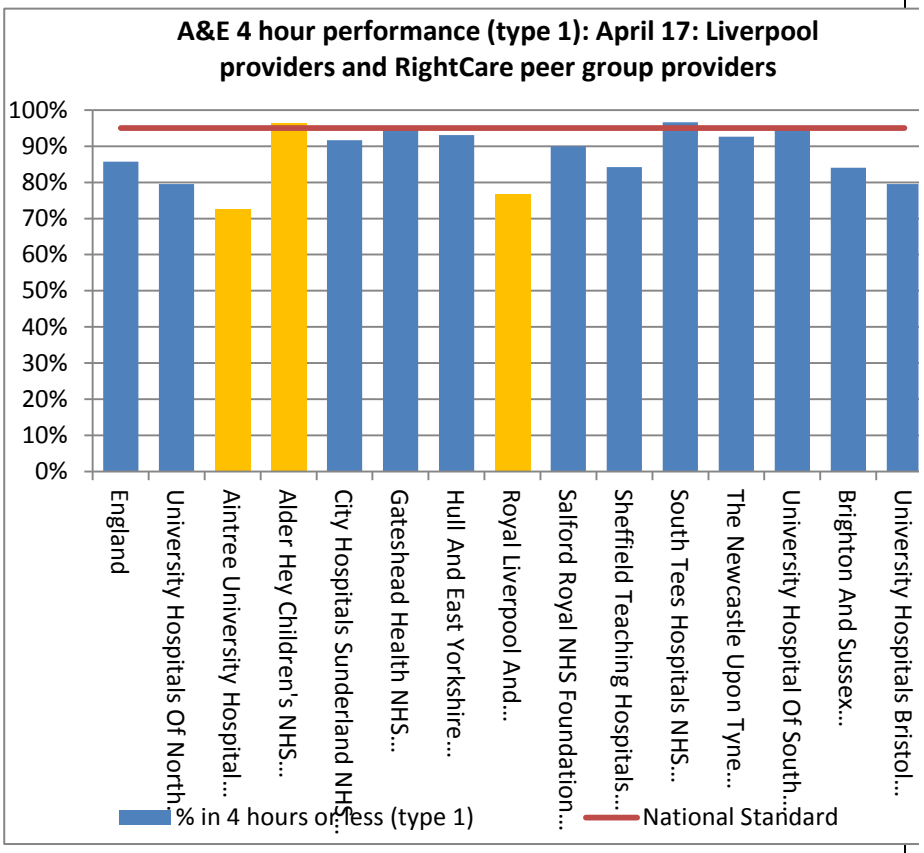
Indicator	Narrative
A&E Waits - % of patients who spend 4 hours or less in A&E (cumulative) 95% threshold ***RED***  ***TREND***  ****CCG performance is calculated based on CCG A&E mapping table produced by NHS England. Provider activity included relates to any provider with CCG activity of 1% or above based on HES 15/16 ratio. Provider data is from Unify Weekly/Monthly SitReps***	Liverpool CCG failed the A&E target during April 2017 with **91.6%** of patients spending less than 4hrs in A&E against the national standard of 95% (all types). This is, however, a slight improvement on March 2017 performance of 91.5% and the highest performance achieved since July 2016 April 2017 performance at provider level shows that the **Royal Liverpool Hospital (90.9%)** and **Aintree University Hospital (86.1%)** both failed the 95% threshold (all types). However, the Royal Liverpool is demonstrating an improved position on March 2017 performance (89.6%). **Liverpool Women's Hospital (97.1%)** and **Alder Hey (96.4%)** both achieved the monthly target in April 2017 (all types) Analysis of Type 1 activity only during April 2017 shows that the **Royal Liverpool Hospital** achieved **76.6% and Aintree University Hospital** achieved **72.7%.** As **Alder Hey** only counts Type 1 activity therefore performance is **96.4%.** The Royal Liverpool has demonstrated improved performance for Type 1 activity in April 2017 when compared to previous months. Performance of "Type 1" and "all types" is seen as the consistent measure of overall A&E performance. Analysis of Type 1 enables a closer focus on the site specific performance but challenges in terms of performance at a specific site can often be masked by the agreed inclusion of Type 2 (Trust specific) and 3 activity (e.g. Walk-in Centre services). Although the inclusion/aggregation of Type 2 and Type 3 attendances does enhance performance, both the Royal Liverpool and Aintree are still some way short of the 95% target (despite the Royal Liverpool demonstrating some improvement in April 2017.) The table below provides a breakdown of A&E activity per provider for April 2017.

	Type 1	Type 2	Type 3	Total performance
Alder Hey Children's Hospital	96.4%			96.4%
Aintree Hospital	72.7%		100%	86.1%
Liverpool Women's Hospital		97.1%		97.1%
Royal Liverpool Hospital	76.6%	99.8%	100%	90.9%

Nationally for the month of April 2017, 25 out of 138 reporting trusts with Type 1 departments achieved the 95% standard on all types during the month. National performance for April was 85.7% for Type 1 and 90.5% for 'all types'.

When comparing Liverpool providers against other providers within the RightCare peer group for A&E attendances (all types), Liverpool Women's and Alder Hey rank amongst the top performing providers ranking 2nd and 3rd respectively out of 15 peers. The Royal Liverpool ranks 10th and Aintree 12th. The peer median performance is 93.8% with the best performing provider achieving 97.2% and the worst 82.3%

When comparing the Liverpool providers against other providers within the RightCare peer group for A&E attendances (Type 1 only), Alder Hey ranks 2nd out of 14 peers. The Royal Liverpool ranks 13th and Aintree 14th The peer median performance is 90.8% with the best performing provider achieving 96% and the worst 72.7%



NHSE has now agreed it is permissible to include Type 3 Walk-in performance data with overall Trust performance until further notice. The caveats to this remain in that including Type 2 and 3 performance very much obscures the Type 1 performance of some of our acute commissioned providers in terms of underachievement, but when combined with all types significantly alters reported performance, however despite inclusion of this activity for both the

	Royal Liverpool and Aintree, performance is still some way off the 95% target

Assurance on CCG control measures

Although the urgent care system continues to be under pressure, achievement of the constitutional 4hr A&E standard target remains, and has been re-affirmed as, a key priority.

Following the Emergency Care Improvement Programme (ECIP) system diagnostic for Royal Liverpool and Aintree Hospitals, which encompassed Acute Trust and community and Primary Care in late 2016 The CCG received the ECIP report at its February 2017 Governing Body meeting. A concordat agreement is now in place, agreed by all system partners, which will support delivery of sustainable improvement in performance.

Responsibility for implementation and oversight of the action plan linked to this concordat, along with existing mandated priority areas for improvement, falls under the remit of the North Mersey AED Delivery Board. The system wide response to the Urgent and Emergency Care requirements set out within 'Next Steps on the NHS 5 year forward view' communicated to CCGs in March 2017 will also be coordinated by the North Mersey AED Delivery Board and will see the CCG working with partners to:

- Put in place a comprehensive front-door primary care streaming within A&E departments by October 2017, in line with the nationally mandated model;
- Ensure implementation of the recommendations of the Ambulance Response Programme by October 2017, freeing up capacity for the service to increase their use of Hear & Treat and See & Treat, thereby conveying patients to hospital only when this is clinically necessary;
- Increase the number of 111 calls receiving clinical assessment, so that only patients who genuinely need to attend A&E, or use the ambulance service, are advised to do this;
- Strengthen support to Care Homes so as to ensure that they have direct access to clinical advice, including where appropriate on-site assessment to avoid inappropriate hospital attendance or admission.

Through the AED Delivery Board and with the support of ECIP the CCG aims to make sustainable performance improvements in 2017/18, utilising the opportunities provided through 'acting as one' to change the way in which our services are provided and delivered.

Maintaining the 'system-wide' focus, all partners continue to explore actions to relieve service pressures and enable consistent flow throughout hospitals on an operational/day to day basis. As previously reported to the Governing Body, 4-hour AED performance is very much a 'symptom' of whole system pressures and solutions therefore lie in that whole system working together to transform the way in which urgent and emergency care is both perceived and used by the public.

5. BETTER CARE - MENTAL HEALTH

No update is available for the following measures:
Proportion of Patients on Care Planned Approach (CPA) and CYP Eating Disorders and improving access rate to CYPMH

5.1.1 Good Performance – Dementia Diagnosis

Indicator	Narrative
Estimated Dementia Diagnosis: % of people aged over 65 ***GREEN***  ***TREND*** 	For May 2017 the CCG continues to achieve the measure with performance reported at **71 %** against the 70% target. This is a slight decline in performance compared to April 2017 (71.7%), however, performance continues into 2017/18 above the 70% local target and above the national target of 66.7%

5.1.2 Good Performance – Early Intervention in Psychosis

Indicator	Narrative
Proportion of people experiencing first episode psychosis (FEP) or an "at risk mental state" that wait 2 weeks or less to start a NICE recommended package of care ***GREEN***  ***TREND*** 	May 2017 performance for Liverpool CCG saw **80%** of patients treated within 2 weeks of referral for first episode psychosis against the 50% standard. This is also an improvement in performance on April 2017 (63.6%). Analysis of the 'incomplete' pathways (waiting list) for May 2017 shows that there were 82.9% of Liverpool CCG patients waiting over 2 weeks. This equates to 34 out of 41 people who are still waiting to start treatment who had already waited over 2 weeks. At provider level the latest data available is for April 2017. **Mersey Care** achieved **68.75%** against the 50% standard. Nationally, the April 2017 position for the proportion of people treated within 2 weeks was 72.5%. In terms of provider performance (Mersey Care), 87.7% of people were waiting over 2 weeks at the end of April 2017. This equates to 43 out of 49 people who were still waiting to start treatment who had already waited over 2 weeks. Nationally the percentage of people who were still waiting over 2 weeks at the end of April was 56.71%

5.1.3 Good Performance – IAPT 6 Week and 18 Week Waits

Indicator	Narrative
% of patients who received their first treatment appointment within 6 weeks ***National data* **GREEN**  **TREND** 	National data for March 2017 for the percentage of patients who received their first treatment appointment within 6 weeks of referral is 95.57% against a target of 75%. Performance throughout 2016/17 was on an upward trajectory and significantly above the 75% target The 2016/17 YTD position is currently reported at 89%.
% of patients who received their first treatment within 18 weeks ***National data* **GREEN**  **TREND** 	National data for March 2017 for percentage of patients who received their first treatment within 18 weeks of referral is 99.37% against a target of 95%. Performance over the last 5 months has improved significantly, and the CCG has been achieving the 95% target YTD 2016/17 performance is at the 95% target

5.1.4 Areas for Improvement – IAPT Access & Recovery (Quarterly Measures)

***IAPT data reported in the dashboard relates to national published financial quarter performance. The narrative below reports the latest published performance for the most recent rolling quarter.*

Indicator	Narrative
IAPT (Access) -% of people who receive psychological therapies (Quarterly Measure 3.75%) **RED**  **TREND** 	National data for quarter 4 (Jan to Mar 17) 2016/17 shows that Liverpool CCG remains significantly below the target of 3.75% with performance reported to be **2.53%.** This is, however an improved position on Quarter 3 2016/17 performance of **2.36%**. Due to the publication of national data being several months behind, this indicator is also monitored using local data supplied by the provider in order to provide a timelier position. Based on local data for the latest rolling quarter (**Mar, Apr and May 2017**) the CCG is showing an improvement but remains below the standard of 3.75% with performance currently reported at **2.88%.**

Assurance on CCG Control Measures
There is an improvement plan in place to increase access into the service. This is overseen by a dedicated Task and Finish Group. Over the last few months resources have been targeted at clearing a significant backlog of people waiting for second treatments, via an interim pathway, whilst maintaining current performance in respect of access. At the start of the process there were just over 3,000 people on the waiting list which now stands at 154. Once these patients have completed treatment resources will be realigned to target improvements in access and actions are already being taken to increase referrals into the service to support this. This work has oversight of the national IAPT Intensive Support Team.

Indicator	Narrative
IAPT (Recovery) - % of people who finish treatment having attended at least two treatment contacts and are moving to recovery ***National data ***RED***  ***TREND*** 	National data for Quarter 4 (Jan to Mar 17) 2016/17 shows that Liverpool CCG remains below the 50% target with performance reported to be **31.17%** This is a decline in performance on the Quarter 3 2016/17 reported position of 32.8% Due to the publication of national data being several months behind, this indicator is also monitored using local data supplied by the provider in order to provide a timelier position Based on local data for the latest rolling quarter **(Mar, Apr and May 2017)** the CCG remains significantly below the standard of 50% with performance reported to be **29.93%.** This is also a decline in performance on the previous reporting period (**31.7%**)
Assurance on CCG Control Measures There is an inherent link between long waits and recovery and therefore we do not anticipate that recovery performance will improve until the cohorts of patients on the interim pathway are discharged. Recovery is monitored closely by the T&F Group and in respect of new patients entering the service we are seeing much better performance at 38%. There is also an action plan in place to improve recovery performance incorporating actions that were identified following a recovery masterclass delivered by the Intensive Support Team.	

6. CLINICAL QUALITY, PATIENT SAFETY AND ENSURING A POSITIVE EXPERIENCE OF CARE

Commissioning high quality, person-centred, safe and effective healthcare for the people of Liverpool is a key priority for the CCG. In line with the recommendations of the National Quality Board (NQB) the CCG's Quality, Safety and Outcomes Committee has established a Quality 'Early Warning Dashboard' to provide the CCG with a robust system which identifies issues and risks relating to patient quality and

safety at the earliest opportunity. The dashboard covers all NHS Trusts within the Merseyside area and includes Risk Profiles for each organisation issued by the Care Quality Commission (CQC) and Monitor Risk and Financial Ratings.

Where risks or themes are identified they will be actively managed through established CCG governance arrangements and overseen by the Quality, Safety and Outcomes Committee, relevant Clinical Performance and Quality Group Meetings and through collaborative commissioning arrangements with other Merseyside CCGs. This section of the report summarises key performance areas of the NHS Outcomes Framework in Domain 4 (ensuring that people have a positive experience of care and Domain 5 - treating and caring for people in a safe environment and protecting them from avoidable harm.

6.1 Ensuring people have a positive experience of care

6.1.1 Good Performance – Mixed Sex Accommodation Breaches

Indicator	Narrative
Mixed sex accommodation breaches ***Monthly plan tolerance of 0*** ***GREEN***  ***TREND*** 	Performance for May 2017 showed that the CCG had **0 (zero)** breaches of the mixed sex accommodation indicator. Year to date for 2017/18 there have been 0 (zero) breaches of the standard. During May at provider level there were 0 (zero) breaches reported at Liverpool providers.

Areas for Improvement – MRSA

Note: Previous month's figures may be subject to minor changes as the data reported in the dashboard is the number at the point in time of reporting. The HCAI DCS System Data is updated on a daily basis and as such reported figures are subject to change.

Indicator	Narrative
Incidence of Healthcare Acquired Infections – MRSA ***Monthly plan tolerance of 0; Annual plan of 0 for 2017/18*** ***RED***  ***TREND*** 	For the period May 2017 there has been one case of MRSA assigned to Liverpool CCG (the first of 2017/18). The breakdown of MRSA cases assigned to Liverpool CCG is below

2017/18	Apr	May
Plan	**0**	**0**
Monthly Actual - Trust Assigned	0	0
Monthly Actual - CCG Assigned	0	1

	Monthly Actual - Third Party Assigned	0	0
	Total	0	1

For Liverpool providers, no new cases have been reported in May 2017. There have been 0 cases of MRSA reported to year to date for 2017/18 for Liverpool Providers.

Assurance on CCG Control Measures

A thorough Post Infection Review (PIR) of the case reported in May has taken place with no lapses of care identified (and no 'lessons learned'). The case was not considered to be preventable and has since been referred to NHS England for arbitration. The final decision/verdict from NHS England is yet to be received but will be reported in the next relevant Corporate Performance Report.

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

2 Areas for Improvement – C.difficile

Indicator	Narrative
Incidence of Healthcare Acquired Infections – C.Difficile ***Annual plan of 138 for 2017/18*** ***RED***  ***TREND*** 	There were **15** new cases of C.diff reported in May 2017 for Liverpool CCG against a monthly plan of **11.** This brings the year to date total to 28 against a plan of 22 At provider level, 8 new cases of C.diff have been reported during May 2017 across the Liverpool providers. **Royal Liverpool and Broadgreen Hospital** During May 2017 there have been two reported cases of C.diff against a plan of 4. This brings the year-to-date total to 7 against a plan of 8 **Aintree Hospital** There have been four reported cases of C.diff against a plan of 4 in May 2017. This brings the year to date total to 12 against a plan of 8 **Walton Centre** The Trust reported one case of C.diff against a plan of 1. This brings the year to date total to 2 against a plan of 2 **Liverpool Heart and Chest** One reported case of C.diff in May 2017 against a plan of 0.7 (annual plan is 4 cases per year) All other Liverpool providers reported 0 cases of C.diff

	in May 2017.
Assurance on CCG control measures One Royal Liverpool case from April 2017 was appealed successfully, which adjusts/reduces the Trust's working total to 7 for the year-to-date. Aintree have successfully appealed cases this year, but none have been identified as Liverpool CCG patents. Overall, numbers of CDI remain above trajectory. Systems are in place for all providers to carry out a robust Root Cause Analysis of reported cases of CDI, along with established review processes to identify and share learning across the wider health economy. The CCG continues its multifactorial approach to all Health Care Associated Infections (HCAI). Where two or more CDI cases occur in Liverpool GP practices within the same financial year a post infection review meeting will be carried out and led by the CCG. Additional work streams also continue to be implemented with the aim of supporting shared learning and understanding across providers. The trajectory presented does not account for the number of cases where a review has been completed and an appeal lodged. For an appeal to be upheld there has to be clear evidence that there were no lapses in care; where this is agreed cases are 'separated' from the numbers and a revised total applied.	

5.2.3 Areas for Improvement – E-Coli

Indicator	Narrative
Incidence of Healthcare Acquired Infections – E-Coli ***Annual plan of 398 for 2017/18*** ***RED***  ***TREND*** 	For the period May 2017 there were **49** reported incidences of E-Coli assigned to Liverpool CCG against a monthly plan of **33**. This is an increase on the previous month when 33 cases were reported for Liverpool CCG and brings the year to date total to 82 against a plan of 66.
Assurance on CCG Control Measures Overall, E Coli numbers remain above trajectory. It should also be noted that 75% of cases are known to originate within community setting. Plans have commenced to collect primary care data on cases to identify lapses in care, whilst Trusts have established reduction strategies. A 'Whole Health Economy Strategy' was recently requested by NHS England to	

tackle these infections in line with the 10% CCG reduction target.

7. OTHER COMMITMENTS

No updates are available for the following measures:
Personal Health Budgets, Children Waiting more than 18 weeks for a wheelchair and Primary Care full extended access.

The indicators within this section (children waiting more than 18 weeks for a wheelchair and Primary Care % of practices offering full extended access during evenings and weekends) are new to 2017/18 monitoring and are to be measured on a quarterly or Bi-annual basis.

8. ACTIVITY

For 2017/18 the latest position for all activity lines submitted within the 2017-19 Operational Plan will be reported in the supporting performance dashboard and narrative for lines where there is a +/- 3% variance will be provided

The comments below relate to month 1 (April 2017)

Indicator	Narrative
Activity: Referrals, Outpatients, Electives, Non- Electives and A&E	The CCG is required to submit detailed activity plans as part of the operational plan. The plan recognises historical growth in demand for secondary services, and explains how initiatives put in place by the Healthy Liverpool programme will avoid or deflect secondary care activity into care delivered at or closer to home, whilst enabling the CCG to maintain financial balance. NHSE monitors the activity plans closely using SUS tNR (NHSE monitoring data) and requests a narrative on the actions the CCG is taking to address any variances that are either +/- 3% for each activity line. Data for month 1 2017/18 has been published and the following activity lines are reporting a variance of +/- 3% (the agreed NHSE

	tolerances) It is important to note that as this is month 1 data, it is too early to say if the following activity lines will continue to present variances outside the tolerance levels in year. Month 1 data also omits Southport and Ormskirk Hospital data. Due to the recent cyber-attack, the provider has yet to submit month 1 SUS data. **Activity lines with +/- 3% variance**
GREEN 	Outpatient first attendances: variance to plan -4.2%
RED 	Outpatient follow up attendances: variance to plan +5.1%
GREEN 	Total elective admissions: variance to plan -6.9%
GREEN 	Total A&E attendance: variance to plan -3.7%
GREEN 	Total Bed days: variance to plan -3.6%

9. CARE QUALITY COMMISSION INSPECTIONS/ISSUES/NOTICES

Where providers are not meeting essential standards, the CQC has a range of enforcement powers to protect the health, safety and welfare of people who use the service (and others, where appropriate). When the CQC propose to take enforcement action, the decision is open to

challenge by the provider through a range of internal and external appeal processes.

9.1 CQC Inspections of Liverpool GP Practices

The following reports have been published by the Care Quality Commission into the public domain during June/July 2017:

9.1.1 Great Homer Street Medical Centre - overall rating 'Good'

The CQC carried out an announced comprehensive inspection at the practice on 11th May 2017. Overall the practice was rated as 'Good' and received an 'Outstanding' rating for the services it provided for vulnerable patients. Key findings across all areas we inspected are summarised below:

- Staff worked well together as a team to support patients to access treatment and address their lifestyle needs;
- Staff were aware of current evidence based guidance and had been trained to provide them with the skills and knowledge to deliver effective care and treatment (in particular for patients who were more vulnerable);
- There was a flexible approach to appointments depending on patient need and urgent appointments were available the same day;
- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.

Elements of 'Outstanding' practice included:

- There was a strong emphasis on promoting wellbeing for patients. The practice referred patients to support groups to help support healthy living and had sent members of staff to courses provided to ensure the services were suitable for their patients;
- The practice recognised that uptake for these services for this population was sometimes low. As a result, the practice had employed a wellbeing co-ordinator to encourage the uptake of healthy living services and information about services was accessible;
- The practice is situated in an area of high social deprivation and responded well to those patients who presented with more challenging issues such as asylum seekers, homeless patients

and those with drug and alcohol addiction. In these instances, the practice team engaged with other health care professionals and social support groups.

The full inspection report can be downloaded from: http://www.cqc.org.uk/sites/default/files/new_reports/AAAG5056.pdf

9.1.2 Kirkdale Medical Centre – Overall Rating 'Good' (Re-inspection)

The practice underwent an announced comprehensive inspection on 8th October 2014. Although the overall rating for the practice was 'Good' following this visit, it was rated as 'Requires Improvement' for providing safe services. An announced 'focused review' was carried out on 9th May 2017 to confirm that the practice had carried out their plan to meet the legal requirements which it had been found in breach of at the inspection on 8th October 2014. Key findings from the focused review are summarised below:

- The systems to assess the risk of and to prevent and control the spread of a healthcare associated infection had been improved;
- Fire drills were now occurring on a regular basis and quarterly fire audits carried out.

The areas where the provider was asked to make further improvements included:

- A record should be made of the weekly checks of cleaning standards;
- A system to ensure single use items are individually packaged and in date should be put in place.

The inspection report can be downloaded from: http://www.cqc.org.uk/sites/default/files/new_reports/AAAG5111.pdf

9.1.3 West Derby Medical Centre - Overall Rating 'Good'

Following an announced comprehensive inspection of West Derby Medical Centre on 24th April 2017, the practice was rated overall as

'Good' but received a 'Requires improvement' rating for providing well led services. Key findings across all the areas inspected were as follows:

- The practice had recently moved from two locations to a purpose built health centre. It was noted as clean and having good facilities, including disabled access to the main entrance, translation services and a hearing loop. The limited car parking facilities were also noted although it was recognised that the practice was working to resolve this issue;
- Disabled access to the upper floor was poor, as there were two heavy doors to the entrance of the waiting room. Access to the toilet area would be very difficult in a wheelchair;
- Patient comments received indicated there were difficulties in getting through to the practice by telephone, waiting for an appointment with a GP of their choice and problems with prescriptions. The practice was aware of the negative feedback and was working towards solutions to increase the number of appointments and having more staff answer the telephones and had recently employed a reception manager to help;
- There were systems in place to mitigate safety risks including analysing significant events and safeguarding, although the management arrangements and records of monitoring systems to improve quality and identify safety risks needed improving;
- The practice had arrangements to respond to emergencies and major incidents;
- Patients' needs were assessed and care was planned and delivered in line with current legislation. Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment;
- Information about services and how to complain was available. However, information about verbal complaints made and actions taken were not recorded.

The full inspection report can be downloaded from:
http://www.cqc.org.uk/sites/default/files/new_reports/AAAG4148.pdf

9.1.4 Speke Neighbourhood Health Centre – Overall Rating 'Requires Improvement' (Re-inspection)

The CQC carried out a comprehensive inspection at Dr Choudhary & Singh's practice on 3rd February 2016 and awarded a rating of

'Requires Improvement'. A follow-up announced focused inspection was carried out on 23rd May 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations identified in the original inspection.

Key findings of the follow-up inspection are summarised below:

- The practice had reviewed the recruitment arrangements for the GPs working at the practice and GP locums. Staff files were kept for each GP, but there was missing information viewed on the day (this evidence was requested by the CQC the day after the inspection);
- The systems in place for significant event and incident reporting had been reviewed. Systems now included how lessons were learnt and what actions should be taken when things go wrong. However, there had been no staff training completed and an incident reporting form was not available to all staff;
- A practice risk assessment process and a revised system of clinical audits was now in place. The practice now used the results of these to monitor and improve patient's outcomes;
- The practice had an active Patient Participation Group (PPG) that met regularly;
- The systems in place for responding to patient safety alerts had been reviewed and a new lead person was in place. However, there was no effective process in place to ensure all actions required, had been taken;
- Arrangements for ensuring all staff receive appropriate appraisals had been reviewed. All staff had a completed annual appraisal.

The practice was rated as 'Requires Improvement' for the domain of safety and asked to remedy the following issues:

- Undertake significant event training with all staff and introduce an incident reporting form for staff use. The provider should also review the system in place for monitoring significant events, ensuring an annual analysis takes place and actions plans are put into place to prevent reoccurrence;
- Develop a monitoring system for patient safety alerts to ensure that actions as required have been undertaken.

The full inspection report can be downloaded from:
http://www.cqc.org.uk/sites/default/files/new_reports/AAAG5002.pdf

9.1.5 Dr Mirza (Knotty Ash Medical Centre) – Overall Rating 'Good'

The CQC out an announced comprehensive inspection at Knotty Ash Medical Centre on 8th May 2017. Overall the practice is rated as 'Good'. The key findings across all the areas inspected were as follows:

- There were disabled access and translation facilities;
- There was an open and transparent approach to safety and a system in place for reporting and recording significant events;
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment;
- Information from Care Quality Commission (CQC) comment cards reviewed indicated that patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment;
- Information about services and how to complain was available;
- Urgent appointments were available the same day;
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on;
- The provider was aware of the requirements of the duty of candour.

The full inspection report can be downloaded from:
http://www.cqc.org.uk/sites/default/files/new_reports/AAAG5112.pdf

10. SUSTAINABILITY - CCG FINANCIAL POSITION

Due to the changing need and complexity of financial reporting requirements the CCG Financial Position is now issued as a separate report.

11. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers)

This section is not applicable to the CCG Corporate Performance Report.

12. DESCRIBE HOW THIS PROMOTES FINANCIAL SUSTAINABILITY

The report provides evidence of the progress being made across the health economy in terms of CCG and local provider performance against NHS Constitutional/National Indicators and Outcomes Measures. The report highlights whether local providers are contributing to overall financial sustainability by measuring performance against activity, quality and value for money and individual contractual requirements.

13. CONCLUSION

Where performance is at variance to plan action is underway with Trusts to deliver corrective action to improve performance with contractual levers utilised to support improvements. These improvements are actively led by CCG Clinicians.

Stephen Hendry
Senior Operations and Governance Manager
29th June 2017

Liverpool CCG - Performance Dashboard 2017-18

NHS Liverpool Clinical Commissioning Group

Metric		2017-18													1617 and 1718 Trend
		Q1			Q2			Q3			Q4			YTD	
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
URGENT AND EMERGENCY CARE															
Accident & Emergency															
4-Hour A&E Waiting Time Target	Actual	91.6%												92%	
% of patients who spent less than four hours in A&E	Plan	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
Ambulance															
Category A Calls Response Time (Red1)	Actual	73.5%												73%	
Number of Category A (Red 1) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes	Plan	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	
Category A (Red 2) 8 Minute Response Time	Actual	78.9%												79%	
Number of Category A (Red 2) calls resulting in an emergency response arriving at the scene of the incident within 8 minutes	Plan	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	
Category A calls responded to within 19 minutes	Actual	94.7%												94.7%	
	Plan	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
REFERRAL TO TREATMENT TIMES & ELECTIVE CARE															
Referral to Treatment (RTT) & Diagnostics															
% of patients waiting 6 weeks or more for a diagnostic test	Actual	5.73%	7.89%											6.9%	
	Plan	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	
Incomplete Pathways	Actual	91.4%	91.2%											91.3%	
% of RTT incomplete pathways (patients yet to start treatment) within 18 weeks	Plan	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	
No of Incomplete Pathways Waiting over 52 weeks	Actual	0	0											0	
	Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	
e-Referral Utilisation															
NHS e-Referral Service (e-RS) Uilisation Coverage	Actual	57%													
% of referrals for a 1st Outpatient appointment that are made using the NHS e-RS	Plan	65%	66%	67%	68%	69%	70%	72%	74%	75%	76%	78%	80%		
EMSA															
Mixed sex accommodation breaches	Actual	0	0											0	
	Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	

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Liverpool CCG - Performance Dashboard 2017-18

NHS Liverpool Clinical Commissioning Group

Metric		2017-18													1617 and 1718 Trend
		Q1			Q2			Q3			Q4			YTD	
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
CANCER															
Cancer Waiting Times															
% Patients seen within two weeks for an urgent GP referral for suspected cancer	Actual	95.7%												95.7%	
	Plan	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	
% of patients seen within 2 weeks for an urgent referral for breast symptoms	Actual	92.7%												92.7%	
	Plan	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	
% of patients receiving definitive treatment within 1 month of a cancer diagnosis -31 days	Actual	97.7%												97.7%	
	Plan	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	
% of patients receiving subsequent treatment for cancer within 31 days (Surgery)	Actual	100.0%												100.0%	
	Plan	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	
% of patients receiving subsequent treatment for cancer within 31 days (Drug Treatments)	Actual	98.6%												98.6%	
	Plan	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	
% of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy Treatments)	Actual	98.4%												98.4%	
	Plan	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	
% of patients receiving 1st definitive treatment for cancer within 2 months (62 days)	Actual	88.6%												88.6%	
	Plan	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	
% of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service	Actual	92.9%												92.9%	
	Plan	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	
% of patients receiving treatment for cancer within 62 days upgrade their priority	Actual	100.0%												100.0%	
	Plan	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	
MENTAL HEALTH															
Dementia Diagnosis															
Estimated diagnosis rates	Actual	71.7%	71.0%											71.0%	
	Plan	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	

Liverpool CCG - Performance Dashboard 2017-18

NHS Liverpool Clinical Commissioning Group

Metric		2017-18												YTD	1617 and 1718 Trend
		Q1			Q2			Q3			Q4				
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
MENTAL HEALTH															
IAPT															
% of people who receive psychological therapies - Roll Out	Actual														
	Plan		3.17%			3.59%			3.99%			4.59%		15.339%	
% of people who finish treatment having attended at least two treatment contacts and are moving to recovery	Actual														
	Plan		50.0%			50.0%			50.0%			50.0%		50.00%	
IAPT Waiting Time -6 weeks % ended referrals that finish a course of treatment in period who received their first appointment within 6 weeks of referral	Actual														
	Plan	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75.00%	
IAPT Waiting Time - 18 weeks % ended referrals that finish a course of treatment in period who received their first appointment within 18 weeks of referral	Actual														
	Plan	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95.00%	
Early Intervention in Psychosis															
Early intervention in Psychosis waiting times: % referrals to and within the Trust with suspected first episode psychosis or at 'risk mental state' that start a NICE-recommended package care package in the reporting period within 2 weeks of referral.	Actual	63.64%	80.00%												
	Plan	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	
Care Programme Approach															
% of patients on (CPA) discharged from inpatient care who are followed up within 7 days	Actual														
	Plan		95%			95%			95%			95%		95%	
Improve Access rate to CYPMH															
Percentage of children and young people aged 0-18 with a diagnosable mental health condition who are receiving treatment from NHS funded community services.	Actual														
	Plan		730			730			730			730		2,920	
CYP - Eating Disorders															
Waiting Times for Routine Referrals to CYP Eating Disorder Services - Within 4 Weeks	Actual														
	Plan		89%			100%			90%			100%			
Waiting Times for Urgent Referrals to CYP Eating Disorder Services - Within 1 Week	Actual														
	Plan		33%			67%			100%			100%			
HEALTHCARE AQUIRED INFECTIONS															
HCAI															
Number of MRSA Bacteraemias Incidence of MRSA bacteraemia (Commissioner)	Actual	0	1											1	
	Plan	0	0	0	0	0	0	0	0	0	0	0	0	0	
Number of C.Difficile infections Incidence of Clostridium Difficile (Commissioner)	Actual	13	15											28	
	Plan	11	11	12	12	12	12	12	12	11	11	11	11	22	
Number of E Coli infections Incidence of E Coli (Commissioner)	Actual	33	49											82	
	Plan	33	33	33	33	33	33	33	33	33	33	33	33	66	

Liverpool CCG - Performance Dashboard 2017-18

NHS Liverpool Clinical Commissioning Group

Metric		2017-18												YTD	1617 and 1718 Trend
		Q1			Q2			Q3			Q4				
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
OTHER COMMITMENTS															
Personal Health Budgets															
Rate of PHBs per 100,000 GP registered population	Actual														
	Plan	2.36			4.72			7.28			9.63				
Children Waiting more thant 18 weeks for a wheelchair															
% of children whose episode of care was closed within the quarter where equipment was delivered or a modification was made.	Actual														
	Plan	86.00%			90.00%			92.00%			92.00%				
Primary Care															
% of practices within a CCG which meet the definition of offering full extended access; that is where patients have the option of accessing pre-bookable appointments outside of standard working hours either through their practice or through their group	Actual														
	Plan	0%						50%							
ACTIVITY															
Total GP Referrals (General and Acute)	Actual	9,051													
	Plan	9,253	10,227	10,714	10,227	9,984	10,227	10,714	10,714	8,766	10,714	9,740	10,230	121,510	
	Variance	-2%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	
Total Other Referrals (General and Acute)	Actual	6,230													
	Plan	6,047	6,684	7,002	6,684	6,525	6,684	7,002	7,002	5,729	7,002	6,366	6,683	79,410	
	Variance	3%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	
Total Referrals (General and Acute)	Actual	15,281													
	Plan	15,300	16,911	17,716	16,911	16,509	16,911	17,716	17,716	14,495	17,716	16,106	16,913	200,920	
	Variance	0%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	
Consultant Led First Outpatient Attendances	Actual	13,464													
	Plan	14,050	15,529	16,268	15,529	15,159	15,529	16,268	16,268	13,310	16,268	14,789	15,531	184,498	
	Variance	-4.2%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	
Consultant Led Follow-Up Outpatient Attendances	Actual	26,580													
	Plan	25,300	27,964	29,295	27,964	27,298	27,964	29,295	29,295	23,969	29,295	26,632	27,963	332,234	
	Variance	5.1%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	
Total Elective Admissions	Actual	4,985													
	Plan	5,355	5,918	6,200	5,918	5,777	5,918	6,200	6,200	5,073	6,200	5,636	5,919	70,314	
	Variance	-6.9%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	
Total Non-Elective Admissions	Actual	4,853													
	Plan	4,906	5,069	4,906	5,069	5,069	4,906	5,069	4,906	5,069	5,069	4,578	5,068	59,684	
	Variance	-1%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	
Total A&E Attendances (excluding Planned Follow Ups)	Actual	27,740													
	Plan	28,807	29,767	28,807	29,767	29,767	28,807	29,767	28,807	29,767	29,767	26,887	29,771	350,488	
	Variance	-3.7%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	
Total Beddays	Actual	25,379													
	Plan	26,339	28,129	28,340	28,129	27,795	27,673	28,795	28,340	26,128	28,795	26,095	28,128	332,686	
	Variance	-3.6%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	

Performance Dashboard 2017/18 : Provider Level

NHS Liverpool Clinical Commissioning Group

METRIC	REPORTING PERIOD	TARGET	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	THE WALTON CENTRE	MERSEYCARE NHS TRUST	SPIRE LIVERPOOL	CLATTERBRIDGE CENTRE FOR ONCOLOY
CANCER											
Cancer Waiting Times											
%Patients seen within two weeks for an urgent GP referral for suspected cancer	Apr-17	93%	94.85%	95.0%		100.0%	98.3%	100.0%			
%of patients seen within 2 weeks for an urgent referral for breast symptoms	Apr-17	93%	93.14%	93.0%							
%of patients receiving definitive treatment within 1 month of a cancer diagnosis (31 days)	Apr-17	96%	97.04%	98.3%		100.0%	100.0%	100.0%			97.8%
%of patients receiving subsequent treatment for cancer within 31 days -Drug Treatments	Apr-17	98%	100.00%	100.0%							98.3%
%of patients receiving subsequent treatment for cancer within 31 days -Surgery	Apr-17	94%	95.00%	96.2%		100.0%	100.0%	100.0%			
%of patients receiving subsequent treatment for cancer within 31 days - Radiotherapy Treatments	Apr-17	94%									98.3%
%of patients receiving 1st definitive treatment for cancer within 2 months (62 days)	Apr-17	85%	86.34%	82.5%		96.8%	100.0%				67.9%
%of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service	Apr-17	90%	91.49%	83.3%							66.7%
%of patients receiving treatment for cancer within 62 days upgrade their priority	Apr-17	85%	100.00%	90.3%		75.0%	96.2%				78.9%
MENTAL HEALTH											
Care Programme Approach											
Proportion of patients on (CPA) discharged from inpatient care who are followed up within 7 days	Q4 2016-2017	95%							92.90%		
Early intervention in Psychosis waiting times											
EIP waiting times: The proportion of people experiencing first episode psychosis (FEP) or an "at risk mental state" that wait two weeks or less to start a NICE-recommended package of care.	Apr-17	50%							68.75%		
HEALTHCARE AQUIRED INFECTIONS											
MRSA											
Number of MRSA Bacteraemias	May-17 (YTD)	Actual	0	0	0	0	0	0	0	0	0
		Plan	0	0	0	0	0	0	0	0	0
Cdifficile											
Number of C.Difficile infections	May-17 (YTD)	Actual	7	12	0	1	0	2	0	0	0
		Plan	8	8	0	0	0	2	0	0	0

Performance Dashboard 2017/18 : Provider Level

NHS Liverpool Clinical Commissioning Group

METRIC	REPORTING PERIOD	TARGET	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	THE WALTON CENTRE	MERSEYCARE NHS TRUST	SPIRE LIVERPOOL	CLATTERBRIDGE CENTRE FOR ONCOLOY
URGENT AND EMERGENCY CARE											
Accident & Emergency											
4-Hour A&E Waiting Time Target: % of patients who spent less than four hours in A&E	Apr-17	95.00%	90.9%	86.1%	96.4%		97.1%				
A&E Attendances: Type 1 Number of attendances Type 1 A&E depts	Apr-17		7,446	6,981	4,744						
A&E Attendances: All Types Number of attendances at all A&E depts	YTD Apr 17		19,128	13,723	4,744		1,016				
12 Hour Trolley waits in A&E : Total number of patients who have waited over 12 hours in A&E from decision to admit to admission	Apr-17	0	0	0	0		0				
REFERRAL TO TREATMENT TIMES & ELECTIVE CARE											
Referral to Treatment (RTT) & Diagnostics											
% of patients waiting 6 weeks or more for a diagnosic test	Apr-17	1.00%	10.9%	1.6%	0.0%	0.2%	0.4%	0.1%		0.0%	0.0%
Incomplete Pathways % of RTT incomplete pathways (patients yet to start treatment) within 18 weeks	Apr-17	92.00%	88.8%	92.8%	92.1%	92.4%	94.5%	95.9%		96.1%	96.8%
No of Incomplete Pathways Waiting over 52 weeks	Apr-17	0	0	0	0	0	0	0		0	0
EMSA											
Mixed sex accommodation breaches	May-17	0	0	0	0	0	0	0	0	0	
Cancelled Operations											
Urgent Operations cancelled for a 2nd time Number of urgent operations that are cancelled by the trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons.	Apr-17	0	0	0	0	0	0	0			0
% of Cancellations for non clinical reasons who are treated within 28 days Patients who have ops cancelled, on or after the day of admission (Inc. day of surgery), for non-clinical reasons to be offered a binding date within 28 days, or treatment to be funded at the time and hospital of patient's choice.	Q4 2016-2017		4%	3%	10%	0%	0%	4%			0%

NHS
Liverpool
Clinical Commissioning Group

Report no: GB 50-17

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
GOVERNING BODY

TUESDAY 11TH JULY 2017

Title of Report	Health Care Associated Infection Annual report 2016-17
Lead Governor	Jane Lunt , Chief Nurse/Head of Quality
Senior Management Team Lead	Jane Lunt, Chief Nurse/Head of Quality
Report Author	Alison Thompson HCAI Programme manager
Summary	The purpose of this paper is to provide an Annual report for 2016-2017 with regards to the Management of Healthcare Associated Infections (HCAI) within the city of Liverpool
Recommendation	That Liverpool CCG Governing Body: ➢ Notes the contents of the report ➢ Notes the performance for 2016-2017
Relevant standards/targets	Preventing people from dying prematurely Treating and caring for people in a safe environment and protecting them from harm Zero tolerance for MRSA Bloodstream Infection (BSI) Clostridium Difficile infection objectives for NHS Organisation

HEALTH CARE ASSOCIATED INFECTION (HCAI) ANNUAL REPORT 2016-17

1. PURPOSE

The purpose of this paper is to provide an end of year progress summary with regards to the management of Healthcare Associated Infections (HCAI) within the Liverpool area

2. RECOMMENDATIONS

That Liverpool CCG Governing Body:

- Notes the content of the report
- Notes the position and performance in 2016-2017

3. BACKGROUND

Healthcare Associated Infection (HCAI) remains a significant cause for concern in all healthcare settings. It is nationally recognised that the cost of HCAI is significant in terms of the direct effect on patients and carers and also the financial costs to the NHS
A reduction in HCAI is known to improve patient experience and outcomes; at the same time it reduces the healthcare costs and mortality rates in a healthcare setting.

HCAI and antimicrobial resistance pose a significant challenge to health and social care at all levels, nationally, regionally and locally. The Health and Social Care Act 2008, *Code of Practice on the prevention and control of infections and related* guidance (also known as 'the Hygiene Code') was re-published in January 2015 to include detail within Criterion 3 for clinicians to use antibiotics appropriately in order to optimise patient outcomes and to reduce the risk of adverse events and to minimise antibiotic resistance. This criterion change fits with a peak of antibiotic resistance in the healthcare system.

Provider Trusts have key infection targets. There is a zero tolerance for MRSA bacteraemia, individual Trust targets for Clostridium difficile infection remain the same as the previous year and for the coming year the CCG has a new reduction target of 10% set in the Quality Premium for E coli bacteraemia

Overall the CCG and Liverpool providers demonstrate robust compliance with infection control requirements with evidence of good systems and processes in place. The CCG has an HCAI Strategy and a local HCAI/ IPC work programme fit for purpose for 2016/18.

The HCAI Programme Manager for Liverpool CCG has worked closely with the Infection Control teams in each Provider organisation, attending Provider Trust Infection Prevention and Control Committee meetings and ensuring informal bi monthly with the Infection Prevention and Control Team Leads to review HCAI Improvement plans. For some Trust's such as Alder Hey, more intensive support has been offered where HCAI risks have been identified and not yet reduced or rectified.

Any pertinent issues highlighted for all Providers' have been raised at CQPG meetings and HCAI rates and progress has been monitored through the HCAI framework monthly returns and the quarterly quality schedule assurance framework.

4. MRSA BACTERAEMIA

A robust Post Infection Review (PIR) process for investigating primary and secondary care attributed Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia has continued with MRSA PIR meetings established on notification of bacteraemia in line with NHS England guidelines. Lessons learnt have been disseminated by the CCG

There is a zero tolerance to MRSA bacteraemia with the CCG setting therefore an Annual plan of 0. For the period April 2016 to March 2017 there have been **11** reported incidences of MRSA assigned to Liverpool CCG.

The breakdown of MRSA cases assigned to Liverpool CCG is illustrated in the following table:-

	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2016/17
Monthly Actual - Trust Assigned	0	0	0	0	2	0	0	0	1	1	0	0	4
Monthly Actual - CCG Assigned	2	0	0	1	0	0	0	1	1	0	1	0	6
Monthly Actual - Third Party Assigned	0	0	0	0	0	0	0	0	0	1	0	0	1
Total	2	0	0	1	2	0	0	1	2	2	1	0	11

For the full year 2016/17, 7 cases of MRSA have been reported at Liverpool providers. These have occurred at Royal Liverpool (2), Alder Hey (2), The Walton Centre (1) and Aintree (2)

MRSA	**Cases**			
	2013-14	**2014-15**	**2015-16**	**2016-17**
Liverpool CCG	17	11	10	11
Aintree University Hospitals	3	2	2	2
Alder Hey Children's Hospital	1	1	3	2
Liverpool Heart and Chest	1	0	0	0
Liverpool Women's Hospital	0	0	1	0
Royal Liverpool and Broadgreen University Hospital	8	7	2	2 (1)

3 of the CCG attributed cases were successfully arbitrated by NHSE and assigned to a 3rd party. The 2 cases identified within the RLBUHT, one was a contaminant and one was successfully arbitrated and assigned to a 3rd party. Both cases at Alder Hey identified lessons to be learnt. More intensive support has been offered by the HCAI CCG Lead during this year.

5. CLOSTRIDIUM DIFFICILE INFECTION (CDI)

Clostridium difficile, also known as C difficile or C diff, is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics, but can spread easily to others. A reduction in numbers has been seen over recent years, principally driven by the use of mandatory targets increasing the focus on use of antibiotics. C diff can be found colonising in the bowel of healthy adults, however antibiotic exposure can increase the risks of developing a condition called C diff associated diarrhoea (CDAD) which is a C diff symptomatic infection.

NHS organisations have continued to be required to demonstrate year on year reductions in *Clostridium Difficile* Infection (CDI) based on the previous year's trend reduction. However, the rate of improvement for CDI rates has slowed over recent years.
There are indications that, for some organisations, the levels may be approaching their irreducible minimum level and that further improvements in patient safety can best be achieved via event closer examination of individual cases and the implementation of relevant learning.

The decision for Trust, or non- Trust apportioned cases is based on when and where the specimen was taken. If it was taken within 72 hours of admission then it is apportioned to the CCG where the patient's GP is identified. If it is over 72 hour since admission it is apportioned to the admitting trust.

All Liverpool CCG commissioned providers have processes in place for reviewing cases of C Diff. A root cause analysis (RCA) is carried out on each *Clostridium difficile* (CDI) case by the healthcare providers for learning purposes. This same process also applies to all CDI community cases for the same learning outcomes.

There is also a process for appeal, if there are no lapses in care identified. The appeals process is based on a National process led by NHSE. Appeals meetings are led by Liverpool CCG for Liverpool patients with reviewed cases being able to be brought by any of the Providers. The process is now well established with regular meetings taking place. From May 17 the plan is to also include non-appealed cases during these meetings to ensure the sharing of identified lessons learnt.

For the community cases, measures have been put in place to establish a more robust system of reviewing these cases to identify themes and trends in conjunction with the Infection Prevention and Control team in the Community. There is no mandatory recording mechanism for non-acute trusts in respect of CDI and the information collected is based on the communications between the Trust and the CCG and data submitted via the assurance framework.

Liverpool CCG

The Public Health England Data Capture System shows that for Clostridium Difficile in 2016/17 there were 163 cases attributed to Liverpool CCG against the annual plan of 138

C. diff	**Cases**			
	2013-14	**2014-15**	**2015-16**	**2016-17**
Liverpool CCG	159	157	163	163
Aintree University Hospitals	76	64	54	46
Alder Hey Children's Hospital	1	0	2	1
Liverpool Heart and Chest	3	4	6	3
Liverpool Women's Hospital	2	1	0	0
Royal Liverpool and Broadgreen University Hospital	50	43	29	55(46)

Royal Liverpool and Broadgreen Hospital
There have been 55 reported cases of CDI against the annual plan of 44. Through the robust appeals panel, which the CCG leads, 9 cases were successfully appealed as there had been no lapses of care identified. Therefore the working total became 46. The Trust has been encouraged to bring further cases to the appeals panel as there were cases identified with no lapses of care.

Aintree Hospital
There have been 46 reported cases of CDI against the annual plan of 46 of which 19 were appealing giving a working total of 27.

Alder Hey
There has been 1 reported cases of CDI against the annual plan of 0 as CDI is not generally seen in children. There were lapses of care identified in this RCA.

Liverpool Heat and Chest
During 2016/17 there have been 3 reported cases of CDI against the annual plan of 4.

Walton Centre

During 2016/17 there have been 9 reported cases of CDI against the annual plan of 10.

For the rest of the Community attributed cases, identified by LCH as 86, the plan for 2016/17 has been to continue to work with Liverpool Community Health Infection Prevention and Control team to develop the PIR process to include Primary Care in the investigation where there are 2 or more infections within the practice within the year. This will enable a wider understanding of key issues and identify themes and trends which are potentially influencing the rates. This will also fit in with the Antimicrobial Resistance agenda (AMR) which is focussing on prescribing trends and aiming to reduce the prescribing of antibiotics to a minimum.

6. MSSA BACTERAEMIA

Staph aureus bacteria often colonise the nasal passage and skin as part of the normal skin flora. There are no DH objectives for compliance given to the acute healthcare providers and CCGs. Mandatory monthly report is more for epidemiological study. According to Public Health England (PHE) report *MSSA* bacteraemia has been on gradual increase year by year since 2011/12. Liverpool CCG HCAI programme manager is informed via the HCAI framework of numbers of MSSA bacteraemia. Provider organisations have systems to collate surveillance data and to look at any key themes identified.

7. E coli BACTERAEMIA

E coli bacteraemia cases are seen more commonly than *MRSA, MSSA* and other micro-organisms; however it can be difficult to ascertain if the microorganism was transmitted by healthcare workers or purely through an endogenous source of an immune-compromised and suppressed patient. *E coli* bacteria are found normally colonising in the intestinal-tract of humans and many animals; therefore, it is easy to transmit through the environment. Keeping a clean environment with appropriate and prompt hand hygiene will reduce the transmission of *E coli* by healthcare professionals and by the public. For *E coli* bacteraemia the top three known sources are identified from urinary tract infections (UTIs), gastrointestinal and hepatobiliary with 75% of cases seen in patients aged 75 years or over.

The CCG has worked with Liverpool providers to implement the patient held catheter passport across the health economy. This contains basic information which can be shared with whoever is providing care with the aim of ensuring that catheters are only used when absolutely necessary and appropriately managed and that this reason for insertion and date for replacement are clearly identified within the passport.

The numbers of patients with a catheter in recent years has seen to be reduced, however patients with catheters still remain with an increased likelihood for E coli blood stream infection because of a portal of entry for infection via the catheter.

From April 2017 the CCG Quality Premium set by NHSE indicates a new reduction target for this infection. A target reduction of 10% for the coming financial year 2017-2018 has been set which in further years is planned to increase to a 50% reduction of all gram negative organism bacteraemia by 2021. Liverpool CCGs count of 440 cases has been set as baseline figure based on last year's data. The 10% reduction target equates to a target count of 398 cases. As the majority of the cases are attributable to the community, whole health economy strategies are required to reduce this infection and so are being considered. Public Health England has provided guidance in the form of a gram negative reduction toolkit guiding planned work to establish UTI reduction plans for hospital, community and primary care.

8. CARBAPENEMASE-PRODUCING ENTERBACTERIACEAE (CPE)

Carbapenemase-producing Enterobacteriaceae (CPE) have become an increasing issue across the UK and Europe. Enterobacteriaceae are a family of bacteria that usually live harmlessly in human and animal guts. However, these bacteria are a common cause of urinary tract infections, intra-abdominal and bloodstream infections. Carbapenemases are enzymes that produced by the bacteria to destroy carbapenem antibiotics; making it virtually impossible to treat patients who have serious infections in need of carbapenem antibiotics.

All Liverpool acute trusts have policies on CPE based on PHE's publication *CPE a toolkit for early detection, management and control in December 2013*. The toolkit gives advice on who should

be screened and how to prevent transmission. Crucial information, like previous hospital admissions and admission to foreign countries will aid early detection, early isolation and prevention of spread in the hospital and in the city of Liverpool as a whole.
There has been an increase in the number of patients screened in line with Trust policies and an expected increase in positive results which is monitored by Public Health England. CPE screening monitoring and number of positive cases is reviewed through the Quality Schedule and assurance framework. Any outbreaks of infection are investigated and reported to the CCG.

9. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers) – Not applicable

9.1 Does this require public engagement or has public engagement been carried out? Yes / No

i. If no explain why

ii. If yes attach either the engagement plan or the engagement report as an appendix. Summarise key engagement issues/learning and how responded to.

9.2 Does the public sector equality duty apply? Yes/no.

i. If no please state why

ii. If yes summarise equalities issues, action taken/to be taken and attach engagement EIA (or separate EIA if no engagement required). If completed state how EIA is/has affected final proposal.

9.3 Explain how you have/will maximise social value in the proposal: describe the impact on each of the following areas showing how this is constructed to achieve the most:

a) Economic wellbeing
b) Social wellbeing
c) Environmental wellbeing

9.4 Taking the above into account, describe the impact on improving health outcomes and reducing inequalities

10. DESCRIBE HOW THIS PROMOTES FINANCIAL SUSTAINABILITY

Not applicable

11. CONCLUSION

This report highlights the position of Health Care Associated Infection reporting and activity from 2016-17 with the aim of providing assurance to the Board of a culture of reporting and learning across the Provider organisations. It also demonstrates the number of areas where the HCAI programme managers and senior Quality team members monitor Provider infections and performance, within Infection Prevention and Control Committees, CCG led Clinical Quality and Performance Groups and Infection Review meetings. When investigations take place the CCG ensure that the learning is shared. This report demonstrates the benefits of collaborative working to improve patient care and reduce the rates of HCAI.

Overall the CCG and Liverpool providers demonstrated robust compliance with infection control requirements with evidence of good systems and processes in place. Where there are gaps in assurance, the CCG has a plan in place to mitigate and develop capacity and monitoring. The CCG continues to work with providers and partners to identify learning and improve patient outcomes and the quality of care.

An increased focus for the coming year will be to support community and primary care awareness and improvement in infection prevention and control and meeting the CCG reduction target of 10% for E coli bacteraemia.

END

GB 50-17 Appendix 1

Governing Body
Health Care Associated Infection Annual Report 2016-17

Patient Stories

It is important to recognise the complexities of the healthcare delivery systems in which patients are cared and treated. There are established processes to review patients with known infections including MRSA post infection review (PIR) and root cause analysis (RCA) for Clostridium difficile infections. These processes aim to identify what went well, as well as when care could have been better. Delivering quality is about getting things right first time, for many patients acquiring an infection is a serious or catastrophic event. Individual circumstances are considered in the cross organisational infection reviews which take into account aspects of care including the systems in place to manage an infection, processes of audit and surveillance along with environmental cleanliness, isolation practices, microbiology and laboratory support.

It is also important to recognise that effective prevention of infection is multifaceted and requires strong leadership, effective training programmes, and evidence-based guidelines and interventions. Leadership and accountability are key, it is essential we take a collaborative approach to deliver this agenda.

Recognising the complexity of the individual patients who acquire health care associated infections and so the individual patients who sit 'behind' the figures reported in the paper will be discussed as 'Patient Stories'.

Two patient stories are to be shared to bring the report to life. The stories are taken from 11 MRSA Post Infection Reviews undertaken last year.

PATIENT STORY 1 - AVOIDABLE INFECTION

20 October 2016:	Patient was admitted to RLBUHT elderly care ward with a urinary tract infection. Documented to be confused and trying to wander on ward.
21 October 2016:	***Patient was Medically Fit for Discharge.*** Package of care requested
31 October 2016:	Patient was screened for MRSA which was negative.
8 November 2016:	Patient had fall
10 November 2016:	Best Interest Meeting, agreed for 28 day assessment bed.
11 November 2016:	Patient had fall
15 November 2016:	Patient had fall
24 November 2016:	***(1 month later)*** *Another* patient admitted with known MRSA positive status.
25 November 2016:	Accepted by a residential care home. Awaiting high/low bed
6 December 2016:	Screened positive for MRSA
8 December 2016:	Discharge delayed by residential care home (D&V)
15 December 2016:	***The patient was discharged from the ward.***
16 December 2016:	Became unwell, refusing to eat, sore mouth , dental abscesses. Prescribed inappropriate antibiotic by GP
17 December 2016:	Patient was admitted to Hospital. MRSA bacteraemia – dental abscesses

Patient later died.

PATIENT STORY 2 - UNAVOIDABLE INFECTION

25 October 2016: Attended South Liverpool Walk In Centre with leg ulcers.
Staff contacted the Vascular Surgeons at the RLBUHT
Agreed to admit.

27 October 2016 to7 November 2016: Ward 8Y planned below knee amputation.
Refused treatment and took own discharge.

8 November 2016: Presented to GP with bleeding leg ulcer, left practice
Later presented to South Liverpool Walk in
Advised to go to A&E, refused.

12 November 2016: Ambulance telephoned by a friend - found collapsed
Admitted to RLBUHT
MRSA bactearemia

14 November 2016: Theatre for Left below knee amputation

NHS
Liverpool
Clinical Commissioning Group

Report no: GB 51-17

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
GOVERNING BODY

TUESDAY 11th JULY 2017

Title of Report	Corporate Risk Register Update (July 2017)
Lead Governor	Katherine Sheerin, Chief Officer
Senior Management Team Lead	Ian Davies, Chief Operating Officer
Report Author	Joanne Davies, Corporate Services Manager (Governance)
Summary	The purpose of this paper is to update the Governing on the changes to the Corporate Risk Register for July 2017
Recommendation	That Liverpool CCG Governing Body: ➢ Notes the new risks (CO65, CO66 and CO67) that have been added to the Corporate Risk Register; ➢ Satisfies itself that current control measures and the progress of action plans provide reasonable/significant internal assurances of mitigation, and; ➢ Agrees that the risk scores accurately reflect the level of risk that the CCG is exposed to given current controls and assurances.
Relevant standards/targets	The Health and Social Care Act states that: *"The main function of the governing body will be to ensure that CCGs have appropriate arrangements in place to ensure they exercise their functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance that are relevant to it."*

CORPORATE RISK REGISTER UPDATE (JULY 2017)

1. PURPOSE

The purpose of this paper is to highlight updates and amendments to the CCG's Corporate Risk Register and the key organisational responsibilities for the mitigation of risks to the delivery of strategic, quality, performance and financial objectives for the financial year 2017/18 and risks carried over from the financial year 2016/17.

2. RECOMMENDATIONS

That Liverpool CCG Governing Body:

- Notes the content of the report;
- Notes the new risks (CO65, CO66 and CO67) that have been added to the Corporate Risk Register;
- Satisfies itself that current control measures and the progress of action plans provide reasonable/significant internal assurances of mitigation, and;
- Agrees that the risk scores accurately reflect the level of risk that the CCG is exposed to given current controls and assurances.

3. BACKGROUND

NHS Liverpool CCG aims to achieve its overall objectives, ambitions and maintain its reputation via effective and robust risk management procedures. As a public body, the CCG has a statutory commitment to manage any risks that affect the safety of its employees, patients and its commissioned, financial and business services by adopting a proactive approach to the management of risk.

The Corporate Risk Register is a structured framework underpinned by concepts of effective governance and other systems of internal control that enable the identification and management of acceptable and unacceptable risks. Opportunities for improvement in controls and assurances are translated into action plans under specific named lead/managerial control so that monitoring, tracking and reporting can be supported, with clear target dates and milestones identified where appropriate.

4. OVERVIEW OF THE CORPORATE RISK REGISTER: JULY 2017

As at 3rd July 2017 a total of 22 risks are included in the CCG's Corporate Risk Register. The CCG's risk profile (low – extreme) is summarised below:

Risk Category	Score Range	Total Risks	Change +/-
Extreme	15-25	**5**	**0**
High	8-12	**15**	**+3**
Moderate	4-6	**2**	**0**
Low	1-3	**0**	**0**

Analysis of the direction of travel for risks since the last Governing Body update in July 2017 can be summarised as follows:

		Total
▲	Risk increased	**0**
▼	Risk reduced	**3**
►	No change (static)	**16**
	New risks	**3**
Total		**22**

4.1 Analysis of 'Extreme' and 'Static' Risks as at 3rd July 2017

A total of five risks currently carry residual score ranges of 15-25, placing them in the 'Extreme' category of risk against achievement of CCG objectives. (Note; two of these risks are recorded under section 4.2 of this report (New Risks on Corporate Risk Register as at 1st July 2017)).

CO29 – 'Red' rating Failure of Royal Liverpool Hospital to meet the 4hr AED target in 2017/18		
Residual Risk Score 20	**Trajectory ►**	**Review Date: Sep 2017**

Year-to-date 4hr performance for the Royal Liverpool (to 30th April 2017) stands at 76.6% (Type 1) and 90.9% (All types). This represents an improvement from previous months' performance during the calendar year 2017 but remains below the required NHS constitutional 4hr standard.

The CCG is working with the trust, to implement the ECIP concordat priorities agreed following the 'system diagnostic' undertaken in Q3 2016/17 and

received by Governing Body on 14th February 2017 and also meet the Urgent and Emergency Care requirements set out within 'Next Steps on the NHS 5 year forward view'. Monitoring of the associated action plans is undertaken by the North Mersey and Southport AED Delivery Board, with ongoing ECIP support to deliver sustainable improvement in performance going forward.

CO35 – 'Red' rating Failure of Aintree Hospital to meet the 4hr AED target in 2017/18		
Residual Risk Score 20	**Trajectory ►**	**Review Date: Sep 2017**

Year-to-date 4hr performance for Aintree Hospital (to 30th April 2017) stands at 72.7% (Type 1) and 86.1% (All types). The Trust continues to underperform in relation to the required NHS constitutional 4hr standard.

The CCG, in partnership with neighbouring CCGs, is working with the Trust, to implement the ECIP concordat priorities agreed following the 'system diagnostic' undertaken in Q3 2016/17 and received by Governing Body on 14th February 2017 and also meet the Urgent and Emergency Care requirements set out within 'Next Steps on the NHS 5 year forward view'. Monitoring of the associated action plans is undertaken by the North Mersey and Southport AED Delivery Board, with ongoing ECIP support to deliver sustainable improvement in performance going forward.

CO64 – Smooth transition of services currently provider by LCH to provider organisations		
Residual Risk Score 16	**Trajectory: ►**	**Review Date: Sep 17**

Remaining Non-Core Community Services transferred to RLBUHT on 01/06/17 as planned. Meeting held with NHSI on 12/06/17 to explore the way forward for the transaction of Liverpool Core Community Services. A meeting is to be arranged with key stakeholders within the Liverpool system to review options for transacting the delivery of the Liverpool Core Community Services, and the associated governance in late June/early July.

4.2 New Risks on Corporate Risk Register as at 1st July 2017

CO65 – Alder Hey Children's Hospital identified potential gap in LCH employed LAC nurses working within the trust.		
Residual Risk Score 12	**Trajectory: New Risk**	**Review Date: Sep 17**

Alder Hey Children's Hospital identified potential gap in LCH employed LAC nurses working within the trust. A number of issues identified within the workforce - i.e. sickness, planning for retirement and providing adequate service provision. In addition, LAC nursing support is insufficient to fully support Alder Hey community paediatricians.

CO66 – The Quality Team has insufficient staffing to provide an adequate level of cover across the whole spectrum of its responsibilities including the SUI process		
Residual Risk Score 16	**Trajectory: New Risk**	**Review Date: Sep 17**

The Quality Team has insufficient staffing to provide an adequate level of cover across the whole spectrum of its responsibilities including the SUI process. SMT paper requesting a review of structure and recruitment to vacant posts has been reviewed and SMT have agreed for the team to recruit to strengthen the team. The team have reviewed their capacity and capability and where possible have prioritised resources.

CO67 – To ensure that the IMT infrastructure that supports the work of the CCG is secure & protected from the risk and impact of a malicious cyber attack		
Residual Risk Score 16	**Trajectory New Risk**	**Review Date: Sep 2017**

Following the recent national cyber-attack (May 2017) a series of additional actions have been taken to further enhance and strengthen the security of the IMT infrastructure and data. Immediate initial action was taken after the May attack and further action is underway and planned. Particular attention has been paid to raising staff awareness of the threat of cyber-attack and the various mechanisms that might be adopted by those wishing to attack the organisation. An NHSE debrief event will be held on the 11th July and any further lessons learnt and any required actions considered.

5. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers)

This section is not applicable.

6. DESCRIBE HOW THIS PROMOTES FINANCIAL SUSTAINABILITY

Effective and robust risk management arrangements (and clear mitigation strategies) support the CCG's delivery of statutory Financial Duties and the 2017/18 Financial Plan.

7. CONCLUSION

The Corporate Risk Register continues to be monitored on a monthly basis. Action plans put in place against each risk identified are reviewed monthly by the appropriate sub-committee of the CCG Governing Body with first-line assurance of controls and actions conducted by the Senior Management Team on a bi-monthly basis. Strategic risks to corporate objectives are monitored on a monthly basis by the Senior Management Team. Where legal issues arise from individual risks the Corporate Risk Register will include plans to mitigate them. There are no inherent legal implications associated with the Corporate Risk Register in July 2017.

Joanne Davies
Corporate Services Manager (Governance)
5th July 2017

Ends

LIVERPOOL CCG: CORPORATE Risk Register (July 2017 Governing Body)						Version: v2.0												
Ref	**Organisational Values & Objectives**	**Date Entered**	**Objective**	**Description of Risks**	**Current Controls**	**Assurance in Controls**	**L**	**C**	**Risk score when entered on to register**	**Risk accepted**	**Management Actions re gaps in controls and assurance or unacceptable risk rating**	**L**	**C**	**Residual Risk (score)**	**Lead Officer**	**Completion Date**	**Review Date**	**Progress since last update**
STRATEGIC RISKS																		
CO19	To maximise value from our financial resources and focus on interventions that will make a major difference	01/12/2013	To agree with Liverpool City Council the 'Better Care Fund' for 2017/18, including individual schemes, outcomes and performance.	Failure to agree with the City Council the investment schedule and associated outcomes, including service delivery and continuity; and relations with the City Council	Negotiations with LCC led by the Chief Finance Officer, regular updates to SMT and, briefings to Governing Body.	Joint governance and delivery systems established to oversee the delivery of the BCF under leadership of the Health and Wellbeing Board.	2	5	10	Y	BCF approved by Governing Body in June 2017 and scheduled for review and approval by Health and Wellbeing Board 22nd June 2017. All schedules to be reviewed by lead officers in LCCG and LCC. Awaiting national guidance on outcome measures and performance targets **(TW update 18/06/17)** Following Health and Wellbeing Board agreement, refresh of Section 75 agreement between Liverpool City Council and Liverpool CCG to be completed by August 2017. **(Update from MB 28/06/2017)** Retention of this risk on the corporate risk register will be reviewed following completion of the refeshed Section 75 agreement.	1	5	5	TW	On going	Sep-17	▶
CO58	Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.	24/06/2016	To improve the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population. It is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services.	Failure to reduce delayed transfers of care and improve pathways out of hospital. Increased waiting times and increasing risk of higher needs as a result. Increased strain of bed management in Acute and Non Acute trusts. The four key contributors to delays are RLBUH, UHA, LCH and Mersey Care. The impact of LCH on adult social care delays is significant accounting for just under 40% of the total bed days delayed. This increased volume for a single provider accounts for 56% of the overall increase in delays for Liverpool since 2014/15.	Monthly and quarterly updates on statutory / BCF measures in line with North West sector led improvement framework. Daily / Weekly co-ordination across health and social care to actively manage delayed discharges. Improved rates for home care providers for reablement services. Implementation of the Enhanced Care Home Model commenced on 1st February 2017	Key national measure within the better care fund. The recent 2016 submission for the BCF target put forward a proposal to account for a predicted increase in delays. Based on projected growth in recorded delays during 2016/17 to 2017/18 the relative target is set to mitigate a 6% growth in delays and improve by a further 5% on current volumes.	3	4	12	Y	The Enhanced care home model in West Derby continues to run as proof of concept in care homes The LCC and LCCG in partnership with care home market are developing a Care Home Improvement strategy which it is expected would be approved via the LCC/LCCG usual governance routes The care homes using telemedicine are being supported by managers using a structured framework to improve and increase their competence and use of the system **(Update from JC 09/06/2017)**	3	4	12	TW	Ongoing	Sep-17	▶

Ref	Organisational Values & Objectives	Date Entered	Objective	Description of Risks	Current Controls	Assurance in Controls	L	C	Risk score when entered on to register	Risk accepted	Management Actions re gaps in controls and assurance or unacceptable risk rating	L	C	Residual Risk (score)	Lead Officer	Completion Date	Review Date	Progress since last update
CO45	To maximise value from our financial resources and focus on interventions that will make a major difference	16/04/2015	Mental Health Access Waits - waiting time standards for people entering a course of treatment in adult IAPT services.	The waiting list that transferred from Inclusion Matters Liverpool to Talk Liverpool has not been addressed. There remains a significant number of patients awaiting second treatment. This impacts on LCCG's waiting time targets and recovery rates. Waiting time standards were introduced for IAPT from 1st April 2016. In addition the service is not on target to hit 15% access for 2016/17.	A contract performance notice was issued on 28th September 2015 in respect of the Talk Liverpool performance and contract sanctions have been in place since April 2016. New patients / referrals monitored against IAPT standards separately from those on inherited waiting list to ensure proportionate provider delivery against standard and monitor progress of recovery plan to address backlog. Patient tracking lists implemented to ensure transparency of waits and those that will fail the standard. Remedial action plan implementation and impact monitored via formal contract review meetings. Despite this the pace of change has been slow and the anticipated impact has not been realised.	Monthly contract review meetings include monitoring of the action plan Governing Body oversight and exception reporting CCG working collaboratively with NHSE regarding the RAP	4	4	16	N	Local contract reporting shows the Month 1 2017/18 performance for Access at 0.9% against a target of 1.25% and Recovery 34% against a target of 50%. Analysis shows that recovery is impacted by the long waits within the service and improvements should be realised when the waiting list is cleared. Work on service improvements continues and further engagement with potential referers is planned to instigate referrals once the waiting list issue is resolved. There has been good progress in clearing the Talk Liverpool internal waiting list via an interim pathway that was introduced in Dec 2016. At that time there 3,083 people waiting for second treatment appointments. At the end of April 2017 there were 252 people awaiting treatments. These should all be booked into clinics by the end of June 2017. Resources will then be fully targeted at access and recovery activity. The risk will remain static until the list is cleared and the impact on access and recovery realised. **(Update from TC 14/06/2017)**	3	4	12	TW	Ongoing	Sep-17	▶
CO60	Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.	27/07/2016	To improve handover of patients from ERT to statutory care providers.	Frailty Service / ERT Delays: handover of patients from ERT to statutory care providers. Capacity of care providers is limited. This is impacting on the Frailty service resulting in the frailty service potentially missing their targets, expected LoS, throughput and activity. This will impact on resource utilisation.	Meetings with the CCG and LCH have taken place in 2015 resulting in new domiciliary care providers brought on line with higher rate of funding established in early 2016. Identified as an issue in the recent Frailty Service Review. Daily report circulated to a wide group of professionals.	Frailty Performance Group re-established with first meeting to be held on 13-10-16. this group will review impact on performance with minutes of meeting noted and action log. On Healthy Ageing Risk log to be discussed at the healthy Ageing Commissioning Group by commissioners across Health & Social Care.	3	3	9	N	473 people have now been completely through Home First pathway since 1st November 2016; 81 people are currently on the pathway currently and 420 have been declined since 1st December 2016. Aprox 23% of those completed need on-going social care, 22% are re-admitted to hospital and 53% need no on-going social care. An additional £900k for each of the current / next Financial Years has been allocated to expand the scheme from IBCF resources. Addtional staffing should be in place by the end of September 2017. **(Update from CF 27/06/2017)**	2	3	6	TW	Ongoing	Sep-17	▶

Ref	Organisational Values & Objectives	Date Entered	Objective	Description of Risks	Current Controls	Assurance in Controls	L	C	Risk score when entered on to register	Risk accepted	Management Actions re gaps in controls and assurance or unacceptable risk rating	L	C	Residual Risk (score)	Lead Officer	Completion Date	Review Date	Progress since last update
CO61	To maximise value from our financial resources and focus on interventions that will make a major difference	01/08/2016	Delivery of the new access standards for Early Intervention in Psychosis services which were introduced from April 2016 and are one of the 9 'Must Do's' in the 2016/17 planning guidance. The access and waiting time standard for early intervention in psychosis (EIP) services requires that more than 50% of people experiencing first episode psychosis will be treated with a NICE-approved care package, within two weeks of referral. The standard is targeted at people aged 14-65.	The new standard extends the upper age range of the service from 35 to 65 and also to those people with an 'at risk mental state'. The service has never been previously been commissioned to provide for this cohort of patients. Furthermore to achieve the standard a NICE approved care package must be in place and the service currently does not have the workforce, both in terms of numbers and skill mix, to deliver this. A business case has been approved in principle via the CCG approvals process but funding cannot be agreed until the prioritisation process takes place in Sept. The risk is that that CCG will not meet the access standard without this additional investment.	Regular meetings with providers taking place and situation is being monitored against the standards. Funding agreed and pathway implemented from April 2017.	NHSE and Governing Body have regular oversight the risk and EIP performance. Regular reporting on UNIFY system.	4	4	16	Y	Analysis of Liverpool CCG waiting lists (incomplete pathways) as at Feb 2017 shows that 86% of patients were waiting over 2 weeks - equates to 38 out of 44 people still waiting to start treatment (and who had already waited over 2 weeks). Discussions taking place with NHSE about how to close some of these pathways as patients are accessing treatment elsewhere in the system. Assurance is also being sought from MCT regarding it's ability to flow the data for EIP due to delays in the roll-out of it's new IT system. Risk will remain on CRR until performance is sustained. Currently there are a high number of incomplete pathways recorded that will not enter the service and we are awaiting advice from NHSE on how these should be dealt with. This has the potential to impact on performance and therefore risk will remain static until this issue is resolved. **Further detailed update to be provided in the September 2017 Corporate Risk Register update, when updated information on progress will be available .**	3	3	9	TW	Ongoing	Sep-17	▶
CO51a	To hold providers of commissioned services to account for the quality of services delivered	03/11/2015	Effective provision of nursing home beds to the residents of Liverpool	Reduction of care home beds in the city as a result of 'inadequate' or 'require improvement' CQC rating	Current nursing home bed availability is updated and shared across the system (Liverpool) on a daily basis. Liv City Council and Liv CCG are working to understand capacity required in Liverpool, and how to effectively commission this. Joint Director of Integrated Commissioning in post to support this joint working. New Residential Nursing contract out to the market, this will improve capacity across the system Bed capacity reported to the joint Quality Assurance & Safeguarding Committee (QASSI) LCC updated fee levels and as a result the city are now average in the league tables. The increased fee rates now take in to account the living wage.	Continued adoption and refinement of the fair cost of care methodology used by LCC	5	4	20	N	Care Home Improvement Programme continues to make solid early progress with reduction in emergency admissions in care homes included in phase 1. Further monitoring required as further data becomes available. Further roll-out of teletriage and commencement of the education component of the programme. Care Home Improvement Workshop held by NHSE through Chief Nurse network to identify best practice and opportunities for collaborative working across wider footprints. New joint post between LCC and LCCG will have operational leadership for joint work across the organisations **(TW 18/06/17)**.	3	3	9	TW	Ongoing	Aug-17	▶

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CO64	To maximise value from our financial resources and focus on interventions that will make a major difference	01/04/2017	To secure a smooth transition of services currently provided by LCH to provider organisations as part of a transactional process led by NHS Improvement, within the financial envelope available.	Uncertainty of future service delivery model following failure of planned transaction and implementation of interim management arrangements. Transaction of remaining non-core services to new providers by agreed deadlines. Stability of the the financial envelope for Liverpool Core Services due to differential transaction dates for others services including Liverpool non-core and Sefton Core Services.	LCH Transition Board in place, led by NHS Improvement, with CCG represented along with other key stakeholders. Transition Risk Register in place, owned by NHSI and overseen by the LCH Transition Board. PMO in place, delivered by LCH and led by NHSI.	CCG Chief Officer, Chief Finance Officer and Community Programme Director are members of the NHSI led LCH Transition Board. Operational oversight by SMT Task and Finish Group to ensure alignment of key areas of risk to service delivery and planning. Strategic oversight by CCG Finance, Procurement and Contracting Committee with standing item report.	4	5	20	Y	Remaining Non-Core Community Services transferred to RLBUHT on 01/06/17 as planned. Meeting held with NHSI on 12/06/17 to explore the way forward for the transaction of Liverpool Core Community Services. A meeting is to be arranged with key stakeholders within the Liverpool system to review options for transacting the delivery of the Liverpool Core Community Services, and the associated governance in late June/early July **(TW 18/06/17)**.	4	4	16	TW	Monthly review	Aug-17	▶

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CO62	We accept responsibility for our actions. We make and support business decisions through experience, evidence and good judgement, and we will deliver against our promises	03/03/2017	To ensure that clinical services are delivered without interruption and that access to key systems to ensure safe decisions are made for patients are always available. To prevent loss of IT service for both clinical and commissioning services.	Due to the age of the current air cooling systems at Bevan House, there is a significant risk that the cooling system could fail causing a restriction of key IT systems including clinical (EMIS) systems and the loss of IP telephony services and core office support including email and access to network files and folders for a minimum of 12 hours. This will affect Liverpool CCG, South Sefton CCG, Southport & Formby CCG, Liverpool Community Health and all Liverpool GP Practices.	Additional servicing is now being carried out on the cooling system, however it has been advised that the system is relatively frail and prone to failure due to its age although this risk is reduced with enhanced servicing. Informatics Merseyside are monitoring the performance of the system constantly to ensure any system failures are detected and acted on immediately.	Weekly updates provided to CCG Digital Lead on performance and issues. Business continuity plan in place with disaster recovery system ready (requires minimum 12 hours fail-over time) and secondary plan in place to move the existing server and network equipment to a secondary location should the cooling system be found beyond repair. GPIT bid submitted to NHSE for funding a replacement system to be built in an enterprise class facility.	3	4	12		The Shared Infrastructure Partnership Group meeting was delayed due to pressures from the Cyber Attack and took place on 9th June. A plan for the transfer of data centre has been completed with an options appraisal and the preferred method identified. The major issue at this stage is availability of GPIT funding from NHSE through a bid submitted during 16/17 by both LCCG and SS/S&FCCG (separately) to allow work to commence. The need for an urgent response to this bid has been escalated within NHSE via LCCG CFO. A clear timeline has been produced to ensure clarity as to what activity needs to commence at what time for the transfer to be safe and effective. No further cooling issues have been raised with the system operating as expected to date and the existing business continuity arrangements remain in place. **(Update from DH 28/06/17)**	3	4	12	TW	Mar-18	Sep-17	▶
CO67	We accept responsibility for our actions. We make and support business decisions through experience, evidence and good judgement, and we will deliver against our promises	01/07/2017	To ensure that the IMT infrastructure that supports the work of the CCG is secure and protected from the risk and impact of a malicious cyber attack	Failure to adequately secure and protect the IMT infrastructure from a malicious cyber attack leading to the loss of service and / or data	The CCG contracts with iMerseyside (Mersey Care) to provide an IMT infrastrucutre, network and user support, which includes infrastructure and data security measures which are compliant with NHS Digital and best practice requirements.	Infrastrucure and data security management security and business continuity plans are in place and subject to regular review against the evolving and changing threats. Advice and guidance is provided by NHS Digital / GCHQ weekly Care Cert updates, alongside scrutiny by internal audit	4	5	20	N	Following the recent national cyber attack (May 2017) a series of additional actions have been taken to further enhance and strengthen the security of the IMT infrastructure and data. Immediate initial action was taken after the May attack and further action is underway and planned. Particular attention has been paid to raising staff awareness of the threat of cyber attack and the various mechanisms that might be adopted by those wishing to attack the organisation. An NHSE debrief event will be held on the 11th July and any further lessons learnt and any required actions considered. **(Update from ID 01/07/2017)**	4	4	16	ID	Ongoing	Sep-17	**NEW RISK**

Ref	Organisational Values & Objectives	Date Entered	Objective	Description of Risks	Current Controls	Assurance in Controls	L	C	Risk score when entered on to register	Risk accepted	Management Actions re gaps in controls and assurance or unacceptable risk rating	L	C	Residual Risk (score)	Lead Officer	Completion Date	Review Date	Progress since last update
QUALITY & SAFETY																		
CO51b	To hold providers of commissioned services to account for the quality of services delivered	03/11/2015	Quality of provision in some care homes is variable. A number of homes are closed to admissions to enable quality improvements to take place.	Quality of provision is variable leading to poor outcome for some residents.	Adult safeguarding board has oversight of the work to improve outcomes. Internally - developing a 'CQPG' approach to care home. Monthly Joint Quality Assurance Group (QASSI) includes CCG, CQC, LCC, and relevant clinicians (designated safeguarding team). QSG has established a Care Homes Group. Care home quality report produced and reported to the CCG QSOC committee (quality sub committee of CCG) each month. NHS Liverpool CCG is engaged in the Liverpool City Region work with regards to care homes via the Integrated Joint Director role and a Cheshire and Mersey summit will be taking place in June 2017.	Nursing Home integrated dashboard will create a single point of access for information and to highlight early warning signs and areas of concern. Further development of the performance dashboard to maximise the intelligence and information available to commissioners, providers and the general public. Care Homes Quality Assurance Group meets monthly.	5	4	20	N	LCCG are working with colleagues across LCC and the provider forum to develop and implement a quality improvement strategy for care homes in the city. This strategy will adopt the principles of the 'Enhanced Health in Care Homes' framework developed by NHSE. LCC has self-assessed itself against the framework and is developing a plan to address gaps in provision and quality. This work will be progressed via the commissioner meetings set up on a monthly basis. **(Update from KL 17/06/17)**	3	4	12	JL	Ongoing	Sep-17	▶

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CO63	To hold providers of commissioned services to account for the quality of services delivered	07/04/2017	Delivery of community services meets commissioning requirements	Quality of services transferred to new providers may deteriorate due to disruption caused by transfer including core bundle now subject to interim management arrangements led by Alder Hey.	Clinical Quality Oversight Group meeting fortnightly and reporting directly to the Transition Board Services transitioned to new providers will be monitored via respective CQPG Current LCH CQPG will continue, in order to monitor quality of core bundle Quality Surveillance Group will continue to receive reports regarding all transitioned services and Liverpool core bundle Services remain on enhanced surveillance Quality Summit took place on 16/03/2017 as part of the formal handover to new providers (please see CO64).	CQPG reports into QSOC and ultimately Governing Body CQPG remains in place currently Transition Board led by NHSI continues QSG have taken an oversight role to ensure quality of services is maintained / improved with receiving organisation	4	4	16	Y	March 2017 - Quality Handover Event for receivers of services from LCH took place with a document and formal handover for each receiving organisation - commissioners also present. CCG has worked with NHSE to determine where services have transitioned to - these will remain on enhanced surveillance until inspected by CQC (anticipated to be at approximately 6 months post transition). QSG has oversight role - reviewed at each meeting. Updates continue via internal LCH transaction meeting. **(Update from JL 15/06/2017)** LCCG has now established a Liverpool community specific CQPG that will operate on an monthly basis for the next 6 months to mainatin oversight and support to current contractual arrangements with LCH. LCCG hold regular meetings with AHCH in relation to transacted services. LCCG is working with NHSE and other commissioners locally to develop a set of KPIs that can be be monitored via associated CQPGs to ensure those teams that have been transacted are being assimilated well into new provider organisations. **(Update from KL 17/06/17)**	3	4	12	JL	Monthly review via CPQG/ QSG	Sep-17	▶

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CO65	To hold providers of commissioned services to account for the quality of services delivered	30/06/2017	To ensure compliance with timescales for Statutory Looked After Children Health Assessments and assurance of robust system-wide processes within provider services	Alder Hey Children's Hospital identified potential gap in LCH employed LAC nurses working within the trust. A number of issues identified within the workforce - i.e. sickness, planning for retirement and providing adequate service provision. In addition LAC nursing support where Alder Hey community paediatricians are not fully completing their tasks. 04.04.2017 sickness and operational issues at LCH have escalated. IHA's not being completed on time. SEND Inspection will include this.	Discussions being brokered between Trusts to clarify roles and responsibilities between LAC nurses and community paediatricians 04.04.2017 Training delivered to LCC Social Workers to highlight the importance of timely information sharing with LCH Staff. Problem escalated to LCC assistant director of Social Care. Carlene Baines continuing to support LCH with staffing issues.	Potential workshop to identify and resolve key issues - Completed 04.04.2017 - Training with LCC Social Workers completed. CB continues to support LCH Staff. Potential for improvement with ACHH taking over LCH services.	4	4	16	N	Identified key issues and have begun process of negotiation between respective clinical groups. Workshop scheduled to take place end of October. Meetings taken place between service leads. Alder Hey supporting LAC IHA with nurse. **(Update from DR 30/06/2017)** IHA workshop with provider services facilitated by the CCG on 18/5/17 – Next steps agreed. Situation has improved with reduction in sickness/capacity issues within LCH team; joint working between AHCH/LCH LAC teams to review care delivery model ongoing. However, given the short amount of time that has passed, these improvements have not yet translated in to a reduction in risk. LCH are still unable to return to the previous model of supporting AHCH clinicians more closely with IHA. There is still no designated Dr for LAC to help oversee the situation. LCH have a temporary Named Nurse LAC in post and there continues to be issues with the Local Authority which impact on IHA performance. **(Update from CB 30/06/2017)**	3	4	12	JL	Ongoing	Sep-17	**NEW RISK**
CO66	To hold providers of commissioned services to account for the quality of services delivered	30/06/2017	Effective provision to complete the CCG statutory function for Quality	The Quality Team has insufficient staffing to provide an adequate level of cover across the whole spectrum of its responsibilities including the SUI process	The issue has been raised at EMT and a paper has been prepared for SMT. SMT are aware of the issues verbally. The team have reviewed their capacity and capability and where possible have prioritised resources. SMT have agreed for the team to recruit to strengthen the team	Positions to be recruited to have been advertised	4	4	16	N	SMT paper- requesting a review of structure and recruitment to vacant posts has been reviewed and SMT have agreed for the team to recruit to strengthen the team. The team have reviewed their capacity and capability and where possible have prioritised resources. **(Update from DR 30/06/2017)**	4	4	16	JL	Ongoing	Sep-17	**NEW RISK**

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PRIMARY CARE																		
CO41a	To hold providers of commissioned services to account for the quality of services delivered	27/01/2015	Effective provision of commissioning support services to the CCG and primary care contractors.	Primary Care Support Services Contract was awarded to Capita in September 2015. This contract represents major transformation to the delivery of primary care support services.	Standing agenda item for Finance, Procurement & Contracting Committee and Primary Care Commissioning Committee Primary Care Team and Finance Team strengthened in anticipation of increased workload. Formal meetings in place between LCCG Finance and NHS England Finance Teams to discuss provision of financial data	Limited assurance on control measures due to uncertainty in terms of gaps. Minutes of committee meetings & exception reporting to Governing Body NHS England awarded contract (22 Jun 2015) to Capita to establish a 'single provider framework' for primary care administrative support functions LMC, Head of Primary Care Quality and Improvement and Practice Manager Governing Body leads on attending local stakeholder forum (monthly).	3	3	9	N	NHS England have the responsibility to manage the contract regarding PCS. LCCG has written to NHS England regarding our concerns and the local experiences which are different in part to the national experiences. A summary of the local issues have been sent to the National team, following the concerns raised by the Primary Care Commissioning Committee and members feedback. Meeting occurred on the 02/05/17 with Jill Matthews – NHS England Lead Contract Manager for Primary Care Support England's Managing Director NHSE, Simon England – Capita National Director Managing Director PCSE and Guy Dickie – Capita National Liaison Manager. GP Practices have been made aware of the outcome of the letter to say the meeting had taken place and PCS were taking forward some of the actions. Initially there had been 19 outstanding practice issues, but there are now just 3 left to resolve. The Primary Care Commissioning Committee have asked NHSE to provide KPIs with regards to this workstream. **(Update from CM 23/06/2017)**	3	3	9	CM	Ongoing	Sep-17	▼

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SYSTEM RESILIENCE																		
CO29	To hold providers of commissioned services to account for the quality of services delivered	01/06/2014	Delivery of the NHS constitution 4 hour standard in AED to patients attending Royal Liverpool & Broadgreen University Hospitals NHS Trust meeting the commissioning requirements (service and quality).	Failure to achieve the 95% 4 hour standard results in delayed care, treatment and poorer outcomes for patients	The CCG continues to work in partnership with the Trust, and broader partners through the AED Delivery Board in order achieve sustainable delivery of the 4hr standard. RLBUHT performance includes attribution of Walk-in Centre (AED type 3/4) activity. Medworx system in place at Trust to provide live data in respect of flow - identified as key component in achieving and sustaining AED performance ECIP concordat signed by all system partners to support delivery of improvement workstreams	Governing Body Corporate Performance Report provides updates/assurance on CCG controls on a monthly basis Performance is monitored via Contract Review Meetings on a monthly basis	4	4	16	N	Year-to-date 4hr performance for the Royal Liverpool (to 30th April 2017) stands at 76.6% (Type 1) and 90.9% (All types). This represents an improvement from previous months performance during the calender year 2017 but remains below the required NHS constitutional 4hr standard. The CCG is working with the trust, to implement the ECIP concordate priorities agreed following the 'system diagnostic' undertaken in Q3 2016/17 and received by Governing Body on 14th February 2017 and also meet the Urgent and Emergency Care requirements set out within 'Next Steps on the NHS 5 year forward view'. Monitoring of the associated action plans is undertaken by the North Mersey and Southport AED Delivery Board, with ongoing ECIP support to deliver sustainable improvement in performance going forward. **(Update from AMcF 23/06/2017)**	5	4	20	ID	Ongoing	Sep-17	▶

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CO35	To hold providers of commissioned services to account for the quality of services delivered	13/10/2014	Delivery of the NHS constitution 4 hour standard in AED to patients attending Aintree University Hospital NHS Foundation Trust meeting the commissioning requirements (service and quality).	Failure to achieve the 95% 4 hour standard results in delayed care, treatment and poorer outcomes for patients	The CCG continues to work in partnership with the Trust, and broader partners through the AED Delivery Board in order achieve sustainable delivery of the 4hr standard. AUH performance includes attribution of Walk-in Centre (AED type 3/4) activity. Medworx system in place at Trust to provide live data in respect of flow - identified as key component in achieving and sustaining AED performance ECIP concordat signed by all system partners to support delivery of improvement workstreams	Governing Body Corporate Performance Report provides updates/assurance on CCG controls on a monthly basis Performance is monitored via Contract Review Meetings on a monthly basis	4	4	16	N	Year-to-date 4hr performance for Aintree Hospital (to 30th April 2017) stands at 72.7% (Type 1) and 86.1% (All types). The Trust continue to underperform in relation to the required NHS constitutional 4hr standard. The CCG, in partnership with neighbouring CCGs, is working with the trust, to implement the ECIP concordate priorities agreed following the 'system diagnostic' undertaken in Q3 2016/17 and received by Governing Body on 14th February 2017 and also meet the Urgent and Emergency Care requirements set out within 'Next Steps on the NHS 5 year forward view'. Monitoring of the associated action plans is undertaken by the North Mersey and Southport AED Delivery Board, with ongoing ECIP support to deliver sustainable improvement in performance going forward. **(Update from AMcF 23/06/2017)**	5	4	20	ID	Ongoing	Sep-17	▶

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CO36	To hold providers of commissioned services to account for the quality of services delivered	13/10/2014	Delivery of Urgent and Emergency Care commissioned services is able to meet likely demands	Failure to meet patient demand leading to a fall in performance and a potential adverse impact upon service responsiveness and quality	The CCG and AED Delivery Board continue to monitor performance closely and support whole system cooperation and collaboration Additional resources have been made available to the local authority to support enhanced domiciliary care. The CCG has funded implementation of Escalation Management System (EMS) which supports transparency of escalation reporting and abaility of system partners to provide mutual aid	Oversight of the plans via the CCG Urgent Care Team and the North Mersey & Southport AED Delivery Board. EMS used across North Mersey economy. ECIP report received by Governing Body on 14/02/2017	3	4	12	Y	AED Delivery Board established as 'primary' governance/control measure in place; significantly strengthened by the support of ECIP and through principle of 'acting as one' Other key control measures such as OPEL system and Escalation Management System (EMS) now making an impact in terms of system-wide surveillance, providing 'early warnings' of significant rising pressures and, more importantly, the coordination of actions to 'cool' the system before it reaches critical levels. In addition to these control measures, the Urgent and Emergency Care Teams of Liverpool and Sefton CCGs continue to essentially 'act as one' in the management of the system and the support of Trusts and providers' escalation status. **(update from AMcF 23/06/2017)**	3	4	12	ID	Ongoing	Sep-17	▼

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HEALTHY LIVERPOOL PROGRAMME																		
CO18	We accept responsibility for our actions. We make and support business decisions through experience, evidence and good judgement, and we will deliver against our promises	01/10/2013	Deliver the transformation of health and health & care services across the city through the Healthy Liverpool Programme	Failure to delivery the transformational programme; due to failure to communicate and engage with stakeholders and to gain understanding and support for the programme; which would lead to a reputational risk due to high profile of NHS change and reconfiguration programmes.	Programme Advisory Board established; Governing Body commitment to HLP; officer-led delivery group in place; Additional senior resource sourced to manage communication, stakeholder management and engagement. Clinically-led settings and programme groups in place; List of Programme roles necessary to mobilise produced with prioritisation of roles assessed to mitigate risks to delivery. Engagement plan for 2017/18 has been developed informed by HLP priorities	SDC completed and approved by Governing Body on 29/09/2015. NHS England service change and reconfiguration tracker (formal assurance process) MiAA review of governance arrangements to oversee the delivery of the Healthy Liverpool programme included in CCG Audit Plan 2015/16 HLP Engagement and Comms Plan refreshed in January 2015.	2	5	10	Y	A plan for North Mersey Engagement consultation for key projects including LWH review and single service orthopaedics & ENT has been developed. The Orthopaedics & ENT consultation has now started and will run for 12 weeks from 26th June 2017 to the 15th September 2017. The responses to the consultation will then be reviewed and considered in reaching a final decision on the reconfiguration of these two services. **(Update from SL 28/06/2017)**	2	5	10	TJ / CH	On-going	Sep-17	▶

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CO54	To hold providers of commissioned services to account for the quality of services delivered	01-Feb-16	To secure the future sustainability and delivery of safe and effective services for women's health and neonates.	Service and financial risks undermine the sustainable delivery of services currently provided by LWH.	Women's health and neonatal services remain a high priority within the HLP. Future generations strategy developed by LWH. Application for distress funding made to monitor. A Financial oversight board has been established to identify potential solutions to the capital funding challenge of the options in the PCBC	Regular oversight and reports to the HLP Hospital and Programme Board. Monitor to undertake review of the Trust in response to application for distress funding. CCG Governing Body received and accepted a strategic case for change at its formal meeting held on 8 March 2016. CCG agreed with LWH to now undertake a full options appraisal of the service delivery options in response to this case for change.	3	4	12	Y	Finance Oversight Board has been established to oversee the work on additional financial assurance for the PCBC due to report in the summer. **(Update from CH 28/04/2017)** An update on the progress being made will be presented in the September register. **(Update from SL 28/06/2017)**	3	4	12	TJ / KS	Apr-17	Sep-17	▶

Ref	Organisational Values & Objectives	Date Entered	Objective	Description of Risks	Current Controls	Assurance in Controls	L	C	Risk score when entered on to register	Risk accepted	Management Actions re gaps in controls and assurance or unacceptable risk rating	L	C	Residual Risk (score)	Lead Officer	Completion Date	Review Date	Progress since last update
CO56	We accept responsibility for our actions. We make and support business decisions through experience, evidence and good judgement, and we will deliver against our promises	30-Mar-16	Deliver the transformation of health and health & care services across the city through the Healthy Liverpool Programme	Failure to meet Statutory requirements and due process	Internal processes to assess risk regarding engagement consultation, equalities responsibilities and service reconfiguration. External NHSE assurance process. Relationship and communication with Health Select and OSC Service reconfiguration progress is updated monthly on the NHSE Service Reconfiguration grid.	HLP Engagement and Comms Strategy In-house expertise around statutory requirements and access to advice from external advisors Healthy Liverpool Programme Board HLP Leadership Group Committees in Common NHSE Assurance meetings North Mersey Committees in Common established.	3	4	12	Y	A North Mersey Joint Committee with delegated responsibility from CCG Governing Bodies is to be established to oversee Major Hospital Service reconfiguration, it is envisaged that this 'new' joint committee will be established by October 2017. **(Update from SL 28/06/2017)**	2	4	8	CH	On-going	Sep-17	▶
CO59	We accept responsibility for our actions. We make and support business decisions through experience, evidence and good judgement, and we will deliver against our promises	22-Jun-16	Deliver the transformation of health and health & care services across the city through the Healthy Liverpool Programme	The ability of the local delivery system to collaborate and act as one to deliver the system plan for financial & clinical sustainability	Healthy Liverpool engagement and governance enables a collaborative opportunity to structural change Establishment of a provider collaborative to enable a system wide approach to reconfiguration. Governance is in place for a Merseyside LDS membership group which is driving a system Sustainability & transformation plan	HLP Governance CCG Network The local system has applied for a North Mersey system control total to facilitate collaboration and ownership	3	4	12	N	A group of Trust Directors of Finance and CCG Chief Finance Officers has now been establlished to explore and embed the operation of the 'Acting as One' agreement and the principles that will apply through 2017-19, with a remit to explore how the system will operate post April 2019. **(Update from SL 28/06/2017)**	2	4	8	CH	Ongoing	Sep-17	▼

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Financial Risk																		
CO57	To maximise value from our financial resources and focus on interventions that will make a difference To meet all statutory duties	24-May-16	To achieve NHS business rules and to meet statutory financial duties	Failure to deliver statutory financial duties Poor or inappropriate use of financial resources Failure to secure maximum value for money in contractual arrangements Failure to deliver cash releasing efficiency savings (CRES).	Development & approval of financial plan delivering NHSE business rules and CCG planning assumptions. Approval of 2017/18 operational financial plan by the Governing Body. Budgets delegated and accepted by budget holders . Financial risk assessments ; Contingency reserves set aside. Monthly reporting including variance analysis; targeted corrective actions as appropriate. Contract negotiation and monitoring processes. Contract Performance monitoring and reporting. Financial Recovery Oversight Group (FROG) continues to meet on a regular basis and has oversight of the CRES plan.	Monthly Finance report to FPC and GB Periodic internal audit reviews on Financial, Contracting and Business Intelligence controls and procedures. External audit review of arrangements for the production of statutory accounts - includes review of contracting arrangements Financial monitoring by NHS E - monthly monitoring reports BI and contract activity reporting to FPC Finance Directors across the region are meeting on a regular basis. Financial Recovery Oversight Group meeting weekly. Financial Effectiveness Plan in place. Governing Body oversight maintained by monthly stand alone 'Financial Performance Report'.	3	3	9	Y	Monthly reporting continues with regards to budget monitoring and CRES delivery against plan. Performance against the CRES Plan will be reported to appropriate committees on a monthly basis, alongside the SMT. A full review of the forecast outturn position will take place after receipt of the Q1 data which is expected in late July. A more detailed update will be provided in September 2017. **(Update from MB 28/06/2017)**	3	3	9	TJ	Ongoing	Sep-17	▶

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		KEY:	Updates to existing risks in 'blue'		new risk						Recommended for removal						▶	Risk Unchanged
																	▲	Risk increased
																	▼	Risk decreased

Risk scoring = likelihood x consequence (L x C)

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

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

1 – 3	Low risk
4 – 6	Moderate Risk
8 – 12	High Risk
15 – 25	Extreme Risk

15 – 25 Extreme Risk

NHS
Liverpool
Clinical Commissioning Group

Report no: GB 52-17

NHS LIVERPOOL CCG GOVERNING BODY
TUESDAY 11TH JULY 2017

Title of Report	Establishing A Joint Committee Across Liverpool, South Sefton And Knowsley CCGs To Agree Options And Take Forward Decision Making On The Future Configuration Of Hospital Services In North Mersey.
Lead Governor	Katherine Sheerin, Chief Officer
Senior Management Team Lead	Katherine Sheerin, Chief Officer
Report Author	Katherine Sheerin, Chief Officer
Summary	This paper presents a proposal to establish a Joint Committee across South Sefton, Southport and Formby, Knowsley and Liverpool CCGs, in order to agree options and take forward decision making on the future configuration of Hospital Services in North Mersey.
Recommendation	That Liverpool CCG Governing Body: ➢ Supports the establishment of a Joint Committee across Liverpool, South Sefton, Southport and Formby and Knowsley CCGs. ➢ Approves the Terms of Reference ➢ Agrees that the Committee(s) in Common is then dissolved.
Relevant standards/targets	Delivering Financial and Clinical Sustainability of hospital services. NHS Five Year Forward View

ESTABLISHING A JOINT COMMITTEE ACROSS LIVERPOOL, SOUTH SEFTON AND KNOWSLEY CCGS TO AGREE OPTIONS AND TAKE FORWARD DECISION MAKING ON THE FUTURE CONFIGURATION OF HOSPITAL SERVICES IN NORTH MERSEY

1. PURPOSE

The purpose of this paper is to present a proposal to establish a Joint Committee across South Sefton, Southport and Formby, Knowsley and Liverpool CCGs, in order to agree options and take forward decision making on the future configuration of Hospital Services in North Mersey.

2. RECOMMENDATIONS

That Liverpool CCG Governing Body:

- Supports the establishment of a Joint Committee across Liverpool, South Sefton, Southport and Formby and Knowsley CCGs.
- Approves the Terms of Reference
- Agrees that the Committee(s) in Common is then dissolved.

3. BACKGROUND

A Committee(s) in Common was established across Liverpool, South Sefton and Knowsley CCGs in October 2014 to consider changes in hospital services arising from the Healthy Liverpool Programme.

The remit of the Committee(s) in Common was -

- Responsibility for agreeing the options for changes to the delivery of hospital services across the city of Liverpool as part of the Healthy Liverpool Programme, taking full account of the work of the clinical reference group and the recommendations from the Leadership Group.

- To identify and make recommendations on a preferred option(s) where appropriate.

- To then steer and support the engagement and consultation process for the changes in hospital services, and recommend conclusions to each host statutory body for approval and implementation.

As a Committee(s) in Common, there was no delegated decision making powers, rather, decisions had to be referred back to each Governing Body.

4. PROPOSED NEW GOVERNANCE ARRANGEMENTS

Joint Committees are a statutory mechanism which gives CCGs an additional option for undertaking collective strategic decision making. CCGs are able to delegate their decision making function to one CCG joint committee, dramatically reducing administration and bureaucracy whilst increasing integration and facilitating greater strategic alignment.

The legal basis on which the CCGs can agree to jointly exercise a group of their functions through delegating them to a joint committee is through the powers under section 14Z3 of the NHS Act 2006 (amended) which provides that –

'(1) Any two or more clinical commissioning groups may make arrangements under this section

(2) The arrangements may provide for

(a) One or more of the clinical commissioning groups to exercise any of the commissioning functions of another on its behalf, or

(b) All the clinical commissioning groups to exercise any of their commissioning functions jointly.

(2A) Where any functions are, by virtue of subsection (2) (b) exercisable jointly by two or more clinical commissioning groups, they may be exercised by a joint committee of the groups ….

(7) In this section, 'commissioning functions' means the functions of clinical commissioning groups in arranging for the provision of services as part of the health service (including the function of making a request to the Board for the purposes of section 14Z9).'

This is confirmed in each of the CCG Constitutions.

It is proposed that a Joint Committee is established across Liverpool, South Sefton, Southport and Formby and Knowsley CCGs which will be delegated the capacity to propose, consult on and agree future hospital service configurations across North Mersey. The work to develop such

proposals has been overseen by the Healthy Liverpool Hospital Programme. However, it is being proposed that this is replaced by the North Mersey Hospital Transformation Board, supported by the Healthy Liverpool Hospital Programme Team and relevant staff from each CCG. This North Mersey Hospital Transformation Board will report into the proposed Joint Committee.

The hospital provider organisations within the scope of the North Mersey Hospital Transformation Programme are –

- Aintree University Teaching Hospital Trust
- Alder Hey
- Royal Liverpool and Broadgreen University Hospitals Trust
- Liverpool Women's Hospital
- Clatterbridge Centre for Oncology
- Walton Centre
- Liverpool Heart and Chest Hospital
- Southport and Ormkirk NHS Trust

The Joint Committee will have no contract negotiation powers meaning that it will not be the body for formal contract negotiations between commissioner and providers, nor will it have responsibilities regarding the monitoring of activity in relation to either finance or quality. These processes will continue to be the responsibility of the individual CCGs and NHSE.

Given the specialist nature of some services, it may be that the Joint Committee is required to work with neighbouring CCGs (including other Joint Committees) on some service configuration proposals. Changes in St Helen and Knowsley Trust and Wirral Foundation Trust will be of particular interest. Given the inclusion of Southport and Ormskirk NHS Trust, discussions are being held with West Lancashire CCG regarding their involvement as an Associate Member of the Joint Committee.

Appendix 1 contains a draft Terms of Reference for the proposed Joint Committee for discussion. Whilst the current proposal is for the

Committee's scope of responsibility to be limited to changes in hospital services, it could be that this vehicle provides a good mechanism for other commissioning decisions which impact on a bigger footprint. This can be reviewed as the Committee develops.

5. STATUTORY REQUIREMENTS (only applicable to strategy & commissioning papers)

5.1 Does this require public engagement or has public engagement been carried out? Yes / No

i. No – each CCG has the power to establish Joint Committees as described in their Constitutions.

5.2 Does the public sector equality duty apply? Yes/no.

i. No.

5.3 Explain how you have/will maximise social value in the proposal: describe the impact on each of the following areas showing how this is constructed to achieve the most:

a) Economic wellbeing
b) Social wellbeing
c) Environmental wellbeing

This will be taken account of in the decision making process on options for future configuration of hospital services.

5.4 Taking the above into account, describe the impact on improving health outcomes and reducing inequalities

This will be taken account of in the decision making process on options for future configuration of hospital services.

6. DESCRIBE HOW THIS PROMOTES FINANCIAL SUSTAINABILITY

This will be taken account of in the decision making process on options for future configuration of hospital services.

7. CONCLUSION

Given the complexity of the hospital system in North Mersey and the need for change to sustain clinical and financial viability, commissioners need to work together to secure effective decision making in order to make progress. A Joint Committee with fully delegated responsibilities should support this, through coherence of approach and more stream lined decision making.

Katherine Sheerin
Chief Officer
NHS Liverpool CCG

Proposed Terms of Reference for the Realigning Hospital Based Care Committee(s) in Common

1.0 Introduction

1.1 The NHS Act 2006 (as amended) ('**the NHS Act**'), was amended through the introduction of a Legislative Reform Order ("LRO") to allow CCGs to form joint committees. This means that two or more CCGs exercising commissioning functions jointly may form a joint committee as a result of the LRO amendment to s.14Z3 (CCGs working together) of the NHS Act.

1.2 Joint committees are a statutory mechanism which gives CCGs an additional option for undertaking collective strategic decision making and this can include NHS England too, who may also make decisions collaboratively with CCGs.

1.3 Although the North Mersey Hospital Transformation Programme will affect services commissioned by the Specialised Commissioning function of NHS England it has been decided that decisions will be undertaken on a collaborative basis, rather than as a single Joint Committee. This will allow sequential decisions to be undertaken allowing clarity of responsibility but also recognising the linkage between the two decisions.

1.4 Individual CCGs and NHS England will still always remain accountable for meeting their statutory duties. The aim of creating a joint committee is to encourage the development of strong collaborative and integrated relationships and decision-making between partners.

1.5 The Joint Committee of Clinical Commissioning Groups is a joint committee of: NHS Liverpool CCG; NHS Knowsley CCG; NHS Southport and Formby CCG; NHS South Sefton CCG. It has the primary purpose of formal public consultation and decision making on the issues which are the subject of the North Mersey Hospital Transformation Programme.

1.6 In addition the Joint Committee will meet collaboratively with NHS England to make integrated decisions in respect of those services within the Programme which are directly commissioned by NHS England.

1.7 The North Mersey Local Delivery System Plan - Health leaders across North Mersey have collectively committed to change the way certain elements of health care are provided to the local population to deliver the highest quality of care possible within the resources available. This work is described in the North Mersey Local Delivery System Plan. A key strand of this is the Hospital Transformation Programme which is designed to deliver key clinical standards consistently across the patch so that all people receive the highest possible care and best outcomes and to secure clinically and financially sustainable hospital services.

1.8 Currently for those people who do need in-hospital treatment care can be variable in terms of outcomes because not all hospitals or services meet the agreed clinical quality standards, the hospitals are competing to provide the same services in a health economy that is constrained by both finance and capacity, particularly certain elements of the workforce, to deliver services at the levels required. From the work carried out to date, it is clear that it is not sustainable to carry on without changing the way health services are delivered both regionally and locally.

1.9 A Programme Board for the North Mersey Hospital Transformation Programme will be established with the following remit -

i. Establish unified clinical standards and clinical teams that will eliminate variation and drive up quality.

ii. Design a hospital system which is fit for the future, by removing duplication in services and consolidating trusts to achieve our vision for single service, system wide delivery delivered through a centralised university hospital campus.

iii. Maximize the benefits of clinical excellence and academic research to improve outcomes for patients.

This Programme Board will report into the Joint Committee. Terms of Reference will be developed for approval by the Joint Committee.

2.0 Statutory Framework for the Joint Committee

2.1 The NHS Act which has been amended by LRO 2014/2436, provides at s.14Z3 that where two or more clinical commissioning groups are exercising their commissioning functions jointly, those functions may be exercised by a joint committee of the groups.

2.2 The CCGs named in paragraph 1.5 above have delegated the functions set out in Schedule 1 to the JC CCGs.

3.0 Role of the Joint Committee

The Joint Committee will have the primary purpose of arranging and undertaking the formal public consultation and then making decision on the issues which are the subject of the consultation in relation to the North Mersey Hospital Transformation Programme. This includes but is not limited to –

- Determine the options appraisal process
- Determine the method and scope of the consultation process
- Act as the formal body in relation to consultation with the Joint Overview and Scrutiny Committees established for this Consultation by the relevant Local Authorities
- Make any necessary decisions arising from a Pre-Consultation Business Case (and the decision to run a formal consultation process)
- Approve the Consultation Plan
- Approve the text and issues on which the public's views are sought in the Consultation Document
- Take or arrange for all necessary steps to be taken to enable the CCGs to comply with their public sector equality duties
- Approve the formal report on the outcomes of the consultation that incorporates all of the representations received in response to the consultation document in order to reach a decision
- Make decisions about future service configuration and service change, taking into account all of the information collated and representations received in relation to the consultation process. This should I include consideration of any recommendations made by the Programme board or views expressed by the Joint Health Overview and Scrutiny Committees(s) or any other relevant

organisations. It should also include consideration of the implications of the decisions in relation to potential risk to the sustainability and viability of the Trusts / Foundation Trusts included in the remit of the Programme.

4.0 Membership of the Joint Committee

- Liverpool CCG (3 Governing Body members)
- Knowsley CCG (3 Governing Body members)
- South Sefton CCG (3 Governing Body members)
- Southport and Formby CCG (3 Governing Body members)

(The Governing Body members will include a Lay Member)

Associate Member(s)

West Lancashire CCG

Co-opted Members (non-voting)

- NHSE (1 member with senior responsibility for commissioning specialised services)
- Liverpool LA (1 member to be nominated through the H and WB Board) - 1 member
- Knowsley LA (1 member to be nominated through the H and WB Board) – 1 member
- Sefton LA (1 member to be nominated through the H and WB Board) – 1 member
- A Healthwatch representative nominated by local Healthwatch groups
- Clinical Lead for North Mersey Hospital Transformation Programme
- SRO for North Mersey Hospital Transformation Programme

Others may be asked to attend to provide information and expertise as required.

Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the joint committee. All deputies should be fully briefed and the secretariat informed of any agreement to deputise so that quoracy can be maintained.

No person can act in more than one role on the Joint Committee, meaning htat each deputy needs to be an additional person from outside the Joint Committee membership.

LCCG Healthy Liverpool Programme Team will act as secretariat to the Committee to ensure the day to day work of the Joint Committee is proceeding satisfactorily.

The Joint Committee will be chaired by one of the CCG members (either Chair or Accountable Officer) to be determined by the Committee members.

5.0 Meetings

The Joint Committee shall adopt the standing orders of NHS Liverpool CCG insofar as they relate to the –

- Notice of meetings
- Handling of meetings
- Agendas
- Circulation of papers
- Conflicts of interest

6.0 Voting

The Joint Committee will aim to make decisions by consensus wherever possible. Where this is not achieved, a voting method will be used. The voting power of each individual present will be weighted so that each party (CCG) possesses 25% of total voting power.

It is proposed that recommendations can be approved if there is approval by at least 75%.

7.0 Quorum

At least one full voting member from each CCG must be present for the meeting to be quorate.

8.0 Frequency of meetings

Meetings will be held at least six times per year.

9.0 Meetings of the Joint Committee

Meetings of the Joint Committee shall be held in public unless the Joint Committee considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meetings. Therefore, the Joint Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of the knowledge and ability, and endeavour to reach a collective view.

The Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

The Joint Committee has the power to establish sub groups and working groups and any such groups will be accountable directly to the Joint Committee.

Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the Joint Committee in which even these shall be observed.

10.0 Secretariat Provisions

The secretariat to the Joint Committee will:

- Circulate the minutes and action notes of the committee within five working days of the meeting to all members

- Present the minutes and actions notes to the Governing Bodies of the CCGs set out in 5.1 above.

11.0 Reporting to CCGs and NHS England

The Joint Committee will make a quarterly written report to the CCG member Governing Bodies and NHS England.

12.0 Decisions

The Joint Committee will make decisions within the bounds of the scope of the functions delegated.

The decision of the Joint Committee shall be binding on all member CCGs, which are:

- NHS Liverpool CCG;
- NHS Southport and Formby CCG;
- NHS Sefton CCG;
- NHS Knowsley CCG.

All decision undertaken by the Joint Committee will be published by the clinical Commissioning Groups set out above.

13.0 Review of the Terms of Reference

These terms of reference will be formally reviewed by the CCGs set out above annually. They may be amended by mutal agreement between CCGs at any time to reflect changes in circumstances as they arise.

14.0 Withdrawal from the Joint Committee

Should this joint commissioning arragmeent prove to be unsatisfactory, the Governing Body of any of the member CCGs or NHS Engaldn can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the new financial year.

15.0 Signatures

NHS Knowsley CCG

NHS Liverpool CCG

NHS Southport and Formby CCG

NHS South Sefton CCG

NHS
Liverpool
Clinical Commissioning Group

Report no: GB 53-17

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP GOVERNING BODY

TUESDAY 11TH JULY 2017

Title of Report	Healthwatch Liverpool Annual Report 2016/17
Lead Governor	Dave Antrobus, Lay Member Lead for Patient & Public Engagement
Senior Management Team Lead	Katherine Sheerin, Chief Officer
Report Author	Sarah Thwaites, Chief Executive Healthwatch Liverpool
Summary	The Liverpool Healthwatch Annual Report sets out the activities undertaken by Healthwatch in 2016/17. The report highlights how the work of the organisation has helped to ensure that decisions taken regarding health and care services put the experience of people at the heart of the agenda.
Recommendation	That Liverpool CCG Governing Body: ➢ Notes the Healthwatch Liverpool Annual Report 2016/17
Relevant standards/targets	Statutory Duties to involve local people in the work of the CCG

healthwatch
Liverpool

Healthwatch Liverpool

Annual Report 2016/17

Contents

Message from our Chair

As chair of Healthwatch Liverpool, I'd like to welcome you to our 2016-17 annual report.

Lynn Collins, Healthwatch Liverpool Chair

This has been a particularly challenging year for Healthwatch Liverpool. As well as maintaining services to patients and the public, we have had to make sure that patient voices aren't overlooked in the increasingly complex and pressurised world of health and social care.

There are tighter financial constraints on health and care services, increasing demand, and a changing political landscape. Not to mention Sustainability and Transformation Plans, The Five Year Forward View, and ever-changing health and care providers both in the public and private sector.

Praise must go to the team who have made sure that Healthwatch Liverpool has remained a respected presence with the local health and care sector. We have always been ready to both listen to the patient view, and then relay this to influence the decision makers. We have continued to take a non-voting observer seat at the Clinical Commissioning Group (CCG) governing body and have been active participants in many of the CCG sub-groups. We also report into the Liverpool City Council Health and Wellbeing Board.

The role of Healthwatch is more important than ever and in Liverpool we hope we have been able to fulfil the role of patient advocate, advisor and supporter by making ourselves accessible and visible.

Regular public facing events, and 'listening days' at local hospitals supplement the telephone advice and enquiry service to make sure we speak with an authoritative voice. Staff work hard to make these events interesting and interactive, and to ensure our presence on social media is current and relevant.

The Healthwatch network remains an important part of our health and social care system, playing a vital role as our annual report shows you. We look forward to continuing to play that role.

Lynn Collins

Message from our Chief Executive

In this report we feedback on our activities in 2016-17. It feels important to set this in the context of the challenges facing NHS and care services and our concerns about the impact that this may come to have on patient care.

Liverpool has long faced major health issues. In 2016-17 some issues became more acute:

+ Challenges in the care home sector intensified;
+ NHS financial controls tightened;
+ Our acute hospitals and A&Es were busier than ever, struggling to meet waiting times targets and with the ambulance service also taking the strain;
+ Pressure grew to 'balance the books' while still meeting immediate and obvious needs.

In recent years organisations had been coming together to think through ways to respond to Liverpool's health challenges and inequalities with some excellent areas of joint work emerging. Increasing financial pressures are putting this at risk. There is no shortage of good ideas and motivation but there are now fewer resources to make things happen.

Valuing what we have – learning from what can be done better.

We do not want to forget the positives. We really do have services to appreciate and value locally. Two of our hospitals, two local GP practices and one local care home received Care Quality Commission (CQC) ratings of 'Outstanding' and patients often tell us about excellent experiences of care at a wide range of services, singling out the level of care they receive from staff.

Learning from patient feedback is more important than ever when services are under pressure. Beyond performance statistics, it is knowing what it is like to be a user of health or care services that shows services how they are really doing, where the pressure points are and which issues need to be tackled before they grow.

Staff members on the front line go to work wanting to deliver the best care. They need and deserve our help, our praise when things go well and our honest but constructive feedback when they don't.

Facing the challenges

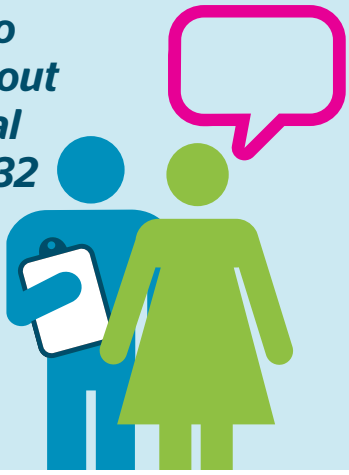
The challenges facing our health and care services are not going away. Budgets are likely to remain tight. We can only hope to influence what happens within the restrictions imposed by those budgets. We will keep encouraging the public to tell us their experiences of services. We will keep sharing these with services and decision makers as a reminder that all decisions need to have people at their heart. Our information services will continue to be there to guide people through the system's complexities.

As always we need your help. When you use a service please take time to feedback your experiences to us. Your stories really can help make services better for everyone.

Sarah Thwaites

Highlights from the year

We've spoken to 1708 people about accessing dental services and 1832 people about accessing GP services.



This year we have taken 2773 public enquiries plus 4226 student enquiries.

We've visited 26 local services through Listening Events and Enter and Views, where we spoke to 702 people about their experiences.

Our reports have tackled issues ranging from hospital discharge to GP continuity of care for people with long term conditions

This year we reached 261881 people on social media.

We've met hundreds of people at local events

Who we are

We all want the best possible health and quality of life for ourselves, our families and others in our communities. Healthwatch exists to make health and care services work for the people who need them. We're here to help local people understand their options, be able to make informed choices and to be listened to about their experiences, needs and preferences.

Our links to local people and communities help us to understand the needs, experiences and concerns of people of all ages who use services and to speak out on their behalf. We believe that asking people about their experiences – and really listening to what they say - can identify issues that, if addressed, will make services better.

Our role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their agenda. We are uniquely placed to do this because:

+ We have an overview of health and care services. Most people and services only have a good knowledge of the parts of the system they use or work in;
+ We have an interest in every aspect of health and adult social care allowing us to see links and connections and to spot where these break down;
+ We are local but nationally connected. As a local service we are in touch with local concerns and with connections into both local communities, services and decision makers. With our neighbouring Healthwatch and a national network behind us we can also help to influence regional and national decisions.

Our vision

A health and care system which:

+ Is stable, well-resourced and trusted;
+ Can meet the growing and changing needs of our diverse population;
+ Enables staff to deliver the best quality, joined-up care;
+ Listens to and learns from patient experiences.

Health and care staff who:

+ Receive and act on both praise and constructive feedback;
+ Know that how they do their work makes a difference and want to keep on making that difference.

Patients who:

+ Know what services and options exist;
+ Are able to make informed choices, with support where needed;
+ Feel able and willing to share their experiences to help services improve further.

A Healthwatch for everyone in Liverpool which helps make this possible.

Our priorities

We have a number of priorities that guide our work. These, together with the reasons why they are important to us, are listed below and will be covered in more detail later in the report:

Helping you find services

Gathering feedback about services

Seeing how services work

Responding to change / system issues

Members of the Healthwatch Liverpool Team at an event (l to r): Amani, Sarah, Danielle and Val

Helping you find the services you need

Helping you find services

The health and care system can be very complicated. Finding your way through it can be overwhelming. By providing people with clear, reliable information through the directory and in a supportive, personalised way through our enquiry work we can make a real difference.

Our enquiry work also underpins all our other areas of work by giving us real, up-to-date information about problems that people are experiencing.

People are often unaware of what services there are or how best to access them. We want everyone to have access to the best quality local care, and knowing what is available is the first vital part of this.

Our directories and enquiries service are important because people need control over their own lives, especially their health. If people don't get timely, accurate advice their problems can get worse, making life more difficult for them and increasing pressure on services.

Online information

We collect, input and update information on thousands of services onto 3 linked online directories:

+ TheLiveWelldirectory.com provides the public with information on health and wellbeing related services and activities. It started off as a Liverpool only directory but is extending to cover the 'Liverpool City Region' with Wirral, Knowsley and Sefton now partner areas. We are responsible for collecting and maintaining the 1678 Liverpool records on the site;
+ Wellbeing Liverpool extracts mental health specific records for easier searching in times of distress;
+ The Ralfy directory provides GPs with information to help support their patients.

Services are constantly changing and we are always working to keep the information on the directories accurate and up-to-date.

Entries include GPs, dentists, pharmacies, specialist health services, care services, lunch clubs, community activities and self-help groups.

LIVE WELL
LIVERPOOL CITY REGION

"The Healthwatch Liverpool team provide outstanding support to the Live Well directory, ensuring that it is up to date, accessible and easy to use and reflects the changing needs of the people of the city. The success of the directory is due mainly to the work of the team, contacting service providers to ensure that details are up to date, but also looking out for new opportunities to add new services from across all sectors ensuring a wide range of content to help improve wellbeing.

The team at Healthwatch have been fantastic in developing the directory, looking at ways that it can be improved to make the experience for users the best that it can be.

The team also provide excellent one to one support for those people who can't access the directory online or who are having difficulties finding what they need." Marie Jones, Liverpool City Council

Search endlessly or ask us

Many people do not have access to the internet or in a time of stress may find a directory too impersonal. We are always happy to be the 'human version' of the directories for our enquirers.

In 2016-17 our enquiry service dealt with 2773 health and social care enquiries, plus 4226 student enquiries at welcome and fresher events at universities and colleges, which included 2519 students asking for information on, or registering for GP or dentist services.

People contact us looking for information for themselves, family members and friends, or for people they are supporting professionally. We provide information in a way that suits their circumstance and we pride ourselves on providing a personalised service to meet individual needs.

Finding the right options

People can contact us about anything that concerns health or wellbeing. Sometimes people aren't sure what it is that they are looking for or what services might be out there to help. We are happy to listen and take it at the person's own pace, sometimes over several calls or emails. We often suggest possibilities that the person hadn't even considered and always remember that people are individuals who need to make their own decisions about what will work for them.

Our team are selected for their ability to relate to people on a human level, with understanding and compassion. People who call us are often relieved that we aren't a call centre but 'real' people who know the system and the city and can help them see their way through the maze. We are often thanked for how quickly we can provide relevant and detailed information and how much of a difference our approach makes.

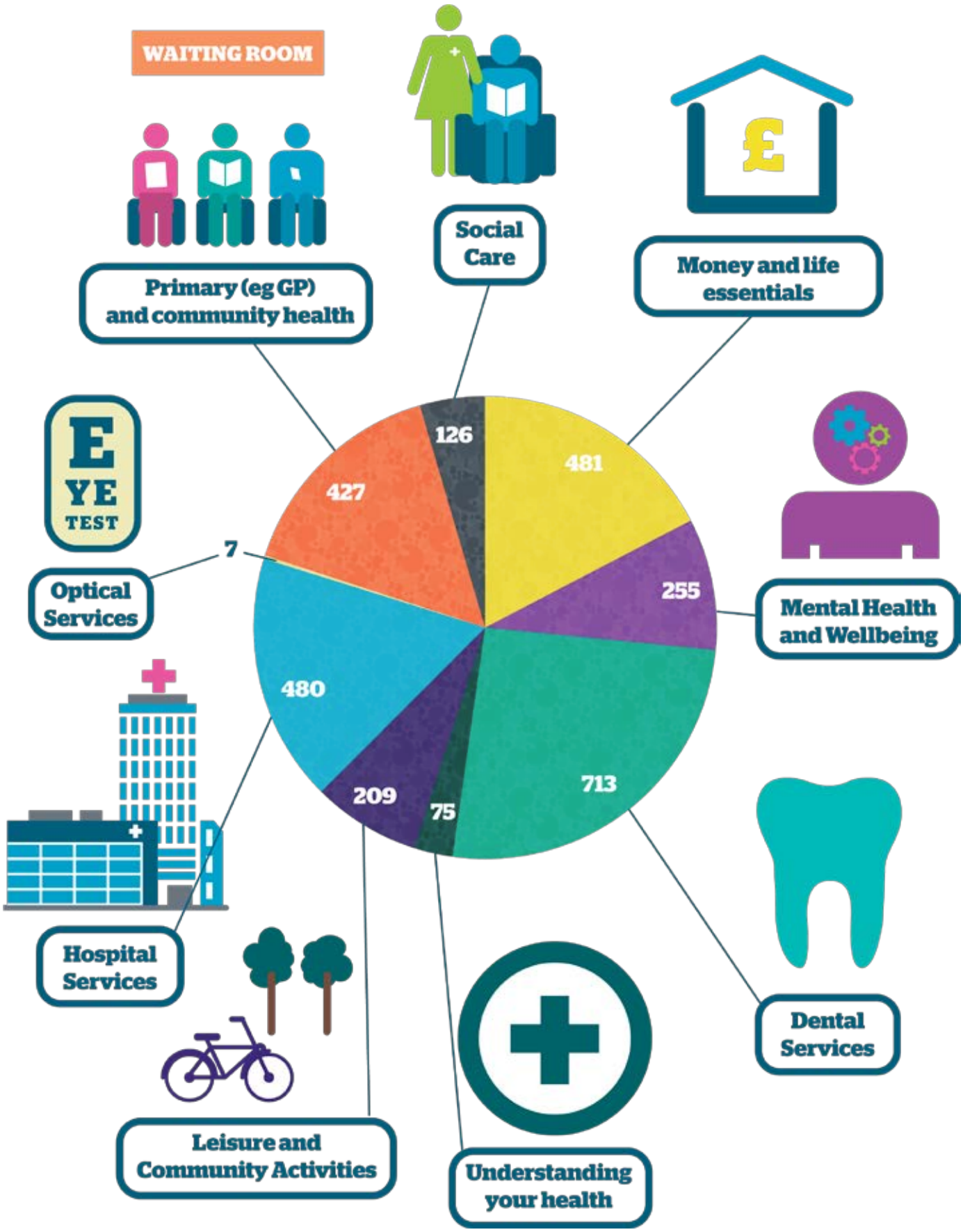
Often our enquirers go on to contribute to our work by providing valuable feedback about services they have accessed. This gives us early warning of where things might be going wrong in a service and so informs the other areas of our work.

"I've been going around making phone calls for two days and nobody has been helpful. You're the only one who has made me feel a bit more relaxed about things. Healthwatch is a life saver, finding your number was the best thing I ever did, many, many thanks". A member of the public

"Thank you so much for all of your help with my requests. I really appreciate the effort and time you have taken and I will pass this information onto my lady who will be very grateful!" Talk Liverpool

"I am really grateful for your service. It has helped to talk. I feel lighter knowing that there are things I can do and that there is support available to get through the maze." A member of the public

What you asked us about



Your views on health and care

Hearing what people really think

Because patients are the experts in how services work for them, decisions made without hearing the patient perspective miss a vital part of the picture.

People can be wary of speaking up. We can give people from across Liverpool's diverse communities a 'safer' way to share their experiences and the assurance that doing so makes a difference.

This is one of our core priorities on which our work is based.

We speak to thousands of enquirers each year. As well as giving them information to help resolve their concerns we try to use their feedback to help prevent the same problem happening to others.

We supplement this with other ways of hearing what people think about health and care services. For example we:

+ attended 57 local community events;
+ held 16 Listening Events in health settings;
+ visited and talked to community groups;
+ used paper and online questionnaires;
+ supported this with conversations with a network of contacts and our social media followers.

We have engaged many diverse groups and communities to hear views and experiences, and to ensure we give everybody equal opportunity to have their voices heard. We know that equality is not as simple as treating all people the same as some people and groups have particular barriers.

As well as the general public we also actively sought out:

+ those whose views are often overlooked
+ those who are particularly affected by this year's priority topics such as hospital discharge and continuity of care for people with long term conditions, This includes older people, carers and members of peer support groups.

Over the past year, we have visited many communities engaging disadvantaged or vulnerable people in our work. These visits and events aim to enable them to have a strong voice in sharing their views and experiences to:

+ discuss our work and what we do;
+ take enquiries about health and social care services;
+ help people understand the benefits and aims of sharing their views, and how their experiences can make a difference;
+ offer an opportunity for people to share their patient experiences.

Examples have included:

Older people

Typically our need for services increases with age and so we tend to speak to a high proportion of older people in our Listening Events in health settings. To ensure that we don't exclude other groups of older people we also visited older people's social groups, a dementia cafe, sheltered housing and care settings. We are also the point of contact for patient surveys for the Frailty Service.

Black, Asian, Minority Ethnic and Refugee communities (BAMER):

Visiting a range of community groups and events to gather people's views including Building Links Women's Group for the Somali Community, PAL Multicultural Centre Women's Group, a health event at the PAL Centre, a Sepas event for the Persian Christian community as well as various Polish community events drawing on the trust established by our Polish team member.

In previous years we received a significant amount of negative feedback about a GP surgery in a very multicultural area of the city. Sharing this feedback with decision makers was vital. That surgery transferred to a different provider this year and we returned, with multilingual community partners, to talk to patients and confirm that patient satisfaction had improved.

People who are deaf or have hearing impairments:

We attended events at Merseyside Society for Deaf People following which we:

+ liaised with PALS at Broadgreen Hospital to improve access to screening;
+ helped with concerns over accessible food labelling for healthy eating.

People with mental health issues:

+ We are long-term and active members of the local Mental Health Consortium and chair their BAMER group;
+ We liaised with mental health service user groups around access to mental health and emotional wellbeing services, as well as physical healthcare services.

Children and young people

It is essential that young people be given an opportunity to have their voices heard in a meaningful way and for these views to be given due weight.

We engage with children at family events through our child-friendly Healthwatch Heroes activities and resources. These also allow us the opportunity to talk to their parent while the child is happily engaged.

At our Listening Event at Alder Hey Children's Hospital, we spoke directly to young patients where appropriate, with additional information from their family members. Our questionnaires were amended to be child friendly for this purpose.

We have engaged with young adults through colleges and universities including our facilitation of a Student Health and Wellbeing Group. The group is attended by student union officers and includes a standing item regarding student feedback. We also have stalls at student freshers and welcome events enabling us to introduce ourselves to thousands of young people, many of whom are new to Liverpool.

What we've learnt from visiting services: Listening Events

In all of our work we carefully choose the most suitable activity to meet our objective. With NHS services we have found that open Listening Events are generally the most effective ways in which we can talk to patients and gather a clear picture of the service's activities. Because many of our hospitals serve people in neighbouring areas too, we work closely with our partners in Healthwatch Sefton and Knowsley and have worked with them on hospital listening events.

During this year we carried out 16 Listening Events which included the following services:

Acute and Specialist Hospitals

+ Aintree University Hospital
+ Alder Hey Children's Hospital
+ Broadgreen Hospital
+ Liverpool Women's Hospital
+ The Walton Centre

Mersey Care services

+ Mossley Hill Hospital
+ Windsor House inpatients wards
+ Drug Alcohol Recovery Team (DART)

Liverpool Community Health services

+ Old Swan Walk-in Centre
+ Smithdown Road Children Minor Injuries Centre

7 Health Centres – which house between them 16 GP practices, 4 dentists and various community health services.

+ Breeze Hill Neighbourhood Health Centre
+ Fiveways Family Health Centre
+ South Liverpool Treatment Centre
+ Kensington Neighbourhood Health Centre
+ Picton Neighbourhood Health Centre
+ Mere Lane Neighbourhood Health Centre
+ Townsend Ln Neighbourhood Health Centre

As well as talking to patients in waiting or entrance areas, we visit wards and clinic areas to talk to as wide a range of patients and their families as possible about their experiences.

During these events we have used carefully considered questionnaires to give people a chance to freely share their experiences and to provide patient insights into some key areas that services and decision makers are grappling with.

The feedback from these events is analysed, shared with the service and the public.

Alder Hey – feedback about the quality of care was overall extremely positive, especially regarding the care of very sick children who have prolonged admissions and treatments. There was however some learning to be done about how difficult it is to be the parent of a child in such circumstances and suggestions from families of ways in which their needs could be better met.

"They talk to my son. Even at 16 months they addressed their questions to him and then I can fill in if he can't answer. If I have a question I can just ring up and ask them and they don't make you feel like you're being daft. They are absolutely fantastic and we are very much involved in his treatment plan. He loves coming here now, it all makes so much difference." Alder Hey patient family member

Liverpool Women's Hospital – a chance conversation on the day of the Listening Event led us to return to the hospital twice to talk to families who use the Honeysuckle Bereavement Service which supports people who have lost a child due to miscarriage, stillbirth or early neonatal death. Feedback from families about the support they received from this team was so positive that we nominated the service and the families for a national Healthwatch award.

"The service is invaluable - They value every loss no matter how early or late. They helped me through the most traumatic time of my life." A user of the Honeysuckle Bereavement Service at Liverpool Women's Hospital

Because of the specialist nature of some of Liverpool's hospital trusts they serve a wide geographical area. We therefore not only engage service users who live within Liverpool, but also people living elsewhere who travel to use specialist services. During these listening events we had meaningful discussions with 673 service users, visitors or members of staff; and of these, 112 (16.6%) did not live inside the Liverpool City Council boundary.

What we've learned from visiting services: Enter and View Visits

We have focussed our Enter and View activity this year on Care Homes. There are major pressures in the care home sector in Liverpool and it is vital that, alongside our partners, we keep a close eye on the sector and those who rely upon it. Enter and View visits provide the best opportunity to engage with care home residents who are often isolated and would not otherwise be able to share their opinions and experiences.

This year we have visited:

+ Brooklands Nursing Home
+ Greenacres Care Home
+ Woolton Manor Care Home
+ Finch Manor Nursing Home
+ Broadway Nursing (twice)
+ Mersey Parks Residential and Nursing Home
+ Stapley Residential and Nursing Home
+ Mayfield Court
+ Cressington Court Care Home

One of the Care Homes we visited was as a follow up visit to see what changes had been made following our earlier recommendations.

Another visit was to a Care Home which had received an Outstanding rating from the CQC and we wanted to see what good practice we could hear about and share.

Our other visits were conducted on a range of homes to help us to understand how the services work and in response to feedback received.

Some of our visits are unannounced (the home is not notified in advance). This allows us to promptly visit and observe the home environment.

Some of our visits were announced in advance allowing time for the home to advertise our visit to family and friends of residents so we were able to get a broader range of feedback about the service. In addition, we always leave feedback sheets and cards for people who can't attend on the day of our visits but still have comments that they would like to share.

As part of each Enter and View visit we:

+ Talk to residents, where they are able and willing to communicate, and to visiting relatives;
+ Tour the premises;
+ Speak to the Manager and/or other key members of staff.

We made 10 recommendations and we will follow up on some of these with return visits to these services in the coming year.

We feedback on our visit to the home, sharing our report with them for comment. If a visit highlights a potential safeguarding issue we report this. Copies of all our reports are sent to the CQC and any concerns have been raised with the Local Authority, Liverpool CCG or the CQC.

The good practice we have highlighted will be shared with Care Home managers and providers by way of a newsletter we are to start sending this coming year.

We have shared our concerns about the care home sector with the public via our website and social media. Healthwatch Liverpool manager Sarah was also interviewed on the BBC Radio Merseyside breakfast show about this issue.

Care home staff are on the sharp end of caring for some of the most frail members of our city with extensive health needs. The staff often have really valuable insights into how the health and care system works in an effective joined up way and where it doesn't. We have opportunities to raise these concerns in a strategic way that the homes might struggle to do.

Information from these conversations also feeds into our understanding of issues like hospital discharge and provides real life examples to indicate where the health and care system is making progress and where it is still falling short.

In a single day two homes shared with us concerns about end of life care. They had noticed an issue affecting some residents who were arriving after a stay in hospital to be supported to live their last days and weeks as peacefully as possible. They did not always have clear discharge paperwork such as a 'Do Not Resuscitate' (DNR) form. This brings a risk that the resident may be subjected to uncomfortable and unwanted medical procedures. We raised this with the CCG who are currently working on a project to improve the coordination of care for end-of-life patients. We were also able to share feedback about the much more effective discharges to homes from Palliative Care wards so that lessons can be learned and shared.

"'It's as good as anywhere. We get allocated carers but the carers only look after their own, if they see a red light but it's not one of theirs they don't answer. My daughter has raised concerns as sometimes I get left on the toilet - I like a bit of dignity." resident

"I feel really supported. Been here 13 years and it feels like a community in here, like chatting and get on with each other really well." resident

"The staff are brilliant, honestly, I'd recommend them and I'm not just saying that. They make me a cup of coffee everyday which makes me as a visitor feel welcome." friend of a resident

Making a difference together

Working with other organisations

Student health and wellbeing

With four universities attracting students from across the world, students make up a high proportion of the city's residents and health service users. We were concerned that students who weren't registered with local GPs were struggling to access health care when they developed physical or mental health problems, or using the 'wrong' service for their needs. We set about developing constructive relationships with students and our universities, bringing them together with key health partners for honest and informative discussions. In this year:

+ We presented a paper on student health to the Health and Wellbeing Board and secured an ongoing reporting link between the Student Health and Wellbeing Group which we helped set up and the Health and Social Care Scrutiny Committee;
+ We attended 9 'Freshers' events across the 4 universities to engage new students on health issues, helping them to access local GPs, dentists and other health services and to hear their thoughts. Across these events we spoke to 4226 students;
+ We brought partners together to plan joint work, share best practice, understand each other's priorities and constraints.

"Healthwatch were pivotal in the development of the Student Health group and these forums are so useful for sharing information, best practice and identifying future opportunities to encourage joined-up working (that actually works!) Healthwatch have been an indispensable resource and a really valued partner" Bernadette McGrath - LJMU Student Advice and Wellbeing Service

Hospital discharge

Public feedback showed that people's experiences of being discharged from hospital is sometimes far from ideal – delayed, rushed or disjointed, at times even dangerous.

We collected views and experiences from the public and staff in all our local hospitals, bringing together a temporary Hospital Discharge Network to share information, best practice as well as highlighting areas of concern.

"A frustrating experience! After seeing a doctor and being discharged I waited another 4 hours before pharmacy provided medication. It meant that I didn't get home until evening, and blocked a bed for another day. The cardiac rehab nurse phoned the day after discharge to make contact and start the rehabilitation. This part of the process was reassuring." patient

The picture that emerged is a complex one. Liverpool's specialist hospitals serve a wide geographic area making discharge more complicated. Liverpool's acute hospitals are increasingly busy and having to find ways to meet increasing demands with limited resources. As the population ages, more people need home or residential care services in place before they can be discharged but with social care budgets drastically reduced and care home beds in short supply, patients can stay in hospital for longer than their health requires.

By sharing patient experiences we help ensure that the work that is underway to improve 'patient flow' has patients and not just targets at its heart.


It starts with you
#NameOneThing

#ItStartsWithYou

GP services – The Gateway to the NHS

GP practices are a key issue for the public. In the past we had concerns raised with us about the quality of a number of GP practices.

We spoke to patient groups and held Listening Events in GP practices to encourage the public to speak to us about the good and the bad of their experiences. We heard from patients with multiple long-term conditions that they often prefer to see the same doctor for continuity. Some patients though have been able to give examples of how good record keeping and high standards allow them to feel confident to see any doctor in the practice knowing that they will be aware of the key issues in their care and that they won't need to repeat these each time.

We have also helped to pilot Patient Opinion (recently renamed Care Opinion) in GP practices, providing patients with a way to leave their feedback and for staff to respond.

We share the feedback we receive with decision makers so that it can inform their work.

We have also been establishing better working relations with a number of GP practices where we are now able to contact them direct to help patients get issues resolved early and hopefully prevent patients needing to make a complaint.

With changes in some providers during 2016-17 leading to a reduction in expressions of concern from patients of those practices we have been able to change our focus for 2017-18.

Now the main concern expressed by patients about GP services is access to appointments with some patients reporting having to phone over 50 times to get through and other patients reporting difficulty getting prompt appointments once they do get through. Surveying patients on this issue and making sure that their feedback is heard is a priority for our work this coming year.

Care homes

Through our enquiry work we hear how difficult it has become to find a suitable care home vacancy when needed and about people's concerns about safety and quality in some homes. This can delay discharge from hospital and increase hospital pressures.

We have:

+ Made care homes the priority for our enter and view visits;
+ Worked closely with partners to share the information that members of the public tell us. Where this has included safety concerns it has influenced the timing of quality and enforcement inspections;
+ Spoken out about our concerns around the challenges facing care homes, the instability of the sector and the risk if more homes close.
+ Joined the Quality Assurance Group, Care Home Needs Assessment Group and Liverpool Care Home Improvement Programme Group to assist with work to monitor, support and develop care homes.

Care homes remain a top priority for our work this year.

#ItStartsWithYou - without your stories we wouldn't know where to focus our work to have the biggest impact for people in Liverpool. A big THANK YOU for your input this year and please keep telling us what's important to you in 2017-18.

Our plans for next year

Our priorities for 2017-18

GP Access

This year we are visiting GP waiting rooms to talk to patients about their experience of trying to make appointments and their priorities. Major changes are planned around GP provision as part of the national 'GP Forward View'. We can help get the patient perspective heard in the local implementation of this.

We are also looking into what people do if they can't get an appointment with their GP. Together with other local Healthwatch, we will be visiting all A&E services on one day to gather a snapshot of people's reasons for attending and what proportion of attendances were influenced by difficulties getting appointments. Visits to Walk-in Centres will follow.

Care homes

Care home provision is Liverpool is under increasing pressure from a number of factors including quality, quantity and finances. Our information helps people needing a care home place for themselves or a family member to make more informed choices in a difficult situation. The feedback we gather helps us to spot problems at the earliest opportunity and our contact with care homes and partners can help tackle problems and enable the sharing of best practice.

This year we will be:

- Improving information available to the public
  - Producing a guide to help people choose a care home.
  - Working with care homes to improve the information they include on the directories adding information which is important to people looking at care homes such as top up fee charges

- Improving the information we provide to care homes
  - looking at our reports, CQC reports and other research to highlight areas of good practice
  - sharing information on this good practice, resources and ideas to help improve the lives of people living in local care homes.

Students

Students are a large and increasing proportion of the population who often don't know where to turn when they experience health problems. We can inform them and the organsiations that support them about appropriate sources of help. By encouraging students to use the right services at the right time, they are more likely to get the help they need and less likely to overuse other services such as A&E. This is good for the population as a whole.

Seeing and influencing how the whole system works

Poor coordination between services is a common cause of the problems that people experience. At the strategic level, there is now an emphasis on health services "working as one" but most routes for patient feedback (such as the Friends and Families Test) only cover individual services and most professionals are still used to seeing only one part of the picture. The Healthwatch overview perspective is unusual and one of our great strengths. We will seek to make the most of this opportunity to help join services more effectively.

A changing NHS

The NHS is going through a period of massive change – facing increased needs, tighter financial constraints and service changes. It is more important than ever that Healthwatch ensures the patient perspective be heard.

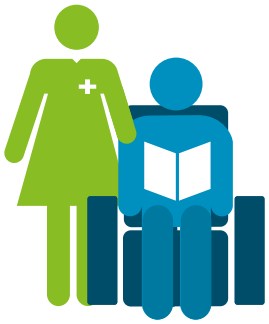
5 ways to expand our reach

1. **Making a film exploring the experience of giving feedback about NHS services**

2. **New translated publicity**

3. **Getting out and about for Enter and Views and Listening Events to see services first-hand and to speak to service users, their friends and family**

4. **New posters in Hospital Trusts to promote relevant local Healthwatch**



5. **Care Home information pack**

Our people

Informing our decision making

Our priorities and activities are informed by what the public tell us. Our enquiry service, our contacts with community organisations and the people we talk to at listening events give us a good insight into what matters to people. We are always looking to hear from more people. Our volunteers and community contacts are a vital part of helping us do this.

Our activities are also informed by what we learn about forthcoming changes that we know will impact on people's care in the future. We can't wait until after changes take place but need to make sure that people's needs are taken into account throughout the planning and decision making process. This is more important than ever given the challenges facing the NHS at the moment and the pace of planned changes.

Ways of getting involved with our work

We are very grateful for the assistance of our volunteers. We know that not everyone has the time to become a volunteer and we want to make sure that other people also have a chance to contribute in the way that suits them best.

Healthwatch contact – people can keep in touch with our work through mailings, website and social media and can then get involved when an issue arises that really grabs them. These people are well placed to help pass on details of our work when a friend, relative or colleague runs into a difficulty or has experiences to share.

Healthwatch champion - We are now recruiting HW champions. Champions are making a more definite commitment to share information with others and to explain our work. To help with this, champions will be able to attend workshop sessions with our volunteers on subjects like "explaining the work of Healthwatch" or "understanding the health and care system".

Healthwatch volunteer - help with a range of tasks and activities depending on their interests, skills and availability. These include attending events, gathering patient feedback, carrying out office based research to support our day-to-day work.

We are also happy to work with other organisations to help their volunteers become Healthwatch champions and even to share volunteers where appropriate such as in our work with Liverpool CCG volunteers.

This year we collaborated with Liverpool CCG and the Liverpool Volunteer Centre to provide 3 training sessions to CCG volunteers focusing on gathering patient feedback. As a result of this, 7 CCG volunteers worked with us and joined us to take part in activities such as the Listening Events mentioned previously.

"I come from a health and social care background. Healthwatch has provided an opportunity to use my skills and experience to help others" volunteer

"It's a privilege to help be the voice for people who might not otherwise have been heard" volunteer

Volunteers Amani and Danielle helping out at a university freshers fair

Our finances

As this report has highlighted, the health and care sector in Liverpool has become more complex and faces growing pressures. This means that the services provided by Healthwatch Liverpool have never been more necessary and there is no shortage of work to be engaged in. Indeed even after increasing our staffing levels last year, we receive more requests for work than we have been able to accommodate. It is a constant balancing act to do as much as we can reasonably manage without reducing the quality of our work or stretching the service to the point where we lose our reliability.

We have continued to make staffing our top priority area of expenditure and keep our staffing structure under review, increasing our staffing again towards the end of this period.

We still employ 15 people but now with more staff hours (12.5 FTE) and a different mix of skills and responsibilities to respond to the changing environment. We now have 2 joint Co-ordinators who oversee our information service and co-ordinate our day-to-day work. We also have a Communications Lead. As in all small organisations, staff multi-task and these team members also provided experienced input into our enquiry service.

To accommodate our growth, towards the end of this year we began planning a move to a larger office space in the same building and moved during June 2017. We have also been investing in staff training, particularly for our new specialist roles and will continue to do so in the coming year.

Income	**£**
Funding received from local authority to deliver local Healthwatch statutory activities	401,543
Expenditure	**£**
Staffing costs	311,528
Office costs	26,016
Operational costs	47,114
Total expenditure	384,658

Contact us

Healthwatch Liverpool is delivered in partnership between Laridae CIC and LCVS.

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We will be making this annual report publicly available on 30 June 2017 by publishing it on our website and sharing it with Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

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HEALTHY LIVERPOOL PROGRAMME

HOSPITAL BASED SERVICES

COMMITTEE(S) IN COMMON

KNOWSLEY, LIVERPOOL AND SOUTH SEFTON CCGS AND NHSE

MEETING ROOM 1 LIVERPOOL CCG

WEDNESDAY 7 DECEMBER 2016

PRESENT:

Nadim Fazlani	Chair	
Tom Jackson	Chief Finance Officer	NHS Liverpool CCG
Fiona Lemmens	GP/Governing Body Member	NHS Liverpool CCG
Fiona Taylor	Chief Officer	NHS South Sefton CCG
Andrew Mimnagh	Chair	NHS South Sefton CCG
Andy Pryce	GP/Chair	NHS Knowsley CCG
Craig Porter	Interim Director of Service Redesign and. Improvement	NHS Knowsley CCG
Ian Moncur	Councillor (Health & Wellbeing Chair)	Sefton Council
Andrew Bibby	Assistant Regional Director of Specialist Commissioning	NHS England
Carole Hill	Healthy Liverpool Integrated Programme Director	NHS Liverpool CCG
Danny Brown	Orthopaedic Surgeon (item 5.0)	Royal Liverpool & Broadgreen University Hospital
Helen Murphy	Hospital Transformation Programme Mgr	NHS Liverpool CCG
Amy Barton	Senior Project Mgr, Hospital Services	NHS Liverpool CCG
Paula Jones	Minute Taker	NHS Liverpool CCG

APOLOGIES:

Katherine Sheerin	Chief Officer	NHS Liverpool CCG
Donal O'Donoghue	Secondary Care Clinician, Gov Body	NHS Liverpool CCG
Dianne Johnson	Chief Officer	NHS Knowsley CCG

1.0	**Welcome, Introductions and apologies:**
1.1	Chair welcomed all to the meeting and introductions were made. It was agreed to take item 5.0 before item 4.0 as Danny Brown was only required for item 5.0.
2.0	**Declaration of Interest:**
2.1	There was no declaration of interest
3.0	**Minutes & Actions of the previous meeting: 2ND NOVEMBER 2016**
3.1	The minutes of the 2nd November 2016 meeting were agreed as an accurate record of the meeting.
3.2	Chair addressed the actions from the meeting of the 2nd November 2016: • 5.2 it was noted that Katherine Sheerin had contacted Andrew Bibby re Specialist Commissioning and Committees in Common making decisions in parallel around the Women's/Neonatal Pre Consultation Business Case. • 5.3 Fiona Lemmens updated the CIC that the report referred to on the Women's/Neonatal pre business case consultation was not new and did not change any conclusions and the scoring carried out stood. The process was correct. • 7.0 Southport & Formby CCG were to be members of the Committees in Common and to be added to the distribution lists. West Lancashire CCG to be invited as and when required for discussions around Southport and Ormskirk services. **Action: Fiona Taylor to supply Paula Jones with the individual contacts for Southport & Formby CCG.**
4.0	**Liverpool Women's Hospital Review – Pre Consultation Business Case – Report No: CIC 01-16 – Dr Fiona Lemmens**
4.1	Carole Hill updated the Committees in Common: • NHS England/NHS Improvement had raised concerns around the capital funding requirements of the options ; , how capital would be raised, where the asset would sit and how the revenue costs of the capital would be afforded.

	• Clinical Case was accepted by regulators, but in light of capital issues there was to be pause around going out to consultation in order for additional work to be conducted to provide assurance regarding capital. • NHS England also wanted the issue of wider financial sustainability for the North Mersey Local Delivery System to be considered. • Escalating clinical risks being experienced in current services needs to be addressed.
4.2	Fiona Taylor asked what would happen if the capital funding issue was not resolved. Fiona Lemmens responded that this could still go to the Overview & Scrutiny Committees with a preferred option for consultation. Carole Hill noted that the Communications Leads were meeting the following day to put together recommendations to be shared virtually over the next couple of days, regarding the choice whether to publish the PCBC in the interests of transparency. Andrew Bibby endorsed that unless the NHS England were assured it would be difficult to proceed to to consultation.
4.3	Carole Hill added that the issues of what to do with the Crown Street estate whould also need to be addressed as part of a future consultation.
4.4	**The Committees in Common:** ➢ **Noted the content of the briefing** ➢ **Noted the issues and risks identified** ➢ **Noted the six month pause in the consultation process until purdah was over, however the recommended next step was to update Overview & Scrutiny Committees on the content of the PCBC and publish the document.**
5.0	**Liverpool Orthopaedic and Trauma Service (LOATS) – Report No: CIC 02-16 – Fiona Lemmens**
5.1	Discussed at the last meeting when the CIC had significant questions and had asked for it to be brought back with more detail. The CIC considered the draft feasibility study and a paper which set out the options for any consultation process. Danny Brown, Orthopaedic Consultant and Clinical Lead on the proposed reconfiguration presented to the CIC.

Key points from the discussion:

- Clinical Case for change had been approved by the Boards of both Aintree and the Royal Liverpool & Broadgreen University Hospitals and the Orthopaedics Oversight Group.

- Feasibility Study was in draft and had been sent to the CIC for consideration. The proposal needed to be endorsed by the three CCGs' Governing Bodies prior to approval by the North Mersey CCG Governing Bodies.

- The paper set out two options for next steps in the process:

  - 1. To proceed to consultation in January 2017

  - 2. To incorporate the proposed reconfiguration into the broader consultation on the proposals for all single service reconfiguration that would be developed through the merger OBC and which was anticipated could be ready for consultation in the summer of 2017.

- Although the clinical rationale was accepted , in order to have a process which was robust and defendable it was agreed that there had not been sufficient pre-consultation engagement in Sefton or Knowsley.

- An option 3 was identified, which would be to proceed with an orthopaedics process but to commence consultation in May/June 2017 after the mayoral elections. This would allow time to do the necessary engagement in Sefton and Knowsley and would provide a way forward if the broader merger process was delayed.

- Ian Moncur noted need to engage the Overview & Scrutiny Committees in all areas on the case for change, which meant that a January commencement for consultation would not be feasible. **Action: Fiona Lemmens agreed to discuss this with OSCs and agree next steps regarding the presentation of the case for change.**

- It was necessary to involve the communications and engagement teams of the two Sefton CCGs and Knowsley CCG to plan for pre-consultation engagement. She offered to be a link into the Communications Team of South Sefton and Knowsley CCGs.

5.2

	The Committees in Common: ➢ **Noted the content of the briefing** ➢ **Noted the issues and risks identified** ➢ **Agreed that it was not possible to go to consultation in January 2017 as more Local Authority engagement particularly with South Sefton and Knowsley needed to be carried out around the proposed options as per the guidance on consultation.** ➢ **The case for change to be presented to the three local authority OSCs in the new year.** ➢ **A recommendation to be made on option 2 or 3 as the way forward.**
6.0 **6.1**	**Any other business** There was no other business.
7.0 **7.1**	**Date of next meeting** Wednesday 7th February, 4pm – 6pm, Boardroom, Boardroom, Liverpool CCG

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
PRIMARY CARE COMMISSIONING COMMITTEE
Minutes of meeting held on Tuesday 18th April 2017 at 10AM
BOARDROOM, THE DEPARTMENT

Present:

Voting Members:

Dave Antrobus (DA)	Governing Body Lay Member – Patient Engagement (Chair)
Katherine Sheerin (KS)	Chief Officer
Tom Jackson (TJ)	Chief Finance Officer
Prof Maureen Williams (MW)	Lay Member for Governance/Deputy Chair of Governing Body
Cheryl Mould (CM)	Primary Care Programme Director
Nadim Fazlani (NF)	GP Governing Body Chair
Dr Rosie Kaur (RK)	GP Governing Body Member/Vice Chair

Co-opted Non-voting Members:

Rob Barnett (RB)	LMC Secretary
Moira Cain (MC)	Practice Nurse Governing Body Member
Tina Atkins (TA)	Governing Body Practice Manager Co-Opted Member
Sarah Thwaites (ST)	Healthwatch

Advisory Non-voting Members:

Mark Bakewell (MB)	Deputy Chief Finance Officer

In attendance:

Colette Morris (CMo)	Locality Development Manager
Scott Aldridge (SA)	Primary Care Co-Commissioning Manager
Jacqui Waterhouse (JW)	Locality Manager
Peter Johnstone (PJ)	Primary Care Development Manager
Victoria Houghton (VH)	Primary Care Accountant
Paula Jones	Committee Secretary

Apologies:

Simon Bowers (SB)	GP/Governing Body Clinical Vice Chair
Jane Lunt (JL)	Chief Nurse/Head of Quality
Dr Adit Jain (AJ)	Out of Area GP Advisor
Tom Knight (TK)	Head of Primary Care – Direct Commissioning NHS England
Paula Finnerty (PF)	GP – North Locality Chair

Public: 1

PART 1: INTRODUCTIONS & APOLOGIES

The Chair welcomed everyone to the meeting and introductions were made. It was highlighted that the public were in attendance but any questions they wished to raise needed to be done via the public Governing Body meeting in writing.

1.1 DECLARATIONS OF INTEREST

It was noted that all practice members present had a potential general and pecuniary interest in item 3.1 Local Quality Improvement Schemes 2017-18 and 3.2 Framework for Discretionary Payment for Locum Cover and the discussions which took place. The decision from the Chair was that these members could take part in the discussions rather than leave the room and their comments were valid on the general clinical implications. However they would not be able to take any part in a vote.

1.2 MINUTES AND ACTIONS FROM PREVIOUS MEETING ON 21ST MARCH 2017

The minutes of the 21st March 2017 were approved as accurate records of the discussions which had taken place.

1.3 MATTERS ARISING NOT ALREADY ON THE AGENDA – Verbal

1.3.1 Action Point One – CM updated the Primary Care Commissioning Committee that the practice survey results

around Primary Care Support Services had been sent to the Chair of the NHS England Audit Committee who had then requested a meeting with the CCG, the Local Medical Committee and TA which was being scheduled for early May 2017. Also two senior members of staff from Primary Care Support Services were to meet with the CCG.

1.3.2 Action Point Two – it was noted that the early findings of the Partners Priority Programme Evaluation for Change on the GP Specification were to come to the June 2017 meeting with the final report to be presented to the October 2017 meeting.

1.3.3 Action Point Three – KS updated the Primary Care Commissioning Committee that she did raise the issue the transfer of Specialist Devices back to Secondary Care from GP Practices at the North Mersey Leadership meeting who had been supportive of the approach but noted that it was the Area Medicines Management Committee who needed to look at this and she would feedback when this had happened.

1.3.4 Action Point Four – it was noted that Transforming Primary Care in Liverpool/General Practice Forward View was on the agenda.

1.3.5 Action Point Five – it was noted that the action of MB pulling together a report on variation against plan for the Primary Care Prescribing Budget during the year was ongoing.

The Primary Care Commissioning Committee:

- **Noted the issues raised under matters arising.**

PART 2: UPDATES

2.1 PRIMARY CARE SUPPORT SERVICES – VERBAL

As TK had sent his apologies to the meeting there was no update given.

The Primary Care Commissioning Committee:

- **Noted that there was no verbal update.**

2.2 FEEDBACK FROM SUB-COMMITTEES – REPORT NO: PCCC 08-17

- **Primary Care Programme Group – April 2017 – PCCC 08a-17**

RK updated the Primary Care Commissioning Committee on the recent meeting:

- ✓ This meeting replaced the Primary Care Quality Sub-Committee which prior to delegated authority had focussed on Primary Care performance (Liverpool Quality Improvement Scheme/Primary Care Quality Framework) and new quality improvement schemes/clinical view on changes. Now the Performance Report was discussed at the Primary Care Commissioning Committee and the new Group had a mandate for overseeing continuous improvement within Primary Care and to provide primary care clinical input into proposed service redesign and new initiatives. The Terms of Reference were attached showing the remit to be Primary Care Development, Performance and Quality of General Practice and Member Engagement.

- ✓ Feedback from the Locality Workshops would go to the Primary Care Programme Group which in turn reported to the Primary Care Commissioning Committee.

MW asked about the role of the Neighbourhood Leads, CM confirmed that the roles were new and there were 12 Neighbourhood Leads who were GPs with a focus on Primary Care and 12 Demand Management Leads. CM and RK met on a monthly basis with the Leads. MW asked how the Leads were chosen and CM replied that expressions of interest had been invited from practices and then a panel was convened to review and then approved the Leads.

KS asked for clarification in the Terms of Reference on where the Group reported to as the Terms of Reference said that key issues identified would be provided to the Primary Care Commissioning Committee and recommendations would be made to the Healthy Liverpool Community Programme Board. CM explained that reporting was to both as the programmes fed

into the Primary Care Commissioning Committee but the clinical issues fed into the Community Programme Board.

MW felt that if this was a Task & Finish Group it should state that clearly in the Terms of Reference, being a Group rather than a sub-committee gave more flexibility under the terms of the Constitution. NF noted that was a working group and issues raised requiring a decision would need to be brought to the Primary Care Commissioning Committee.

DA felt that the reporting should be amended to say "as appropriate".

Subject to the amendments mentioned the Primary Care Commissioning Committee approved the Terms of Reference of the Primary Care Programme Group.

- **Transformation of Primary Care (Response to General Practice Forward View) – PCCC 08b-17**

CMo feedback to the Primary Care Commissioning Committee:

- ✓ This was a Task & Finish Group set up to implement the work of the General Practice Forward View. The first meeting had been held on 13th March 2017 and reporting would be bi-monthly to the Primary Care Commissioning Committee.

- ✓ The feedback form had been produced in a different format which was aligned to the other programmes and comments were invited.

- ✓ Work to date had been around scoping and planning what to do for the key work streams.

- ✓ Focus on implementation and training.

- ✓ Key risks were around funding nationally and locally, engagement of member practices/public/patients and development/availability of clinical and non-clinical workforce.

- ✓ Estates, Technology and Quality Improvement work streams were rag-rated as Green.

- ✓ Care Redesign, Workforce and Workload were rag-rated as Amber.

RB was concerned that the Estates work stream was rag-rated as Green when he felt that progress to date in this area was poor, this was also the case for workforce which should be rag-rated as red. MW asked for clarification around the categories. DA felt that the Risks section on page 8 was too brief and only provided a quick snapshot.

CMo responded that the Risks then fed into the Primary Care Commissioning Committee Risk Register so had been kept brief to avoid duplication but was prepared to add more information for future reporting if this was what was required. CM noted that the intention had been to keep the same format as the reporting of the Programmes to the Healthy Liverpool Programme Board. KS commented that she liked the "snapshot" approach.

In response to RB's comment about Estates CMo noted that two bids had been submitted. For Hunts Cross Health Centre an extension was being progressed as part of the process of utilising independent funding from NHS England and was a final contract/plan stage. For Westmoreland and Long Lane Health Centre meetings had been held with practices in February 2017 and now the funding proposal was being put together and a site needed to be identified. None had been found as yet and also how to ensure a joined up approach with neighbouring practices was being looked at. The build needed to be futureproof and fit with the needs of practices in the area. Both bids had been included in the Estates Strategy which had been approved by the Primary Care Commissioning Committee in November 2016. The Primary Care Estates Development Group had been set up which considered the requirements of each Neighbourhood which TA was part of.

RB expressed his disappointment at the lack of progress made around Estates and was very critical of the pace and direction. He highlighted in particular the area of Woolton and effect of new residential building projects on the requirements for a GP service in the area re workforce and capacity with the need for new GP premises in the area and lack of suitable sites. RK responded that workforce pressures current and future were being addressed via the changes in staffing mix (Allied Health Professionals, Physicians Associates, Nurse Practitioners etc).

TJ commented that he liked the layout of the reporting template and felt that progress had been made, noting that the summary reporting sat on top of a wealth of information and work which had been ongoing. He suggested that at the next meeting a more

detailed update should be brought highlighting what was in scope and progress against milestones.

MC asked if there was any update on Health Education England providing funding for training. TA responded that the funding information so far was 2016/17 so we did not yet know what the allocations for 2017/18 would be.

The Primary Care Commissioning Committee:

- **Considered the report and recommendations from the Sub-Committees**

PART 3: STRATEGY & COMMISSIONG

3.1 LOCAL QUALITY IMPROVEMENT SCHEMES 2017-18 – REPORT NO: PCCC 09-17

CMo presented a paper to the Primary Care Commissioning Committee seeking approval for the commissioning of Local Quality Improvement Schemes from May 2017 to 31st March 2018. There were nine schemes in total which were reviewed each year with clinical changes approved by the Primary Care Commissioning Committee. For 2017/18 a review had been undertaken and considered by the Local Medical Committee and the Primary Care Programme Group and these were the changes which were presented today with the schemes. Monitoring of the schemes was to be strengthened and if approved today would be considered by the Finance Procurement & Contracting Committee the following week for the procurement route.

KS queried the role of Public Health as part of this review given these were commissioned by the CCG. SA confirmed that Public Health were not approving the schemes but that is was useful to have their input/suggestions although the CCG was under no obligation to take their comments on board.

The Primary Care Commissioning Committee:

- **Noted the content of the paper**
- **Noted the clinical changes to the specifications**
- **Approved the commissioning of the specifications until March 2018 subject to Finance, Procurement and Contracting Committee reconfirming the schemes are to be commissioned through general practice list based providers**

3.2 FRAMEWORK FOR DISCRETIONARY PAYMENT FOR LOCUM COVER – REPORT NO: PCCC 10-17

The Primary Care Commissioning Committee considered a paper which proposed a framework to enable discretionary payments to be made to General Practices outside of the Statement of Financial Entitlement ('SFE') for locum cover during sickness, maternity, paternity and adoption leave and was asked to approve the proposed framework.

The 2017-18 GP Core Contract negotiations outlined the levels of remuneration that General Practice could receive to cover locum costs with levels set at the cost of GP locum cover for sickness, maternity, paternity/adoption leave of £1,734.16 from after week two. To support the improvement of access during core hours as per the GP Specification and General Practice Forward View there was provision for GP appointments to be offered by other clinicians such as Nurse Practitioners, Pharmacists and Physician Associates so a framework was required to enable discretionary payments to support this re locum cover. Practices would need to submit alongside the usual locum papers the details of the number of GP sessions per week to be covered, number of sessions to be delivered by alternative means, how many patients would access the sessions and triage information, how the practice would be affected and how the practice would manage any prescription requests arising from these consultations. Should the request be supported practices would need to submit an audit detailing patients seen and the outcome of any consultations.

MW asked about the cost of replacing a GP with another clinician. It was noted that a non GP replacement would be at the equivalent rate for that position not at the GP rate.

DA wondered if changes to the Constitution would be required. TJ noted that the key questions to ask were what were the problems we were trying to solve and where did discretion get exercised. CM responded that the problem was that getting GP locum cover was proving to be increasingly more difficult so the problem of workforce and different skill mix to be used needed to be investigated. As for payments the Finance Department and Practices would be working very closely together to formalise a payment process. TJ asked if this was what we wanted to be communicating and how would any limit be set.

MW asked for a regular report on the performance of this matter to come to the Primary Care Commissioning Committee and it was agreed that this should be on a quarterly basis.

RB commented that under the old SFE it was difficult for practices to obtain locum cover so this SFE had re-written the rules. NF reminded the Primary Care Commissioning Committee that it was the principle which was being discussed for agreement. CM added that this framework would support practices with workforce issues they were facing and how they could work differently to achieve access targets. In response to a query about budget requirement from TJ, MB noted that a £440k spend was budgeted for so we just need to see how this worked out.

It was agreed that the Primary Care Commissioning Committee was happy with the principle but required the full framework to come back to the Primary Care Commissioning Committee for approval.

The Primary Care Commissioning Committee:

- **Noted the content of the paper**
- **Approved the proposal for a framework for discretionary payments to be made to General Practices outside of the SFE for locum cover.**

PART 4: PERFORMANCE

4.1 PRIMARY CARE COMMMISSIONING COMMITTEE PERFORMANCE REPORT – REPORT NO: PCCC 11-17

RK presented a paper to the Primary Care Commissioning Committee on the key aspects of the CCG's performance in delivery of Primary Care Medical services quality, performance and financial targets for Q3 2016/17. The report referenced national performance measures and the Local Quality Improvement Scheme for 2016/17 for which she highlighted:

- Access target of 80 appointments per 1,000 weighted practice population per week – because of problems with EMIS we could not collect the data but we did have the

proxy measure of ACS attendances at A&E which was decreasing indicating an improvement.

- ACS admissions rate had decreased to 7.62 taking the indicator from Band C to Band B. The number of practices achieving Band A in general was increasing and was now 39 compared to 28 in the previous year. This was monitored closely by the Primary Care Team.

- Outpatient Referrals – the rate of GP referrals had decreased to 66.97 per 1,000 weighted population and the number of practices achieving Band A had increased to 42 from 26 the previous year. 19 practices were in Band C therefore there was still a great deal of work to be done.

- Alcohol consumption – the proportion of patients who had had their alcohol consumption recorded had increased to 66.23.

- There had been a decrease in the performance of childhood vaccinations and immunisations and work was on-going with the Primary Care Team but performance was still above national requirements.

- The three demand management areas of ACS admissions, referrals, access and referrals had all shown improvement.

- Brownlow Group Practice had been awarded an "Outstanding" status by the Care Quality Commission.

KS referred to anti-psychotic prescribing and childhood vaccinations, commenting that it was good to see the control measures in place. She asked why the levels of anti-psychotic prescribing were over target. PJ explained that this prescribing was authorised in Secondary Care and general practice had no influence over it. NF noted that anti-psychotic drugs had been over-prescribed in the past and now needed to prescribed only where absolutely necessary.

CM noted that transfer of the APMS contracts to the new providers had gone smoothly.

MB gave a financial performance update, as at the end of February 2017 Primary Care budgets were £1.1m overspent against plan. The prescribing financial performance position was showing a year to date £1.2m benefit however this might

need to be reviewed again in month 12 due to on-going conversations with NHS England regarding the treatment of prescribing stock adjustments and application of a consistent approach with other CCGs across the North of England. Overall Business Rules had been delivered across all areas.

In summary NF felt that there was a great deal to celebrate in the report. DA added that this demonstrated that the GP Specification was working and where it counted i.e. for the benefit of patients.

The Primary Care Commissioning Committee:

- **Noted the performance of the CCG in delivery of Primary Care Medical commissioned services and the recovery actions taken to improve performance.**

PART 5: GOVERNANCE

NO ITEMS

6. ANY OTHER BUSINESS

None

7. DATE AND TIME OF NEXT MEETING

Tuesday 20th June 2017 Formal Meeting - 10am Boardroom LCCG

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
FINANCE PROCUREMENT AND CONTRACTING COMMITTEE
MINUTES OF MEETING HELD ON TUESDAY 30TH MAY 2017
10AM TO 12PM
ROOM 3, LIVERPOOL CCG, THE DEPARTMENT, LIVERPOOL, L1 2SA

Present

Nadim Fazlani (NF)	Chair
Katherine Sheerin (KS)	Chief Officer
Maureen Williams (MW)	GB Member -Lay Member – Governance/Deputy Chair
Dave Antrobus (DA)	GB Member – Patient Engagement Lay Member
Maurice Smith (MS)	GB Member – GP

In Attendance

Mark Bakewell (MB)	Deputy Chief Finance Officer
Derek Rothwell (DR)	Head of Contracts, Procurement & BI
Ian Davies (ID)	Chief Operating Officer
Teresa Clarke (TC)	Programme Lead, Adult Mental Health (up to and including item 4.2 only)
Paula Jones	Committee Secretary (Minutes)

Apologies

Tom Jackson (TJ)	Chief Finance Officer
Tina Atkins (TA)	Practice Manager

Part 1: Introductions and Apologies

NF chaired the meeting and introductions were made and apologies were noted.

1.1 Declarations of Interest

There were no declarations of interest made specific to the agenda.

1.2 Minutes and action points from the meeting on 25th April 2017.

The minutes of the meeting on 25th April 2017 were accepted as an accurate record of the discussions which had taken place subject to the following amendments:

- DA requested that item 4.1 Catheter and Stoma Appliance Management Services page 6 first paragraph should be amended to clarify that "they" referred to South Sefton CCG.

- KS requested that the symbol on page 5 last paragraph be removed as it was a typographical error.

1.3 Matters Arising Not already on the Agenda

1.3.1 KS gave an update on the Liverpool Community Health Transaction process. The leadership team of Alder Hey had been appointed to Liverpool Community Health on an interim basis by NHS Improvement who had confirmed that the new arrangements would be in place for 1st October 2017. However, due to purdah they were not allowed to make any progress around the final decision and a meeting had been scheduled for 12th June 2017 for the CCG to meet with NHS Improvement to discuss the process for the on-going decision around Liverpool Community Health services.

1.3.2 KS referred to the Finance Update for March 2017 Month 12 and updated the Finance Procurement & Contracting Committee that TJ had attended a meeting of the Directors of Finance where NHS England had presented a report stating that Liverpool CCG had not met its financial duties as per NHS England guidance. The Local NHS England team were more flexible given the 2% surplus provided and had indicated that they would advocate for Liverpool CCG. MB added that the document in question was not formal and had been tabled on the day. In response to a query from NF, ID confirmed that this had not been raised via the NHS England assurance process.

1.3.3 Action Point One – it was noted that the Financial Recovery Oversight Group ('FROG') review was an action for the July 2017 meeting.

1.3.4 Action Point Two - it was confirmed by DR that the Interim Provider Policy had been published on the CCG external website.

1.3.5 Action Point Six – it was noted that a paper on the preferred option for the future commissioning of Continuing Healthcare services was to be brought to the June 2017 meeting.

Part 2: Updates

No items.

Part 3: Performance

3.1 Cash Releasing Efficiency Savings ('CRES') Report No: FPCC 27-17

MB provided a brief update paper to the Finance Procurement & Contracting Committee on progress with regards to the development of Cash Releasing Savings position within the 2017/18 financial year. MB commented that it was still very early on in the financial year and therefore no "live" data was currently available and that information would be available in June/July 2017 and it was anticipated that a more comprehensive report would be provided. MB highlighted:

- £25.1m of savings were required as at 17th March 2017, the plans totalled £23.6m which left an unidentified savings gap of £1.5m (increased to £1.84m (unidentified) after further amendments).

- Further amendments were made to the planning assumptions in relation to voluntary and community sector anticipated expenditure values for the financial year.

- An additional amount of potential savings had been identified through Senior Management Team sessions during April 2017 which amounted to £2.8m.

- This resulted in a revised CRES plan of £26.18m for 2017/18.

- CRES templates were being finalised with the Senior Management Team/Programme Leads. Oversight would be via the FROG.

- A clearer picture would emerge when we had two to three months' worth of data to work with.

- A CRES Tracker had been developed to support in year monitoring.

The Finance Procurement & Contracting Committee commented as follows:

- DA asked for a description of the movement from the required CRES savings of £25.1m to £26.1m. He also requested clarification re End of Life Care savings and the reference in appendix 2 to Continuing Healthcare packages of £860k over year set at a regular £72k per month. MB responded that he could provide a reconciliation between the two sets of figures for End of Life. With regard to Continuing Healthcare ('CHC') this was information provided via the tracker and he was working with the respective CHC leads to gather intelligence.

- MW asked if there was any information on the external funding opportunity of £1m. MB responded that (firstly) the trackers needed to be completed but he was not as optimistic about this funding opportunity now. This was potentially from two sources: additional income from North Mersey and European funding.

- KS referred to the savings profile and commented that some savings proposals were certain of meeting the profile (such as Better Care Fund) and MB noted that the voluntary sector savings was also secured. KS went on to refer to the

prescribing profile, MB noted that the savings were profiled largely to year end achievement and that this had been tested through the FROG process and then via the Finance Procurement & Contracting Committee.

The NHS Liverpool CCG Finance Procurement & Contracting Committee:

- **Noted the updates to CRES assumptions for the 2017-18 financial year**
- **Noted the current position and potential impact upon the delivery of NHS England Business Rules Delivery within the financial year.**

Part 4: Strategy & Commissioning

4.1 Contract Update May 2017 – Month 12 2016/17 Report No: FPCC 28-17

DR presented a report to the Finance Procurement Contracting Committee summarising the actual contractual performance for 2016/17. He noted that this was the end of year report and that there was little variance from the presentation two months' ago. He highlighted:

- Royal Liverpool Hospital - The 16/17 position had shifted to a year-end variance of £1.2m higher than the month ten forecast.
- The fixed year end deal for providers mostly benefitted the CCG.
- Total over-performance for the year was £9.6m (1.77%).
- Planned Care was £5.4m over-performing.
- High Cost and Specialist was £2.3m overspent which was largely attributable to the Royal Liverpool Hospital and Aintree hospital.
- With regard to the Royal Liverpool Hospital:

- ✓ £1.2m higher over-performance compared with month 10 at £2.6m over-performance at year end. A year end agreement of £1.1m of over-performance had been agreed in January 2017.

- ✓ There were still issues/disputes around the 15/16 position as well as the 16/17 position. MB noted that this resulted in a large financial variance with the Royal and that this would be addressed at the Audit Risk & Scrutiny Committee and the external auditors were reviewing. There were also invoice/systems issues contributing to this along with national accounting issues and when resolved this would be a gap in excess of £12m.

- ✓ DR further commented that there were also coding issues in 15/16 to 16/17 for costs allocated to CCG rather than to specialist commissioning which was being discussed with NHS England.

- Aintree Hospital:
  - o Slight worsening of the position, however the year end agreement negated any financial impact to the CCG.

  - o Planned care and urgent care both had adverse financial performance in month 12.

  - o High cost drugs over performed by approximately 12% at year-end position agreed at £80m.

- Liverpool Women's Hospital:
  - o High performance in deliveries although some costs in this area may be allocated to specialist commissioning which might reduce the financial over performance.

- Alder Hey:
  - o Activity continued to increase for months 11 and 12 and Business Intelligence were reviewing this.

  - o Year-end position variance was £0.35m less than month 12 actual.

- LCCG meeting with the provider to discuss changes in recording which the CCG had asked an external auditor to review.

- St Helens & Knowsley Hospitals:
  - £1.8m over-performance and the reasons behind this have been discussed at previous committee meetings.

- Spire:
  - Minor under-performance at year-end attributable to reduced outpatient follow ups.
  - Minor over-performance in high cost and specialist activity.
  - Spire had agreed the planned levels of activity for 2017/18 and 2018/19.

- Liverpool Heart & Chest Hospital:
  - Over-performance throughout the year attributable to NEL and unbundled diagnostics.
  - Outpatients above plan but a great deal of work had been carried out by the trust to reduce unnecessary outpatient appointments.

- Walton Centre:
  - Over-performance of £197k (10% of contract value).
  - Improvements being made to the clinical pathway for follow up attendances.

- Mersey Care:
  - Over-performance continued.
  - There were data quality issues and difficulties in splitting out NHS England Criminal Justice Liaison Service driven activity.
  - 2017/19 contract was looking at outcomes, 3% of the contract was linked to outcomes and not driven through a contract.

- Improving Access to Psychological Therapies ('IAPT') was already on the agenda and would be discussed later on the agenda in more detail, however the waiting list was reducing and was down from around 3,000 to 300.

- Liverpool Community Health:
  - Core services had now transferred to Alder Hey.
  - The six non-core services were transferring to RLBUHT as at 1st June 2017 with no issues expected.
  - Six month contract had been offered to Liverpool Community Health on 19th May 2017 and this would be followed up next week.

- North West Ambulance Service:
  - Slight over-performance on Paramedic Emergency Services and Patient Transport Services.
  - NHS 111 were expecting a reduction in the number of calls.
  - Over-performance did not reflect the year-end agreement but if it did it would be £10m.

The Finance Procurement & Contracting Committee members commented as follows:

- DA referred to the performance of the Improving Access to Psychological Therapies ('IAPT') contract where it was stated in the report that further guidance was awaited from NHS Improvement and asked if the report later on the agenda contained new information. TC responded that national guidance was still awaited, the report later on the agenda referred to the Intensive Support Team.

- Query raised regarding Section 7 of the report and specifically one provider, DR explained that Ramsey was a small private hospital.

- ID commented that the 5 Boroughs were now North West Boroughs.

- KS referred to composite over-performance of £10m and the need to understand the areas of over-performance in order to have the right packages for the future and to assist with understanding whether the Acting as One contract was having the desired impact. DR noted that he would bring this information every two months.

- KS referred to St Helens and Knowsley who were not part of "Acting as One" and the huge variance last year. She asked what the contract value was set at for this year. DR responded that the contract value for 17/18 was based on 16/17 out turn value. NF noted that St Helens CCG led in this area not Liverpool CCG.

- KS referred to Liverpool Community Health and the appointment by NHS Improvement of Alder Hey for a six month period to November 2017. NHS Improvement had also said that the new arrangements needed to be in place by 1st October 2017. DR explained that there was a one month termination clause in the contract so it could be terminated earlier (if appropriate).

The NHS Liverpool CCG Finance Procurement & Contracting Committee:

- **Noted the reported contractual position**
- **Supported the on-going investigation of contract issues by officers of the CCG**

4.2 Talk Liverpool Contract and Procurement Options Report No: FPCC 29-17

TC presented a paper to the Finance Procurement Contracting Committee on The Improving Access to Psychological Therapies ('IAPT') contract held with Mersey Care Trust ('MCT') which was due to expire on 31st March 2018. The purpose of this report was to update the Finance, Procurement and Contracting Committee ('FPCC') following discussions with Mersey Care NHS Foundation Trust regarding a contract extension, as a result of the discussion paper presented to the April 2017 FPCC, and to seek approval for

the preferred option. The preferred option was to extend the contract with Mersey Care Trust for the Talk Liverpool IAPT Service for one year until 31st March 2019 with an option for a further one year extension until 31st March 2020 dependant on performance and subject to FPCC approval.

TC commented that the waiting list had reduced from approximately 3,000 to around 300 and that the NHS England Intensive Support team was using this intervention model as a success case study for national events. Some improvement was still required to meet access standards but recovery rates were looking more positive.

The contract negotiation meetings had been very positive, with Mersey Care prepared to accept a twelve month extension until 31st March 2019 with the access standard to be increased to 19% as per the Mental Health Five Year Forward View, a reduction in the tolerance level at which contract sanctions were imposed (12% access and 30% recovery) and a focus on meeting the needs of people with long terms conditions and better integration with primary care. There was a request by Mersey Care that contract sanctions for 2017/18 are re-invested into the service which was the subject of on-going discussion / negotiation

The options available for the Finance Procurement & Contracting Committee to consider were:

- Option one – Re-procure the service from 1st April 2018
- Option two – Extend the contract for 1 year until 31st March 2019 with no option to extend
- Option three – Extend the contract for one year until 31st March 2019 with a further option to extend until 31st March 2020, based on performance.

DA commented that this was a very difficult decision to make and although he noted the improvements made still felt that this was in effect rewarding failure, but would support option three to extend the contract for one year with option to extend until 31st March 2020 based on performance to date.

MW noted her concerns around sustainability of performance after the Intensive Support Team moved on and was in favour of

extending the contract for one year with no option for further extension (option two).

MS expressed the need for a "line in the sand" to be drawn at which point performance was assessed to determine progress and should this be June 2018? MW suggested an extension until 31st March 2019 with a major review to be carried out prior to that date to determine whether the contract should be extended or not (i.e. a modified option two). In response to this ID noted that the CCG needed to be able to withstand challenge from other providers. KS commented that this was really what was already stated in option three.

DR asked for it to made clear that that if option two was followed, performance improvement was maintained as desired and there was no option to extend in place there might still be issues around the CCG going out to the market to re-procure hence option three was the preferred option.

It was agreed by the Finance Procurement & Contracting Committee that Option three to extend the contract for one year until 31st March 2019 with a further option to extend until 31st March 2020, based on performance was approved. It was noted that it was for the Finance Procurement & Contracting Committee to approve the criteria for extension with the Mental Health Team. TC confirmed that these were:

- 16.8% access for 2017/18
- 50% recovery 2017/18
- More uptake from people with Long Term Conditions
- Working city wide with primary care.

It was agreed that the proposal for extension for a further 12 months and criteria for success would need to be brought back to the Finance Procurement & Contracting Committee in June 2018.

The NHS Liverpool CCG Finance Procurement & Contracting Committee:

- **Approved the preferred option, option 3, to extend the Talk Liverpool contract for one year until 31st March 2019, with an option to extend for a further year until 31st March 2020 based on performance.**

- **Requested that the appraisal for extension of the contract for a further year until 31st March 2020 be brought back to the Finance Procurement & Contracting Committee for approval.**

4.3 Translation Services Waiver Paper Report No: FPCC 30-17

DR presented a paper to the Finance Procurement & Contracting Committee which followed on from the paper brought to the April 2017 meeting. The purpose of the paper was to request a competition waiver in respect of translation services.

The paper submitted to the committee in April 2017 outlined the options for: Face to Face Translation services, Telephone Translation Services and Translation Services for deaf and hard of hearing patients. The application of a waiver allied with the negotiation of terms and conditions for a 17 month contract should provide savings to the CCG of up to £100k against costs applicable on inheritance of the contract although these savings could not be assessed directly against the benefits of undertaking a procurement exercise. A saving of £56k per annum had been identified in terms of 2017/18 CRES savings and a total of £80k over the 17 month period. A full procurement process would cost £20k and was therefore within the limit for a procurement waiver subject to the savings being achieved. The proposal was to contact the current service providers with a view to agreeing the fixed term contracts in line with the procurement waiver to finish 31st October 2018.

The NHS Liverpool CCG Finance Procurement & Contracting Committee:

- **Approved a competition waiver in respect of translation services for a period of 17 months until 31st October 2018.**

4.4 Better Care Fund 2017/18 & 2018/19 Report No: FPCC 31-17

MB presented a paper to the Finance Procurement & Contracting Committee to summarise the revised Better Care Fund arrangements for Liverpool Health and Social Care partners in

response to the recently released policy framework and the draft approach agreed between Liverpool CCG and Liverpool City Council for 2017- 2019 financial years.

The Policy Framework for the Better Care Fund ('BCF') was released in March 2017 and covered two financial years (2017-2019) to align with NHS planning timetables and to give areas the opportunity to plan more strategically.

The Mandate to NHS England for 2017- 2018 requires NHS England to ring-fence £3.6 billion (within its overall allocation to Clinical Commissioning Groups) to establish the BCF in 2017-2018. The Mandate was published on 20th March 2017.

The 'Improved Better Care Fund' (new grant for adult social care) for Liverpool CCG was £14m.

The national conditions that areas would need to meet in their plans for 2017-2018 and 2018- 2019 were:

- Plans to be jointly agreed;
- NHS contribution to adult social care is maintained in line with inflation;
- agreement to invest in NHS commissioned out of hospital services; and
- managing transfers of care.

As in 2015- 2016 and 2016- 2017, local areas were asked to agree and report metrics in the following four areas:

- Delayed transfers of care;
- Non-elective admissions (General and Acute);
- Admissions to residential and care homes; and
- Effectiveness of reablement

Partner contributions from Liverpool CCG and Liverpool City Council for 2017- 2018 were set out in the paper with a proposed expenditure from Liverpool CCG of £43.6m against a minimum contribution set of £40.6m. The total expenditure was £89.95m combined Liverpool CCG and Liverpool City Council.

Plans would be developed locally and then assured and moderated regionally in line with the assurance process. Guidance was expected to be received after the General Election.

Liverpool had applied to be an early adopter. There were a number of risks attached to the 2017 - 2018 Better Care Fund which were set out in the paper, the financial risk was only linked to demand driven areas as the contributions were fixed i.e. joint funded packages of care. Operational and quality risks existed around monitoring of performance which would be undertaken by the Finance Procurement & Contracting Committee, the Joint Commissioning Group and then the Health & Wellbeing Board.

The Finance Procurement & Contracting Committee commented as follows:

- DA felt that this was the first clear description of the Better Care Fund which he had reviewed. His concern lay with understanding Liverpool City Council's monitoring and who would pay should there be a shortfall. MB responded that there should not be a shortfall and the contributions were fixed. The risk lay with the demand led areas and the risk of increases needed to be mitigated. The reporting arrangements were to the Finance Procurement and Contracting Committee, Joint Commissioning Group and the health & Wellbeing Board. Reporting to the Finance Procurement & Contracting Committee would be rag-rated and the suggestion was put forward of including this in the Governing Body performance Report. However, it was noted that this process was still work in progress.

- DA raised a concern about Continuing Healthcare Funding as the CCG funded the nursing care element of residential care and Liverpool City Council the rest, the danger he felt was that Liverpool City Council would classify it all as nursing care (continuing healthcare). DR responded that there were meetings with Liverpool City Council to understand the data.

- ID referred to the A&E Delivery Board discussions around the Improved Better Care Fund funding for A&E Locality working. The CCG had funded this out of transformation monies for several months so that it would continue. ID could not see this in the Better Care Fund and wanted to

know if Liverpool City Council were funding it or was it to come back to the CCG. MB agreed to check this. KS noted that the Better Care Fund had been discussed at the A&E Delivery Board but it was the Health & Wellbeing Board which signed if off. In response to a query from MW she agreed to review whether it required approval (firstly) by the CCG Governing Body.

- NF noted that the Health & Wellbeing Board was meeting on 22nd June 2017 and the concerns raised could be covered by the Interim Director for Adult Health & Social Care Liverpool City Council and the CCG Programme Director for Community Services and Digital Care.

The NHS Liverpool CCG Finance Procurement & Contracting Committee:

- **Noted the 2017-19 Integration & Policy Framework released in March 2017**
- **Approved detailed plans for Liverpool Health & Social Care Better Care Fund arrangements in 2017-18 as per this report**
- **Approved that the plan is used as the basis for submission to the Health and Wellbeing Board for approval**
- **Noted Upon agreement, a revised Section 75 agreement is developed for the relevant period and is routinely monitored / reported to the relevant committees of each partner organisation.**
- **Liverpool CCG and City Council have agreed to submit an expression of interest for Graduation from the BCF.**

Part 5: Governance

5.1 Risk Register Report no: FPCC 32-17

MB gave a verbal update to the Finance Procurement & Contracting Committee on the committee Risk Register.

MB presented the refreshed Finance, Contracting and Business Intelligence Risk Register to the Finance Procurement & Contracting Committee for it to consider and advise if there were any changes to be made. The members noted that this was a work-in-progress.

MS felt that the risks seemed relatively low compared to the potential impact on the organisation. He referred to the risk around relationships with providers, MW asked if he meant that "Acting as One" was at risk and MS responded that he was not sure about the financial implications to all provider relationships.

ID referred to risk C01 (legacy contract issues from previous years with Liverpool Community Health) and commented that it would be sensible for the risk rating to be higher. There was overview and scrutiny for all providers within the detailed narrative. KS enquired why the residual risk score for the risks were not calculated and stated at zero. MB responded that first the risk was a concept then there would be movement.

KS asked about the likelihood for risks F01 and F02 (delivery of financial plan 2017/18 and delivery of Cash Releasing Efficiency Savings for 2017/18) and felt that this should be higher. DA referred to risks B01 and B02 (having sufficient data management services) and felt that the comments were out of date, it was noted that the information supplied for the Register had been out of date and that these risks were now addressed.

KS asked about IM&T risks, ID responded that these would be on the Digital Programme Risk Register. The Senior Operations & Governance Manager was working with all the Senior Management Team Leads to refresh on progress and decide if anything should be updated to the Corporate Risk Register.

MW asked if there was anything on this register which should be escalated up as showing as Red. ID responded that step two should be to consider if a risk should be Red (i.e. score of 16). There was discussion about at what the scoring thresholds should be, for example ID felt that 3x4 (total 12 i.e. likelihood possible and consequence major) was more appropriate. It was noted that this was an on-going discussion. More detail would be brought to the next Risk Register presentation.

The NHS Liverpool CCG Finance Procurement & Contracting Committee:

- **Noted the contents of this report and review of risks for the financial year within the 'directorate'.**

- **Considered current control measures and whether action plans provide sufficient assurance on mitigating actions.**
- **Agreed that the risk scores accurately reflected the level of risk that the CCG was exposed to given current controls and assurances.**

6. Any Other Business

None

7. Date and time of next meeting

Tuesday 27th June 2017 Room 2 10am The Department Lewis's Building L1 2SA.

HEALTHY LIVERPOOL TRANSFORMING THE HEALTH OF OUR CITY

NHS Liverpool Clinical Commissioning Group

Minutes of the Healthy Liverpool Programme Board
Wednesday 31 May 2017

Present

Dave Antrobus (Chair)	Lay Member/Patient Engagement/Vice Chair
Dyane Aspinall	Programme Director- Integrated Commissioning Health and Social Care
Dr Nadim Fazlani	GP/Governing Body Chair
Dr Chris Grant	Programme Director, Hospitals
Carole Hill	Integrated Programme Director
Dr Fiona Lemmens	GP/Governing Body Member/Clinical Director, Hospitals and Urgent Care
Katherine Sheerin	Chief Officer
Dr Maurice Smith	GP / Governing Body Member / Clinical Director, Living Well
Tony Woods	Programme Director, Community and Digital Care

In Attendance

Jackie Dobbins	PMO Project Support Officer/Minutes
Sue Lavell	Integrated Programme Manager
Helen Murphy	Programme Manager, Hospitals

Apologies

Dr Simon Bowers	GP/Governing Body Member/Clinical Director, Digital Care
Sandra Davies	Director of Public Health / Programme Director, Living well
Hannah Hague	Programme Manager, Urgent Care
Tom Jackson	Chief Finance Officer / Integrated Programme SRO
Gina Perigo	Programme Manager, Living Well
Kate Warriner	Programme Manager, Digital

1.0	**Welcome, Introductions and Apologies**
1.1	The Chair welcomed everyone to the meeting.
2.0	**Minutes of the Last Meeting**
2.1	The minutes of the last meeting held on 26 April 2017 were agreed as an accurate record.
3.0	**Matters Arising**
3.1	All actions from the previous meeting were completed or covered in the agenda for this meeting.
4.0	**Governance**
4.1	**Risk Register**
4.2	Carole Hill presented a revised risk register for the consideration and approval of the Healthy Liverpool Programme Board.

4.2.1	Members were asked to focus on key issues. Dates and officers are still to be added; a complete Risk Register will be presented to the Healthy Liverpool Programme Board meeting on 28 June 2017.
4.2.2	Members discussed whether political risks should be included. It was agreed that the wording of risk 4 be changed to include a broader set of variables relating to general changes in the political environment.
4.2.3	Dr Smith requested a risk be added to highlight the impact a lack of resources will have on achieving outcomes.
4.2.4	The Healthy Liverpool Programme Board agreed for the continued development of the Risk Register using the revised format.
	Actions: **Carole Hill:** **Risk 4 – amend wording to include a broader set of variables relating to general changes in the political environment.** **Add a risk to highlight the impact that a lack of resources will have on achieving outcomes.** **Present a revised Risk Register to the Healthy Liverpool Programme Board meeting on 28 June 2017.**
4.2	**MIAA Audit Report and Action Plan**
4.2.1	Carole Hill advised that MIAA had carried out an audit of the Healthy Liverpool Programme with the objective of providing assurance that appropriate control mechanisms are in place and to inform the Programme Governance design for future projects and programmes.
4.2.2	The audit identified some weaknesses in the design and operation of controls but concluded that these should not have a significant impact on the achievement of organisational objectives. Six areas for action were recommended.
4.2.3	**1 - Transition to North Mersey LDS**
	Specific Risk – The programme structure for Healthy Liverpool within North Mersey LDS may not be clear leading to the risk of inefficient or ineffective decision making and monitoring processes.
4.2.4	This was outside the scope of the audit but as the Healthy Liverpool Programme is coming to an end, it was felt it should be included. A paper relating to this item will be discussed under agenda item 6.1 below.
4.2.5	**2 – Cost Control Reporting**

	Specific Risk – Programme Management and the Governing Body may not be aware of the level of spend on the programme and whether sufficient committed funds remain to complete the scheduled projects.
4.2.8	As part of the 2017-18 Budget setting process, cost codes are being re-aligned to enable cost reporting for each Programme within Healthy Liverpool. Management of the Healthy Liverpool Budget will be tracked through a new performance management framework – CRES (Cash Releasing Efficiency Savings)
4.2.9	In response to a question regarding Right Care methodology and reporting of outcomes, Carole Hill advised that Business Intelligence produce a report tracking performance and outcomes. The focus of the report is on demand management until the impact and delivery of particular schemes can be realised. The performance report is issued to the North Mersey Leadership Group and will be presented to future Healthy Liverpool Programme Board meetings. **Action:** **Carole Hill to add the performance and outcomes tracking report to the agenda for future Healthy Liverpool Programme Board meetings.**
4.2.10	**3 - Post Investment Reviews and Embedding of Outcome/Benefit Tracking**
	Specific Risk – The planned benefits from the projects and programmes may not be realised as quickly as possible and/or lessons may not be captured and taken forward to future projects.
4.2.11	Post investment reviews will be conducted when projects are concluded. The majority of projects are still in progress.
4.2.12	An overarching review of benefits realisation for programme will be contained in concluding reports and documents that will be presented to the Governing Body, the Health and Wellbeing Board and at a final Mayoral Summit.
4.2.13	**4 – Change Management**
	Specific Risk – If no formal change management/request process is in place a consistent approach to change may not be adopted which has the potential to impact on the delivery of certain elements of the Programme.
4.2.14	Further discussion is required regarding the level of standardisation. The organisation has previously adopted a flexible approach to change management.
4.2.15	This action will also be discussed with the STP portfolio office to agree the scope of a change management process. Governance for approval of changes also needs to be agreed and this forms part of the work on emerging LDS governance and structures.
4.2.16	**5 – Issues Management**

	Specific Risk – If issues are not formally managed through an issues log process there may be delays in resolution, difficulties in prioritisation and delays in escalation to Programme Boards and Senior Management.
4.2.17	A proposed Issues management framework and guidance is in development and will be presented to the next Healthy Liverpool Lead Officers group. **Action: Carole Hill to present the Issues Management Framework and Guidance to the Healthy Liverpool Lead Officers group.**
4.2.17	**6 – Project Management Standards**
	Specific Risk – If the Project Management Standards required are not followed in practice, there may be delays in relevant issues and risks being highlighted to Programme Management for review and resolution.
4.2.18	Reporting templates have been standardised for the Healthy Liverpool Programme and work carried out to ensure consistency across programmes.
5	**Performance**
5.1	**Programme Highlight Reports**
5.1.1	**Living Well** – Maurice Smith highlighted the key points within this month's report.
5.1.2	This Girl Can – campaign launch events will coincide with the Cancer Research Race for Live on 1 and 2 July 2017.
5.2.3	Sport England – a series of applications have been made for a range of funding opportunities. A recent bid for a place based scheme was unsuccessful, feeback is awaited.
5.2.4	European Commission – a proposal to tackle childhood obesity - SHINE (Shaping Healthier lives in Early Years) - was successful at a stage 1 evaluation; work is ongoing for stage 2 of the application. If successful, this bid will provide €470,000 for Liverpool. Liverpool will be leading implementation across 8 European cities.
5.2.5	Commonwealth Games – Liverpool has placed a bid to host the Games in 2022. In recognition of the bid, the Mayor's Fund will support local not for profit organisations to engage with people in one or more Commonwealth Games sports. 22 projects will be supported with up to £500 each in start-up funding with further support from LCC Sports Development Officers.
5.2.6	In response to a question from the Chair regarding why projects that have ended were marked amber, Carole Hill advised that the end date relates to Healthy Liverpool funding and continuation of these projects is dependent on identifying new funding streams.
5.3	**Digital –** Tony Woods highlighted key points within this month's report.

5.3.1	Planning is underway for the next ILinks conference on 5 July 2017. The key theme is “Acting As One”.
5.3.2	A re- run of the procurement for assistive technology ITT is in its final stages, results are expected in June 2017.
5.3.3	Representatives from the NHS Choices team will be visiting Liverpool to work on development of a digital version of “No Wrong Door”, enabling the public to interact electronically with health services.
5.3.4	**Community** – Tony Woods highlighted key points within this month’s report.
5.3.5	A meeting had been held with LCH to review the community nursing structure to ensure the right skills are deployed across Community Care Teams. LCH are developing a leadership model to present at a further meeting in June 2017.
5.3.6	Telemedicine is now installed in 33 Care Homes and 30 are live. Data is being evaluated to establish the impact. Anecdotal feedback indicates that carers value this service.
5.3.7	In response to a request from Dyane Aspinall, Tony woods will arrange for telemedicine data to be sent to Councillor Paul Brant, the Local Authority Cabinet Member for Adult Health and Social Care. **Action: Tony Woods to arrange for Care Home telemedicine data to be sent to Cllr Paul Brant.**
5.3.8	In response to a question from Dr Lemmens relating to the follow up of any lost telemedicine opportunities, Tony Woods advised that Immedicare staff are trained in engaging with care homes. Work is also ongoing around staff training and education.
5.3.9	In response to a question from Dr Lemmens relating to progress of the Care Home model, Tony Woods advised that the enhanced MDT approach was piloted in West Derby. Due to insufficient GP interest, the model was reviewed with a focus on links with Community Matrons. MDTs in North and South neighbourhoods is nurse led, interacting with GPs. Two geriatricians operate in South and Central. Tony Woods agreed to send a written update to Dr Lemmens. **Acton: Tony Woods to forward a written update to Dr Lemmens relating to Care Home MDTs.**
5.3.10	Carole Hill advised that a bid through Cheshire and Mersey STP was successful. This will provide £6.8 million for the early detection of cancer across the Cancer Alliance who will determine distribution of funds.
5.4	**Hospitals** – Helen Murphy highlighted the key points within this month’s report.
5.4.1	**Orthopaedics, ENT and Urology**

	• A Communications and Engagement Plan has been approved by the Orthopadic Oversight Board. • A Joint OSC meeting will be held during week commencing 19 June 2017 • Public Consultation to begin on the 26 June 2017 and run for 12 weeks
5.4.2	**Liverpool Women's Hospital Review** • Work is continuing on the capital financial model and a workshop will be held during June 2017. • NHS Improvement have asked LWH to look at an interim position and to develop a business case. • Helen Murphy, Dr Lemmens and Dr Grant had recently visited Durham to meet the review panel. The panel will be visiting Liverpool on 7 and 8 June 2017 to meet key clinical stakeholders.
5.4.3	**Single Service Reconfiguration** Helen Murphy and Amy Barton from the Hospitals Team are working at Aintree Hospital for two days per week to focus on service integration.
5.4.5	A Transformation Board has been established and Terms of Reference drawn up.
5.4.6	Katherine Sheerin advised members that a discussion paper around establishing a joint committee will be presented to a Committee in Common meeting on Friday 9 June 2017. Governance will be included in this discussion.
5.4.7	Carole Hill requested that Transformation Board Terms of Reference be shared with the joint committee. **Action: Helen Murphy to forward Transformation Board Terms of Reference to Committee in Common.**
5.5	**Communications and Engagement** – Carole Hill highlighted key points within this month's report.
5.5.1	Preparation and planning of events to support the orthopaedics consultation is underway. Materials will be shared when available.
6.0	**Strategy and Commissioning**
6.1	**Road Map for Programme End and Transition**
6.1.2	Carole Hill requested the Healthy Liverpool Programme Board to note the recommendations and endorse the road map for programme end and transition.
6.1.3	Steps and actions to consider in the time up to 31 March 2018 include:
6.1.4	A review of the plans and milestones for each project and programme in the Healthy Liverpool portfolio to consider whether they will be completed by the end of March 18.

6.1.5	For projects that will not be completed by the end point further review will be required to agree whether they cease; mainstream into CCG delivery or transition to the North Mersey LDS programme.
6.1.6	Each project and programme will conduct a benefits realisation exercise to inform a Healthy Liverpool review of outcomes, to demonstrate the benefits that have been achieved. This information would form the basis of a post programme review and formally conclude the programme.
6.1.7	The insight detailed above will be presented to the Healthy Liverpool Programme Board and Governing Body.
6.1.8	A further Healthy Liverpool public document; Delivering the Change, will set out the achievements that have been delivered.
6.1.9	A final Healthy Liverpool Mayoral Summit will be held to communicate the achievements of Healthy Liverpool at the end of the programme.
6.1.10	Katherine Sheerin advised that at a recent Governing Body development session, members had discussed the way forward and the need to differentiate NM LDS and local transformation plans. Further discussions will take place at the next Governing Body development session on 21 June 2017.
7.0	**Any Other Business**
	There was no other business
8.0	**Communications/Messages from this Meeting**
	Road Map for the Healthy Liverpool Programme end and transition.
9.0	**Date and Time of Next Meeting**
	Wednesday 28 June 2017 from 3pm to 5pm in the Board Room.

NHS LIVERPOOL CLINICAL COMMISSIONING GROUP
QUALITY SAFETY & OUTCOMES COMMITTEE
Minutes of meeting held on Tuesday 6th June 2017 at 3pm
Boardroom, The Department, Lewis's Building

Present

Dave Antrobus (DA)	Chair/Lay Member
Katherine Sheerin (KS)	Chief Officer (left at 4.20pm)
Shamim Rose (SR)	GP Governing Body Member
Jane Lunt (JL)	Head of Quality/Chief Nurse & Vice Chair
Fiona Lemmens (FL)	GP Governing Body Member

In attendance

Kerry Lloyd (KL)	Deputy Chief Nurse
Denise Roberts (DR)	Clinical Quality & Safety Manager
Peter Johnstone (PJ)	Primary Care Development Manager
Mavis Morgan (MM)	Patient Representative
Sarah Thwaites (ST)	Healthwatch
Alison Thompson (AT)	Healthcare Acquired Infections Programme Manager
Jacquie Ruddick (JR)	Senior Project Manager
Paula Finnerty (PF)	North Locality Chair
Imran Vardak (IV)	
Carlene Baines (CB)	Designated Nurse for Looked After Children, Safeguarding Service
Paula Jones	Committee Secretary

Apologies

Donal O'Donoghue (DOD)	Secondary Care Clinician
Rosie Kaur (RK)	GP Governing Body Member
Jacqui Waterhouse (JW)	Locality Manager

Part 1: Introductions & Apologies

1.1 WELCOME & INTRODUCTIONS

The Chair welcomed everyone to the meeting and apologies were noted.

1.2 DECLARATIONS OF INTEREST

There were no declarations made specific to the agenda.

1.3 MINUTES AND ACTIONS FROM 2ND MAY 2017

The minutes of the meeting which took place on 2nd May 2017 were agreed as an accurate record of the discussions which had taken place, subject to the following amendments:

- KS noted there were some minor typographical errors which she would inform about after the meeting.

- FL asked for the paragraph on page 15 section 5.3 Engagement Plan, Redesign of Liverpool's Orthopaedic and Trauma Services to be amended to read "…FL reminded the committee that we should not lose sight of the impact on the south of the city with regard to ENT and Trauma."

1.4 MATTERS ARISING NOT ALREADY ON THE AGENDA:

1.4.1 From matters arising it was noted that re the submission of a quarterly report to the Governing Body on patient experience had not yet happened and should be included on the Governing body work plan possibly for July 2017 which would be a good time to coincide with the Annual Report/Annual General meeting. It was agreed that JL would speak to the Chief Operating Officer.

1.4.2 From matters arising – KS asked about the practice which had been rated by the Care Quality Commission as "Inadequate" – DA confirmed that this was Princes Park which was now under a new provider, he agreed to find out which practices were still to be inspected/report due.

1.4.3 From matters arising KS commented on the level of scrutiny which had been applied to the 1-1 Midwifery Service compared to other obstetric providers and that it might prove useful to take a similar approach with other maternity providers.

1.4.4 From matters arising – it was noted that the revised Complaints Policy had been discussed as going to the Governing Body once the amendments requested by the Quality Safety &

Outcomes Committee had been made. This would be presented to the June 2017 Governing Body for information.

1.4.5 Action Point Three – it was noted that the update on generic nhs.net accounts was on the agenda for the July 2017 meeting.

1.4.6 Action Point Four – it was noted that the Mersey Internal Audit Agency Patient Engagement Action Plan update was on the agenda for the October 2017 meeting.

1.4.7 Action Point Five – it was noted that the Quality Surveillance Assurance group report was coming to the August 2017 meeting.

1.4.8 Action Point Six – it was noted that ST had provided the complaints team with Healthwatch complaints activity feedback.

1.4.9 Action Point Seven – it was noted that the changes requested to the Complaints Policy were being made.

1.4.10 Action Point Eight – JL updated the Quality Safety & Outcomes Committee that this discussions had ben had at Chief Nurse level on how we could influence the Sustainability & Transformation Plan and ensure that quality was explicit and not implicit – all Chief Nurses were engaged in looking at this across Cheshire and Mersey.

1.4.11 Action Point Nine – it was noted the issue around the ability of the Quality Team to cope with demand following staff moving on had been reported up to the Governing Body and put on the Corporate Risk Register.

Part 2: Updates

2.1 ANTIBIOTIC PRESCRIBING – TARGET PRACTICES – PRESENTATION

PJ gave a presentation to the Quality Safety & Outcomes Committee on antibiotic prescribing and the performance of Liverpool practices. He highlighted:

- Liverpool as a city was performing better than its comparators.

- Prescribing of high risk antibiotics was flat compared to our comparators where antibiotic prescribing was rising.

- The need to prescribe less was now embedded, now the need was to focus on patient expectation.

- We did not understand why Brighton was included as a comparator area.

- When the new practices were embedded we could then look at the areas to target.

- The CCG needed to have a specialist/high risk Sepsis lead, SR confirmed that she was in fact in this role.

- PF noted that high risk and high prescribing were not the same. PJ commented that established GPs had particular ways of working.

- AT asked about the impact of the media campaigns, PJ responded that there had been a decrease in prescribing for January and February 2017 so this might have been due to the campaigns. PF added that there had been a change in attitude from the public.

The Quality Safety & Outcomes Committee:

- **Noted the presentation.**

Part 3: Strategy & Commissioning

3.1 QUALITY ACOUNTS 2016/17 – REPORT NO: QSOC 32-17

JR presented a paper to the Quality Safety & Outcomes Committee highlighting the current position and process undertaken to achieve sign off of individual Quality Accounts to achieve assurance of quality for each NHS commissioned service from providers. She highlighted:

- The quality of services was measured by looking at patient safety, effectiveness of treatment and patient feedback/experience.

- CCGs took it in turn to “host” the Quality Account Review event.

- Prior to the event the Liverpool CCG Quality Team reviewed all the draft accounts and completed the template and feedback was then sent back to the providers. The new approach was for all CCGs to work together.

- The Checklist was contained in Appendix 1. The CCG completed this and then sent back to the trust for feedback, the final statement would then be sent to the trust and the trust would submit the quality accounts once signed off by their auditors. At this point the final version would be uploaded to the NHS Choices website.

- Liverpool would be the host CCG next year.

The Quality Safety & Outcomes Committee members commented as follows:

- DR noted that the paper referred to the Liverpool Women's Hospital not submitted their account, in fact they did not present it on the date but it went to the Sefton Overview and Scrutiny Committee. South Sefton CCG has hosted the Quality Assurance event on behalf of the three CCGs, Liverpool had co-ordinated all the statement which was a huge task and JR was to be thanked for all her hard work. A summary of the Quality Accounts focussing on Trusts' priorities, how they performed against these and their priorities for 2017/18 would be brought to the August 2017 Quality Safety & Outcomes Committee and then annually.

- MM commented that patients were not represented in these consultations and that there should patient representation on these consultations. ST responded that there was always a Healthwatch representative present who represented a wide range of patients and their opinions. JR added that the trusts themselves talk to a wide range of stakeholders when they were pulling the Quality Accounts together.

The Quality Safety & Outcomes Committee:

➢ **Noted the content of the paper.**

3.2 STATUTORY HEALTH ASSESSMENTS FOR LOOKED AFTER CHILDREN – INCREASED ACTIVITY FOR COMMISSIONED HEALTH SERVICES – REPORT NO: QSOC 33-17

CB presented a paper to the Quality Safety & Outcomes Committee to give an overview of reported increased activity in relation to statutory health assessments for children new into care. This was a very complex area and was therefore the sole focus of the report. She highlighted:

- Statutory timescales (20 working days from entering care) for Initial Health Assessments were not being met and achievement rate was 30%. The pathway for children entering care as not as efficient as it used to be and demand for services was increasing.

- The number of children entering care was increasing in Liverpool but the routine process could be managed sufficiently with the resource. The child's journey needed to followed to understand their situation. We needed to challenge the Local Authority's communications pathway in notifying when children came into care so the health assessment trigger would come into play. Work was on-going to look at streamlining the pathway and workshop had been held. DA noted that the Local Authority had not been present and ultimate responsibility lay with them. CB noted that there had been a conscious decision not to invite the Local Authority to the workshop, she had met with Bernie Brown, Assistant Director for Children and Young People's Services Liverpool City Council, to clarify the pathway and escalation process. All delays in meeting the pathway target were due to late notification by the Local Authority, not due to health. JL noted that more formal discussions needed to take place with Liverpool City Council. KS referred to the Quarter One to Quarter Three data at 41% of children new into care not having initial health assessments carried out with 20 days and it was highlighted that the issue was not around the number of appointments routinely available but around late notification from the Local Authority. KS asked which committee of the Local Authority was responsible for this and the response from JL was that this was the Corporate Parenting Board. The Local Authority data was significantly late in coming through and was therefore not triggering the health assessment notification.

JL agreed to contact Bernie Brown for this matter to be raised formally at the Corporate Parenting Board. The appointments and resources were available to meet the set timescales it was simply the late notification from the Local Authority which was the issue. DA agreed that this should be made clear on the reporting template to the Governing Body

The Quality Safety & Outcomes Committee:

- **Noted and approved the contents of the report.**
- **Requested a letter was sent to Bernie Brown outlining the current health position.**

Part 4: Performance

4.1 LIVERPOOL HEART & CHEST HOSPITAL NHS FOUNDATION TRUST – QUALITY PROFILE – REPORT NO: QSOC 34-17

KL presented a paper to the Quality Safety & Outcomes Committee summarising the key risks to quality at Liverpool Heart & Chest Hospital and the quality improvement work in place to mitigate those risks. Liverpool CCG was the lead commissioner but a number of other commissioners provided its income including Specialised Commissioning. The Care Quality Commission had rated the trust as outstanding with particular mention of its infection prevention control measure, good staff skill mix and use of the Mental Capacity Act. The Clinical Quality & Performance meetings had moved to bi-monthly from quarterly, the representation at this meeting did vary both in terms of roles and levels of seniority to give the appropriate assurance.

The report detailed the Serious Incidents which were reported in 2016/17 which were low in number but not low as a percentage of patients. For performance against CQUINs for 2016/17 overall there were no real issues.

The strength of the trust lay in patient experience which was a priority. ST confirmed that for Healthwatch data overall the public were very positive about the trust and about staff attitude. The only negative comments were around parking being too far away.

FL commented that the report contained an error as it stated that the Trust had the largest critical care unit in the country and in fact it had one of the largest in the country.

The Quality Safety & Outcomes Committee:

- **Noted the content of the report**
- **Requested additional information where required.**

4.2 MORTALITY – SYSTEMS AND PROCESSES UPDATE – REPORT NO: QSOC 35-17

KL presented a paper to the Quality Safety & Outcomes Committee which gave a broad overview of the complexity if the systems in place to look at mortality within commissioned services. There was national guidance from the National Quality Board on learning from deaths upon which our trusts would be held to account. Each Clinical Quality & Performance Group would look at delivery against the milestones set out in the guidance which were:

- Mortality data had to be collected from 1st April 2017;
- Quarterly data collection with learning and actions attached would be reported to the Trust Board in the Public section;
- From April 2017 have an existing Board-level leader and an existing Non-Executive Director to lead and take oversight of the process
- Prepare a mortality policy by the end of Q2 that set out the Trust systems and processes for mortality review;
- Publish a Learning from Deaths Data Dashboard including learning points from Q3 onwards; and
- Provide a summary of findings published in Quality Accounts, June 2018
- Inclusion of families and carers at the outset of any review or investigation into a death.

Locally the Summary Hospital-level Mortality Indicator ('SHMI') and Hospital Standardised Mortality Ratio ('HSMR') were the most commonly used metric to monitor death rates. Across the city there were eight trusts all of whom had a different patient case mix. It was felt that to some degree the CCG did not always have the level of expertise to challenge on this when needed. A Cheshire & Mersey Mortality Working Group involving NHS England, CCGs and providers to look at avoidable mortality had been set up by the

National Quality Board and there had been one meeting and a workshop held to date.

The CCG had a contract with Dr Foster which could be better utilised, hence the workshop.

PF the North Locality Chair was now fully embedded into the clinical mortality workstream at Aintree Hospital. She had been involved now for four years and was an established member of the Aintree monthly mortality meetings. PF explained that the SHMI was higher than expected and HSMR was within range. There was no doubt of the link between mortality and quality as well as the link between SHMI, staff shortages and healthcare acquired infections. Each month different areas were considered.

The Working Group set up in response to the National Quality Board requirement would support standardising an approach to mortality across the city. In order to learn from deaths the data was to be published each quarter stating if deaths were avoidable or not. There was a possibility for an independent person to review the deaths database and NHS England were to come up with a standardised approach. All deaths should always be considered i.e. patients with learning disabilities. PF had been invited to join the new NHS England Working Group to look at this approach with them. The SHMI looked at deaths within 30 days of discharge so trusts with high numbers of palliative care patients would have a higher SHMI and 54% of Aintree patients had a palliative coding, one of the highest in the country.

The Quality Safety & Outcomes Committee commented as follows:

- FL commented that this was an excellent report and that good progress had been made over the last four years. However she asked about the processes of mortality review at other trusts, not just Aintree. It was noted that KL attend the Royal Liverpool Hospital Mortality Group and KL informed the committee that the formal output for this group had been requested to put on the agenda for the Clinical Quality & Performance Group. The Royal's report was more specific than Dr Foster.

- FL referred to palliative care coding and asked if there should be a specific End of Life coding. PF noted that Aintree Hospital had a palliative care hospice in its grounds.

- KS asked for the mortality process to come back to the Quality Safety & Outcomes. KL agreed to bring back an update on progress against the National Quality Board requirements.

- JL commented that she was pleased to see that work was being led by NHS England at a Cheshire & Mersey level but felt that we still had not addressed the issue of lack of expertise within CCGs. FL noted that the expertise must exist at Cheshire & Mersey level via the Working Group.

- FL referred to the outlier position of Liverpool Women's hospital and noted that there was a clinical risk management Group which was attended by herself, JL and the Medical Director of the trust amongst others which looked at mortality. JL commented on the unusual position of the trust and the difficulty in making comparisons with other acute trusts due to complexities around neonatal transfers. Analysis of this data was beyond the skills we held.

The Quality Safety & Outcomes Committee:

- **Noted the content of the report**
- **Sought further assurance if required**
- **Made recommendations where appropriate.**

4.3 HEALTH CARE ASSOCIATED INFECTION ANNUAL REPORT 2016-17 – REPORT NO: QSOC 36-17

AT presented a paper to the Quality Safety & Outcomes Committee which provided the Annual Report for 2016/17 with regards to the management of healthcare associated infections within the city of Liverpool. She highlighted:

- A reduction in healthcare acquired infections was known to improve patient experience and outcomes as well as reduce costs and mortality.

- Antimicrobial resistance – there had been significant challenges and continued to be challenges at the trust.

- There was a zero tolerance target for MRSA but the CCG now had a new target of 10% for e-coli.

- The Liverpool provider landscape was complex – an assurance framework was completed monthly by providers which went to their infection control meetings and then to the Clinical Quality & Performance Groups.

- MRSA: post infection reviews process was robust for review and learning. There were eleven cases reported in the year attributed to Liverpool CCG. One of thee CCG attributed cases was successfully arbitrated by NHS England and assigned to a third party. For the two cases at the Royal Liverpool Hospital one was a contaminant and one was successfully arbitrated and assigned to a third party. Both of the Alder Hey cases identified lessons to be learnt and more intensive support had been offered by the HCAI CCG Lead during the year.

- C Difficile: if a specimen is taking within 72 hours of admission the case would be allocated to the CCG, after 72 hour it was apportioned to the admitting trust. There was an appeal process if there were no lapses in care identified – non appealed cases would now be included to ensure sharing of lessons learnt. There had been 55 cases reported at the Royal Liverpool & Broadgreen Hospital against an annual plan of 44, nine cases were successfully appealed which brought the total to 46 and the Trust was encouraged to bring further cases to appeal.

- For the rest of the Community attributed cases, identified by LCH as 86, the plan for 2016/17 had been to continue to work with Liverpool Community Health Infection Prevention and Control team to develop the PIR process to include Primary Care in the investigation where there were 2 or more infections within the practice within the year. This would enable a wider understanding of key issues and identify themes and trends which were potentially influencing the rates. This would also fit in with the Antimicrobial Resistance agenda (AMR) which was focussing on prescribing trends and aiming to reduce the prescribing of antibiotics to a minimum.

- For e-coli there had been 440 cases last year. The top three know sources were urinary tract infections, gastrointestinal and hepatobiliary. Data collection needed to be improved to prove what the issues were. Dr Jamie Hampson was leading on this area but there was no one to input the data on the database so

we would fail the Quality Premium for a target reduction of 10% for the coming financial year 2017/18.

- Carbapenemase-Producing Enterbacteriaceae ('CPE'): there were no submissions for patients.

- The national action plan was attached.

The Quality Safety & Outcomes Committee commented as follows:

- DA referred to the first amber rating on the Action Plan re the quality premium reduction of E-coli by 10% for 2017/18 and the work to be done to achieve this. AT noted that a communication to general practice was being prepared. KL noted that this had been discussed at the Antimicrobial Resistance Steering Group which the Local Medical Committee Chair was part of. FL noted that this was something that could be piloted at a Neighbourhood level rather than at individual practices. AT added that NHS England had new guidance reducing Urinary Tract Infections. MM asked simple hygiene precautionary measures but AT responded that UTIs were preventable but not e-coli and the 10% reduction target had been set which meant that NHS England thought that there was some room for preventative measures.

- A query was raised about the figures on C Difficile per trust set out on page six of the report as Aintree had 46 for the year but no appeal figure. AT responded that the Royal had 55 which post appeal had reduced to 46. Aintree appealed at least 50% of cases

The Quality Safety & Outcomes Committee:

- **Noted the content of the report**
- **Requested additional information where required.**

Part 5: Governance

5.1 RISK REGISTER– REPORT NO: QSOC 37-17

DR presented the Risk Register to the Quality Safety & Outcomes Committee which highlighted the key quality and Safety risks to

Liverpool CCG, identified mitigating actions and action plans and showed all new and on-going risks. She highlighted:

- There were 18 risks on-going at various stages of review.

- Aintree Hospital: the issues around mortality had already been discussed, A&E four hour waits risks were being mitigated by the A&E Delivery Board, Choose and Book issues were being monitored by the Clinical Quality & Performance.

- Royal Liverpool Hospital: A&E four hour wait target risk remained, the Safeguarding risk had been removed as reasonable assurance had been provided to the Safeguarding Service, however this would continue to be reviewed by the Clinical Quality & Performance Group.

- Liverpool Community Health: on-going risks as identified by the Care Quality Commission and CCG of Transaction of Services to the new provider, Pressure Ulcers, Looked After Children, Safeguarding and Paediatric Speech & Language Therapy. The Quality Risk Profile had now been closed following improvements with monitoring going forward.

- Alder Hey: ongoing risks relating to single services i.e. optometry, audiology and palliative care. Infection prevention and control was an area for concern with a comprehensive action plan developed with clear timescales and ownership.

- Mersey Care: Talk Liverpool contract had shown some improvement in performance but it was still not where it should be.

- Two new risks added:
    - Serious Incident management process.
    - Capacity within the Quality Team.

  JL emphasised the pressures of the quality team due to staff leaving and the ensuing delay before vacant posts were filled, coupled with the increasing workload/demand on the team. FL referred to risks LCCG 1 and LCCG 2 and asked what the difference was between them. JL agreed that the comment needed to be reworded. FL agreed that these risks needed to escalated to the governing Body and that it should be made very clear via the reporting template to the Governing Body.

- DA asked for risks Aintree 4 (Choose & Book), Alder 6 (audiology provision), Alder 9 (gaps in services and loss of skilled staff) and Alder 11 (reputational risks for packages of care moving to new providers) to be removed.

- ST commented that the risk should contain titles for ease of identification.

The Quality Safety & Outcomes Committee:

- **Noted the content of the risk register that are rated as high risk.**
- **Noted the updated information provided concerning on-going risks**
- **Added any additional risks identified at the meeting.**

6. ANY OTHER BUSINESS

No items.

7. DATE AND TIME OF NEXT MEETING

Tuesday 4th July 2017 – 3pm to 5pm

NHS Liverpool CCG Remuneration Review Report

Information Reader Box (IRB) to be inserted on inside front cover for documents of 6 pages and over, with Publications Gateway Reference number assigned after it has been cleared by the Publications Gateway Team. *Publications Gateway guidance and the IRB can be found on the Intranet.*

NHS Liverpool CCG Remuneration Review

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Prepared by: Operations and Information Directorate

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Contents

Executive Summary

1. On Wednesday 22 March 2017, the MP for West Lancashire, called on the Prime Minister to investigate pay increases at NHS Liverpool CCG. A freedom of information request from the MP had identified that members of the governing body of the CCG received large pay rises mainly in FY2014/15.

2. In response, NHS England instructed its internal auditors to undertake a fact finding investigation to understand the governance processes and decisions taken at NHS Liverpool CCG to agree the remuneration for the Governing Body members (excluding GP members) for the years ended 31 March 2014, 31 March 2015 and 31 March 2016.

3. The fact finding investigation identified a requirement to strengthen the governance arrangements over remuneration at NHS Liverpool CCG. More specifically, the investigation identified a failure to adhere to NHS England's guidance on remuneration and decisions on remuneration being taken outwith the CCG's Constitution.

4. The governance processes to agree the remuneration for the Governing Body members, excluding GP members, did not clearly define the delegation of authority to the Remuneration Committee ('the Committee') and the rules governing the management of conflicts of interest, as defined in the Constitution, were not followed in respect of non-GP members' remuneration.

5. Decisions were taken by the Committee that resulted in the CCG agreeing to remuneration for Governing Body members which was significantly higher than CCGs in its peer group, as defined by NHS England, and not in accordance with NHS England's guidance.

6. Furthermore, a situation arose in which the Committee were both proposing and accepting a decision to award themselves increased remuneration. Based on interviews with Governing Body and Committee members and a review of relevant papers and minutes, the decision to increase non-GP members' remuneration was primarily intended to bring equality in pay between GPs and non-GPs on the Governing Body.

7. In addition, the Committee meeting minutes did not document whether the Committee was making decisions or recommendations to the Governing Body on increasing non-GP members' pay. Although the Committee's proposals were noted and supported by the Governing Body, the Constitution only allowed the Committee to make recommendations on remuneration, which had to be approved by the Governing Body.

8. The remuneration of the Governing Body members was reported in the annual report and accounts for FY2013/14, FY2014/15 and FY2015/16, which were all in the public domain.

1. Introduction

1.1 Background

9. The Constitution of NHS Liverpool Clinical Commissioning Group (CCG), in accordance with section 14L(2)(b) of the National Health Service Act 2006, as inserted by section 25 of the Health and Social Care Act 2012, states that the CCG must at all times observe "generally accepted principles of good governance" in the way it conducts its business.

10. These include, but are not limited to, the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the "Nolan Principles" and the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business.

11. On Wednesday 22 March 2017, the MP for West Lancashire, called on the Prime Minister to investigate pay increases at NHS Liverpool CCG. A freedom of information request had identified that members of the governing body of the CCG received large pay rises mainly in FY2014/15.

12. A summary of the remuneration paid is included in Table 1[1].

Name and Title	Salary (Bands of £5,000)			All Pension Related Benefits (Bands of £2,500)			Total		
	2015/16 £'000	2014/15 £'000	2013/14 £'000	2015/16 £'000	2014/15 £'000	2013/14 £'000	2015/16 £'000	2014/15 £'000	2013/14 £'000
Chief Officer	155-160	155-160	135-140	57.5-60	27.5-30	290-292.5	215-220	185-187.5	405-410
Chief Finance Officer	145-150	145-150	125-130	45-47.5	0	195-197.5	195-200	135-137.5	300-305
Chief Nurse	115-120	130-135[2]	95-100	130-132.5	332.5-335	50-52.5	245-250	465-467.5	135-140
Chair	150-155	150-155	100-105	0	0	0	150-155	170-175	105-110
Deputy Chair	100-105	100-105	70-75	0	0	0	100-105	110-115	75-80
Clinical Vice Chair	60-65	70-75	60-65	0	0	0	60-65	90-95	60-65
Lay Member Patient Eng.	50-55	50-55	45-50	0	0	0	50-55	55-60	45-50
GP 1	60-65	65-70	60-65	0	0	0	60-65	70-75	60-65
Practice Nurse	65-70	65-70	40-45	0	0	0	65-70	70-75	40-45
GP2	0	75-80	65-70	0	0	0	0	85-90	65-70
GP3	0	15-20	60-65	0	0	0	0	15-20	60-65
GP4	60-65	75-80	65-70	0	0	0	60-65	90-95	70-75
Locality Chair Central	0	75-80	65-70	0	0	0	0	85-90	65-70
Secondary Care Doctor	90-95	90-95	55-60	0	0	0	0	90-95	55-60
GP5	60-65	60-65	55-60	0	0	0	60-65	70-75	60-65
GP6	60-65	75-80	60-65	0	0	0	60-65	90-95	60-65
GP7	65-70	50-55	0	0	0	0	65-70	55-60	0
GP8	45-50	0	0	0	0	0	45-50	0	0
GP9	45-50	0	0	0	0	0	45-50	0	0

Table 1: NHS Liverpool CCG Annual Report and Accounts FY2015/16 and FY2014/15 (excluding expenses)

[1] The scope of the fact finding investigation work covered the roles in Table 1 excluding GP members.
[2] Includes £17k pay arrears in relation to FY2013/14

13. The Prime Minister responded: “I understand that my right hon. Friend the Health Secretary has asked NHS England to investigate the remuneration of non-executive directors[3] at NHS Liverpool CCG, and I am sure that he will keep the hon. Lady updated... As I say, NHS England is investigating the issue that the hon. Lady has raised[4].”

14. NHS England undertook a desktop review of the CCG’s Remuneration Committee meeting papers and minutes. Based upon the conclusions, the brief to internal audit was to undertake a fact finding investigation of the governance of the Remuneration Committee and how the Governing Body oversees and scrutinises its work, including interviews with key stakeholders.

15. The scope of the work requested covered:

- All Governing Body members and was not restricted to Lay Members.
- All pay decisions made by the Remuneration Committee, not restricted to pay rises.

1.2 Scope and objectives of the fact finding investigation

16. The overall objective was to undertake a fact finding investigation to understand the governance processes and decisions taken at NHS Liverpool CCG to agree the remuneration for the Governing Body members (excluding GP members)[5] for the years ended 31 March 2014, 31 March 2015 and 31 March 2016.

17. The fact finding review:

- Understood the governance processes in place at NHS Liverpool CCG for the years ended 31 March 2014, 31 March 2015 and 31 March 2016 including:
    - The Constitution and operation of the Remuneration Committee.
    - The scheme of delegation from the Board to the Remuneration Committee.
    - The processes followed to propose and agree all remuneration decisions, including the setting of initial remuneration levels and any subsequent changes, for Governing Body members.
- Understood the decisions taken at NHS Liverpool CCG for the years ended 31 March 2014, 31 March 2015 and 31 March 2016 relating to Governing Body Remuneration decisions, including:
    - The individuals involved in the decision.

[3] For the purposes of the fact finding investigation non-executive directors at NHS Liverpool CCG has been taken to include members of the Governing Body, more specifically Lay Members and non-GP members as the CCG does not have non-executive directors.
[4] Hansard, 22 March 2017
[5] The scope of the work covers the roles in Table 1 excluding those titled GP1 to GP9.

  - The processes to manage conflict of interest around decisions.
  - The timing of decisions.
  - The supporting documentation considered in arriving at decisions.

- Assessed whether the governance arrangements in place and the decision making processes were in accordance with Instructions, Policy, Guidance and Direction issued by NHS England.

- Assessed whether the governance arrangements in place and the decision making processes were in accordance with accepted corporate governance principles for example the Nolan Principles, HM Treasury Corporate governance in central government departments: Code of Good Practice and the UK Corporate Governance Code.

1.3 Assumptions and limitations

18. The investigation assumed that the meeting minutes from the Remuneration Committee and the Governing Body provided an accurate reflection of the discussions and decisions taken.

19. There was no independent confirmation of the remuneration paid to Governing Body members, reliance was placed on the accuracy of the annual report and accounts in respect of the salaries reported for Governing Body members.

2. Key findings and recommendations

20. The fact finding investigation made four observations and a numbers of recommendations. NHS England have agreed management actions to address each of these which are summarised below.

CCG governance arrangements

21. In its first year of operation, the CCG had to implement and embed its operational infrastructure and finalise its staffing arrangements, along with the necessary governance arrangements and other processes underpinning its statutory role and duties. However, weaknesses in the governance processes initially established at the CCG led to a lack of clarity over whether the Remuneration Committee or the Governing Body had authority to make decisions to determine the remuneration of Governing Body members.

22. During the period under review, the Remuneration Committee took decisions outside its delegated authority as defined in the Constitution by setting and uplifting the remuneration of members of the Governing Body. This resulted in a situation where the Committee were proposing and accepting a decision to award themselves increased remuneration and this conflict of interest was not managed in line with the Constitution.

23. It was recommended that the delegation of authority to the Committee should be clarified such that it has an advisory role only; the Committee should seek independent advice when making recommendations on remuneration; and independent members should be appointed to the Committee to scrutinise decision making. NHS England have asked the CCG to prepare an action plan to address the recommendations and will monitor the implementation thereof.

CCG decision making

24. The CCG took decisions that were not in line with NHS Commissioning Board guidance. This resulted in the rates of remuneration for the NHS Liverpool CCG Governing Body becoming an outlier in comparison to similar CCGs. Internal audit were informed that the Remuneration Committee and the Governing Body were aware of this at the time the decision was taken; however, this was not documented in the meeting papers or the minutes.

25. NHS Liverpool CCG has to manage significant complexity in terms of its diverse and large membership of over 90 GP practices, multiple NHS Trusts and poor health outcomes and social deprivation amongst its registered population. In addition, in FY2013/14 the CCG established a major five year transformation programme, the Healthy NHS Liverpool Programme, to shape the future of health services in NHS Liverpool. From FY2013/14 to FY2015/16, NHS Liverpool CCG's budget increased from £730m to £854.9m and the registered population increased from 493,964 to 501,619.

26. Notwithstanding this complexity, the remuneration of NHS Liverpool CCG's Governing Body members, excluding GP members, in FY2015/16 was significantly higher than a peer group of ten other CCGs selected based on allocation. More specifically:

    - The Chair, Chief Finance Officer and Chief Nurse had the highest pay in their peer group.
    - The Chief Officer had the second highest pay in their peer group.
    - The two lay members were paid significantly more than any of their peer group[6].
    - The Practice Nurse and secondary care doctor[7] were paid significantly more than any of their peer group.

27. Furthermore, the Remuneration Committee minutes did not demonstrate that sufficient scrutiny and challenge was given to the proposals to increase executives' and other non-GP members' remuneration.

28. It was recommended that an independent chair is appointed to the Remuneration Committee. Independent remuneration consultants should review the remuneration of Governing Body members, in conjunction with NHS England's guidance and the prevailing approach at similar CCGs, and provide recommendations on appropriate rates. Remuneration rates should be amended accordingly. NHS England have asked the CCG to prepare an action plan to address the recommendations and will monitor the implementation thereof.

Management of CCG conflicts of interest

29. On 10 September 2013, the Remuneration Committee discussed the report on Governing Body remuneration. The report noted that "All members of the Remuneration Committee and the full [Governing Body] other than paid staff are clearly in a conflict of interest situation because they are proposing, and or accepting a decision to award themselves remuneration". The minutes recorded that all members of the Remuneration Committee had declared an interest.

30. The Committee minutes record that "by minuting this conflict of interest and adhering to good governance guides on conduct as adduced by the Nolan Principles et al, we will have demonstrated transparency and management of the conflict of interest". However, the conflict of interest was not managed in accordance with the Constitution. For example, independent individuals with

[6] Lay members at NHS Liverpool CCG were remunerated through a rate per session (£320) based on the number of sessions undertaken. The NHS England guidance states that remuneration for lay members should be "in line with non-executive director payments in other NHS organisations" and does not specify the basis for the calculation of remuneration.

[7] The internal auditors were informed that the secondary care doctor's remuneration was set by their employer, an NHS Foundation Trust. The CCG was recharged by the Trust for the time incurred and did not directly make any additional payments to them for their work.

no conflict of interest were not invited on a temporary basis to scrutinise the decision-making of the Committee.

31. The Committee was recorded on 3 May 2016 as agreeing to appoint an independent person to oversee the decision making when there is a conflict of interest. However, at the time of the fact finding investigation, the Terms of Reference had not been updated to include an independent person.

32. It was recommended that the Committee Terms of Reference was updated to require independent representatives to be invited to scrutinise decision-making where the removal of members with a conflict of interest would make the meeting no longer quorate. Further, the Committee should record in the meeting minutes the steps taken to manage any identified conflicts of interest in accordance with the requirements of the Constitution. NHS England have asked the CCG to prepare an action plan to address the recommendations and will monitor the implementation thereof.

NHS Commissioning Board guidance

33. In FY2012/13, there were significant changes to the health and social care system as a result of the Health and Social Care Act 2012 ('the Act'). During FY2012/13, the NHS Commissioning Board ('NHS England') and NHS Liverpool CCG were operating in shadow form under new organisational structures with limited staff resources. Both organisations became officially operational in their current form on 1 April 2013.

34. Prior to 1 April 2013, there was a need for the NHS Commissioning Board to rapidly develop and provide CCGs with a range of guidance materials, which gave direction whilst recognising CCGs' autonomy under the Act.

35. Accordingly, the guidance on remuneration for Chief Officers and Chief Finance Officers recognised that CCGs had flexibility in determining remuneration levels, but stated that CCGs were "strongly encouraged to follow the arrangements set out in this guidance in determining, reviewing, and operating their own pay arrangements". However, the guidance in relation to non-GP members' pay described its principles as 'advice' which 'may be considered'.

36. The guidance on executive pay did not define which population measure should be used to determine the pay award ranges for the roles of Chief Finance Officer and Chief Officer and no guidance was provided on the remuneration of the role of Chief Nurse.

37. NHS England reviews CCGs' probity and governance as part of the CCG improvement and assessment framework. However, this does not explicitly require consideration of CCGs' compliance with its guidance on remuneration of Governing Body members.

38. It was recommended that that a 'comply or explain' mechanism is implemented for guidance on Governing Body members' pay, which enables

CCGs to deviate from the principles and supporting provisions if justifiable for the good governance of the CCG. CCG responses should be considered by NHS England as part of the CCG improvement and assessment framework.

39. In addition, it was recommended that NHS England's guidance should be updated to include the population measure to determine CFO and CO pay ranges and guidance on the remuneration of the role of Chief Nurse.

3. Next steps

40. The table below sets out a summary of the key actions that NHS England will take based on the findings and recommendations:

#	Actions	Timescale
1	Confirm that NHS Liverpool CCG have an agreed action plan to: • Clarify the delegation of authority from the Governing Body to the Remuneration Committee in the Constitution such that it has an advisory role only. It should be clearly defined that no member should be involved in deciding his or her own remuneration. In addition, the Remuneration Committee ToR should be aligned to the Constitution. • Update the Remuneration Committee terms of reference to require it to: ○ Seek independent advice when making recommendations on the remuneration of Governing Body members. ○ Scrutinise systems for identifying and developing leadership and high potential. ○ Scrutinise plans for orderly succession of appointments to the Governing Body and of senior management, in order to maintain an appropriate balance of skills and experience.	30 June 2017
2	Confirm that NHS Liverpool CCG have an agreed action plan to: • Appoint a new chair to the Remuneration Committee who has hitherto been independent of the CCG. • Appoint independent remuneration consultants to review the remuneration of Governing Body members in conjunction with NHS England's guidance and the prevailing approach at similar CCGs. • The review's recommendations on appropriate rates should be considered and remuneration rates amended accordingly. • Appoint members to the Remuneration Committee who have the skills and experience to provide effective scrutiny and challenge to proposals to change Governing Body remuneration.	30 June 2017

#	Actions	Timescale
3	Confirm that NHS Liverpool CCG have an agreed action plan to: • Update the Remuneration Committee Terms of Reference to require the Committee to invite independent representatives to scrutinise decision-making where the removal of members with a conflict of interest would make the meeting no longer quorate. • Record in the Remuneration Committee minutes the steps taken to manage any identified conflicts of interest in accordance with the requirements of the Constitution.	30 June 2017
4	Liaise with the Department of Health to update the remuneration guidance for CCGs to include the population measures to determine CFO and CO pay ranges and guidance on the remuneration of the role of Chief Nurse. The pay ranges in the guidance should be reviewed on a periodic basis to confirm they remain in line with inflation and market trends.	30 June 2017
5	Consider the implementation of an additional indicator in the CCG improvement and assessment framework to evaluate CCGs' compliance with NHS England's remuneration guidance.	30 September 2017