

Southport and Formby Clinical Commissioning Group

MEETING OF THE GOVERNING BODY July 2014

Agenda Item: 14/108	Author of the Paper: Debbie Fagan Chief Nurse Email: debbie.fagan@southportandformbyccg.nhs.uk 0151 247 7000
Report date: July 2014	
Title: Safeguarding Service Children & Vulnerable Adults Policy 2014 (Incorporating Safeguarding & Mental Capacity Act Standards for Commissioned Services)	
Summary/Key Issues: The Safeguarding Service has updated the Safeguarding Service Children & Vulnerable Adults Policy for ratification across the Merseyside CCGs. This policy incorporates updated Safeguarding & Mental Capacity Act Standards for Commissioned Services. This policy will be considered by the CCG Quality Committee 23 July 2014 and any recommendations will be verbally presented to the Quality Committee by the Chair or the Chief Nurse.	
Recommendation	Receive <input type="checkbox"/> Approve <input type="checkbox"/> Ratify <input checked="" type="checkbox"/>
The Committee is asked to approve the recommendation	
Links to Corporate Objectives (<i>x those that apply</i>)	
X	Improve quality of commissioned services, whilst achieving financial balance.
	Sustain a 2% reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Care Closer to Home.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

Process	Yes	No	N/A	Comments/Detail (<i>x those that apply</i>)
Patient and Public Engagement			X	
Clinical Engagement	X			Quality Committee; Safeguarding Team
Equality Impact Assessment			X	
Legal Advice Sought			X	
Resource Implications Considered			X	
Locality Engagement			X	
Presented to other Committees			X	Quality Committee

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



***Southport and Formby
Clinical Commissioning Group***

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**Safeguarding Children & Vulnerable Adults Policy
2014 (Incorporating Safeguarding and Mental Capacity
Act Standards for Commissioned Services)**

1.0 Introduction

1.1 Southport and Formby Clinical Commissioning Group (CCG) has a statutory duty to ensure it makes arrangements to safeguard and promote the welfare of children and young people and to protect vulnerable adults from abuse or the risk of abuse. The arrangements should reflect the needs of the vulnerable population they commission or provide services for. Southport and Formby CCG is also required to contribute to multi-agency arrangements to protect vulnerable adults and children from radicalisation.

1.2 As a commissioning organisation Southport and Formby CCG is required to ensure that all health providers from whom it commissions services have comprehensive single and multi-agency policies and procedures in place to safeguard and promote the welfare of children and to protect vulnerable adults from abuse or risk of abuse. Southport and Formby CCG should also ensure that health providers are linked into the local safeguarding children and safeguarding adult boards and that health workers contribute to multi-agency working.

1.3 This policy has two functions:

- a) It details the roles and responsibilities of Southport and Formby CCG as a commissioning organisation, of its employees and GP practice members;
- b) It provides clear service standards against which healthcare providers will be monitored to ensure that all service users are protected from abuse and the risk of abuse.

1.4 This policy should be used in conjunction with the Sefton Safeguarding Children Board (LSCB) and Sefton Safeguarding Adult Board (SAB) guidance.

2.0 Scope

2.1 This policy aims to ensure that no act or omission by Southport and Formby CCG as a commissioning organisation, or via the services it commissions, puts a service user at risk; and that robust systems are in place to safeguard and promote the welfare of children, and to protect adults at risk of harm.

2.2 Where Southport and Formby CCG is identified as the co-ordinating commissioner it will notify collaborating commissioners of a provider's non-compliance with the standards contained in this policy or of any serious untoward incident that is considered to be a safeguarding issue.

3.0 Principles

3.1 Southport and Formby CCG recognises that safeguarding children and vulnerable adults is a shared responsibility and there is a need for effective joint working between agencies and professionals that have differing roles and expertise if vulnerable groups

are to be protected from harm. To achieve effective joint working, there must be constructive relationships at all levels which need to be promoted and supported by:

- a) A commitment of senior managers and board members to seek continuous improvement with regard to safeguarding both within the work of Southport and Formby CCG and within those services commissioned.
- b) Clear lines of accountability within Southport and Formby CCG for safeguarding.
- c) Service developments that take account of the need to safeguard all service users, and is informed where appropriate, by the views of service users or advocates.
- d) Staff learning and development including a mandatory induction which includes familiarisation with responsibilities and procedures to be followed if there are concerns about a child or adult's welfare.
- e) Staff training and continuing professional development so that staff have an understanding of their roles and responsibilities in regards to safeguarding children, adults at risk, looked after children and the Mental Capacity Act (2005).
- f) Appropriate supervision and support for the workforce.
- g) Safe working practices including recruitment and vetting procedures.
- h) Effective interagency working, including effective information sharing.

4.0 Equality and Diversity

4.1 The population of Southport and Formby is diverse and includes areas of high deprivation. Children and adults from all cultures are subject to abuse and neglect. All children and adults have a right to grow up and live safe from harm. In order to make sensitive and informed professional judgments about the needs of children (including their parents' capacity to respond to those needs) and the needs of adults at risk, it is important that professionals are sensitive to differing family patterns and lifestyles that vary across different racial, ethnic and cultural groups.

4.2 Professionals need to be aware of the broader social factors that serve to discriminate against black and minority ethnic populations. Working in a multi-cultural society requires professionals and organisations to be committed to equality in meeting the needs of all children and adults at risk and to understand the effects of harassment, discrimination or institutional racism, cultural misunderstandings or misinterpretation.

4.3 The assessment process should maintain a focus on the needs of the individual child or adult at risk. It should always include consideration of how the religious beliefs and cultural traditions influence values, attitudes and behaviours and the way in which family and community life is structured and organised. Cultural factors neither explain nor condone acts of omission or commission that place a child or adult at risk of significant harm. Professionals should be aware of and work with the strengths and support systems available within families, ethnic groups and communities, which can be built upon to help safeguard and promote their welfare.

5.0 Definitions

5.1 Children

5.1.1 In accordance with the Children Act 1989 and the Children Act 2004, within this policy, a **'child'** is anyone who has not yet reached their 18th birthday. **'Children'** will mean children and young people throughout.

5.1.2 **'Safeguarding children'** is defined in the Joint Inspectors' report *Safeguarding Children* (2002) as:

- a) All agencies working with children, young people and their families take all reasonable measures to ensure that the risks of harm to children's welfare is minimised; and
- b) Where there are concerns about children and young people's welfare all agencies take all appropriate actions to address those concerns, working to agreed local policies and procedures in partnership with other agencies.

5.1.3 The phrase **vulnerable child** is multi-factoral and difficult to define. It includes, but not exclusively, those children and young people who are particularly vulnerable due to the following: - age, disability, lack of parental control, children living away from home (including looked after children), migrant children and unaccompanied asylum seekers, children who are missing from home or education, children abused by other children (including bullying), children engaging in anti-social and or criminal activity, young carers, and those living in families where substance misuse, domestic abuse and mental health issues are having an adverse impact on the child. (Working Together 2010; 2013)

5.1.4 **Looked After Children** are those children and young people who are looked after by the state under one of the following sections of the Children Act 1989 including:

- Section 31 - Care Order
- Section 38 - Interim Care Order
- Section 20 - Voluntary accommodation at the request of or by agreement with their parents or carers
- Section 44 - Emergency Protection Order

In addition, the term Looked After Child may also be used to describe the following specific groups of children and young people:

- Children under a criminal law supervision order with a need to reside in local authority accommodation.

- Children who have appeared in court and have been bailed to reside where the local authority directs; and for whom the local authority is funding the placement.
- Children who are remanded to the care of the local authority where bail has not been granted
- Children under a court ordered secure remand and held in council accommodation
- Children who are subject to a secure accommodation order where the local authority is funding the placement. Where this accommodation is due to offending behaviour the cost is funded by the Home Office and these children are not classed as Looked After Children.
- Unaccompanied asylum seeking children are also required to be treated as Looked After Children

5.1.5 Private Fostering – this is a private arrangement made between a child's parents and someone who is not a close relative to care for a child for 28 days or more: where the child lives with the carer. Close relatives include aunt, uncle, brother, sister or grandparents but not a great aunt or uncle. Southport and Formby CCG staff have a responsibility to notify Children's Social Care of any private fostering arrangements that they become aware of.

5.2 Adults at risk

5.2.1 A person aged 18 or over and who:

- a) Is eligible for or receives any adult social care service (including carer's services) provided or managed by the local authority.
- b) In receipt of direct payments in lieu of adult social care services.
- c) Funds their own care and has social care needs.
- d) Otherwise has social care needs that are low, moderate, substantial or critical.
- e) Falls within any other categories prescribed by the Secretary of State.
- f) Is or may be in need of community care services by reason of mental or other disability, age or illness.
- g) Who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation; and is at risk of *significant harm*, where harm is defined as ill-treatment or the impairment of health or development or unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion).

5.2.2 For the purpose of this policy the term adult at risk will be used rather than the term vulnerable adult because it focusses on situations causing risk rather than any characteristic of the adult concerned (Law Commission 2011). "Adults at Risk" is the term advised by the law Commission which replaces the previous term "Vulnerable adult" and will be the term used throughout this policy.

5.2.3 Whilst there is no formal definition of vulnerability within health care, some people receiving health care may be at greater risk from harm than others,

sometimes as a complication of their presenting condition and their individual circumstances. The risks that increase a person's vulnerability should be appropriately assessed and identified by the health care professional/ care provider at the first contact and continue throughout the care pathway (DH 2010).

5.2.4 Under Section 59 of the Supporting Vulnerable Groups Act 2006, a person aged 18 years or over is also defined as a vulnerable adult where they are 'receiving any form of health care' and 'who needs to be able to trust people caring for them, supporting them and/or providing them with services'.

5.3 Adult safeguarding

5.3.1 The principles for adult safeguarding are as follows (DH 2011):

- a) **Empowerment** – Presumption of person led decisions and informed consent.
- b) **Protection** – Support and representation for those in greatest need.
- c) **Prevention** – It is better to take action before harm occurs.
- d) **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented.
- e) **Partnership** – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- f) **Accountability** – Accountability and transparency in delivering safeguarding.

5.3.2 Prevent – Radicalisation of vulnerable people. The government counter terrorism strategy is called **CONTEST** and is divided into four priority objectives:-

Pursue – stop terrorist attacks.

Prepare – where we cannot stop an attack, mitigate its impact.

Protect – strengthen overall protection against terrorist attacks.

Prevent – stop people becoming terrorists and supporting violent extremism.

The Prevent Strategy addresses all forms of terrorism including extreme right wing but continues to prioritise according to the threat posed to our national security. The aim of Prevent is to stop people from becoming terrorists or supporting terrorism and operates in the pre-criminal space before any criminal activity has taken place. Prevent aims to protect those who are vulnerable to exploitation from those who seek to encourage people to support or commit acts of violence.

5.3.3 Definitions of abuse are contained within the glossary section of the policy.

5.4 Specific safeguarding issues

5.4.1 Domestic Abuse

The cross-government definition of domestic violence and abuse is:-

“Any incident or pattern of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial or emotional”. (Home Office circular 003/2013)

This is regardless of race, culture, religion, gender, age and disability. It is also important to note that domestic abuse can also occur in lesbian, gay, bisexual and transgender relationships. Heterosexual females can also abuse heterosexual males and children also abuse adults. Domestic abuse also features highly in cases of child abuse and in an analysis of serious case reviews, both past and present, it is present in over half (53%) of cases. (HM Government 2010) Approximately 200,000 children in England live in households where there is a known risk of domestic violence (Brandon et al, 2009)

The term “domestic abuse” includes issues such as female genital mutilation (FGM), so called honour based crimes, forced marriage and other acts of gender based violence, as well as elder abuse, when committed within the family or by an intimate partner. Family members are defined as mother, father, son, daughter, brother, sister, and grandparents whether directly related or stepfamily.

NB: Whilst an adult is defined as any person aged 18 or over, the new definition has been altered to include 16 and 17 year olds. Despite this change in definition, domestic abuse involving any young person under 18 years, even if they are parents, should be treated as child abuse and the Southport and Formby Safeguarding Children Board procedures apply.

5.4.2 Forced Marriage

“marriage shall be entered into only with the free and full consent of the intending spouses” (Universal Declaration of human Rights, Article 16 (2))

A forced marriage is where one or both people do not (or in the case of people with learning or physical disabilities, cannot) consent to the marriage and pressure or abuse is used. The pressure put on people to marry against their will can be physical, (including threats, actual physical violence and sexual violence), emotional or psychological (for example when a person is made to feel like they are bringing shame on their family) and financial abuse (taking money from a person or not providing money).

5.4.3 Female Genital Mutilation (FGM)

Female genital mutilation is a collective term used for procedures which include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. FGM is typically performed on girls between the ages of 4 and 13 years, although it may also be performed on infants, and prior to marriage or pregnancy. The Prohibition of Female Circumcision Act 1985 made this practice illegal in this country and the Female Genital Mutilation Act 2003 which replaced it has now made it illegal for girls to be taken abroad for the purpose of performing this procedure.

6.0 Roles and Responsibilities

- a) Ultimate accountability for safeguarding sits with the Chief Officer for Southport and Formby CCG. Any failure to have systems and processes in place to protect children and adults at risk in the commissioning process, or by providers of health care that Southport and Formby CCG commissions would result in failure to meet statutory and non-statutory constitutional and governance requirements.
- b) Southport and Formby CCG must demonstrate robust arrangements are in place to demonstrate compliance with safeguarding responsibilities. The NHS Commissioning Board (NHSCB) monitor compliance with safeguarding as required through authorisation (see appendix 1) and beyond.
- c) Southport and Formby CCG must establish and maintain good constitutional and governance arrangements with capacity and capability to deliver safeguarding duties and responsibilities, as well as effectively commission services ensuring that all service users are protected from abuse and neglect.
- d) Establish clear lines of accountability for safeguarding, reflected in governance arrangements.
- e) To co-operate with the local authority in the operation of the local safeguarding children and safeguarding adults board.
- f) To participate in serious case reviews and domestic homicide reviews.
- g) Secure the expertise of a designated doctor and nurse for safeguarding children; a designated doctor and nurse for looked after children (LAC); a designated paediatrician for child deaths; a safeguarding adult lead and a mental capacity act lead.
- h) Ensure that all providers with whom there are commissioning arrangements have in place comprehensive and effective policies and procedures to safeguard children and adults at risk in line with those of the Southport and Formby LSCB / SAB.
- i) Ensure that all staff in contact with children, adults who are parents/carers and adults at risk in the course of their normal duties are trained and competent to be alert to the potential indicators of abuse or neglect for children and vulnerable adults, know how to act on those concerns in line with local guidance.
- j) Ensure that appropriate systems and processes are in place to fulfil specific duties of cooperation and partnership and the ability to demonstrate that Southport and Formby CCG meets the best practice in respect of safeguarding children and adults at risk and looked after children.

- k) Ensure that safeguarding is at the forefront of service planning and a regular agenda item of Southport and Formby CCG governing body business.
- l) Ensure that all decisions in respect of adult care placements are based on knowledge of standards of care and safeguarding concerns.
- m) Ensure that there are robust recruitment and vetting procedures in place to prevent unsuitable people from working with children and adults at risk. These procedures must be in line with national and Southport and Formby LSCB/ SAB guidance and will be applied to all staff (including agency staff, students and volunteers) who work with or who handle information about children and adults at risk.

6.1 Chief Officer for Southport and Formby CCG

- a) Ensures that the health contribution to safeguarding and promoting the welfare of children and adults at risk is discharged effectively across the whole local health economy through the organisation's commissioning arrangements.
- b) Ensures that the organisation not only commissions specific clinical services but exercises a public health responsibility in ensuring that all service users are safeguarded from abuse or the risk of abuse.
- c) Ensures that safeguarding is identified as a key priority area in all strategic planning processes.
- d) Ensures that safeguarding is integral to clinical governance and audit arrangements.
- e) Ensures that all health providers from whom services are commissioned have comprehensive single and multi-agency policies and procedures for safeguarding which are in line with the local safeguarding children and adult board procedures and are easily accessible for staff at all levels.
- f) Ensures that all contracts for the delivery of health care include clear standards for safeguarding - these standards are monitored in order to provide assurance that service users are effectively safeguarded.
- g) Ensures that Southport and Formby CCG staff, and those in services contracted by Southport and Formby CCG, are trained and competent to be alert to potential indicators of abuse or neglect in children and know how to act on their concerns and fulfil their responsibilities in line with the Southport and Formby LSCB policies and procedures.
- h) Ensures Southport and Formby CCG cooperates with the local authority in the operation of LSCB and LSAB.
- i) Ensures that all health organisations with whom Southport and Formby CCG has commissioning arrangements have links with Southport and Formby LSCB and SAB; that there is appropriate representation at an appropriate level of seniority; and that health workers contribute to multi-agency working.
- j) To ensure that any system and processes that include decision-making about an individual patient (e.g. funding panels) takes account of the requirements of the Mental Capacity Act 2005 – this includes ensuring that actions and decisions are documented in a way that demonstrates compliance with the Act.

6.2 Southport and Formby CCG Governing Body Lead with responsibility for safeguarding

- a) Ensures that Southport and Formby CCG has management and accountability structures that deliver safe and effective services in accordance with statutory, national and local guidance for safeguarding children and looked after children (LAC)
- b) Represents Southport and Formby CCG on both the LSCB and SAB.
- c) Ensures that service plans / specifications / contracts / invitations to tender etc. include reference to the standards expected for safeguarding children and adults at risk.
- d) Ensures that safe recruitment practices are adhered to in line with national and local guidance and that safeguarding responsibilities are reflected in all job descriptions.
- e) Ensure that staff in contact with children and or adults in the course of their normal duties are trained and competent to be alert to the potential indicators of abuse or neglect and know how to act on those concerns in line with local guidance.

6.3 Southport and Formby CCG Individual staff members

- a) To be alert to the potential indicators of abuse or neglect for children and adults and know how to act on those concerns in line with local guidance.
- b) To undertake training in accordance with their roles and responsibilities as outlined by the training frameworks of Southport and FormbyLSCB and SAB so that they maintain their skills and are familiar with procedures aimed at safeguarding children and adults at risk.
- c) Understand the principles of confidentiality and information sharing in line with local and government guidance.
- d) All staff contribute, when requested to do so, to the multi-agency meetings established to safeguard children and adults at risk.
- e) All staff will cooperate with Local Authority solicitors and Merseyside Police as required in order to safeguard and protect children and vulnerable adults.

6.3.1 See appendices for guidance as to what action needs to be taken where there are concerns that a child or an adult at risk is being abused; and information sharing guidance:

- a) Appendix 2 – What to do if you are worried a child is being abused
- b) Appendix 3 – Possible signs and indicators of child abuse and neglect
- c) Appendix 4 – Flowchart of key questions for information sharing
- d) Appendix 5 - What to do if an adult is at risk of abuse

6.4 Southport and Formby CCG GP member practices

6.4.1 Southport and Formby CCG GP member practices will take account of the safeguarding standards as detailed in Appendix 6; 7; 8; 9. Compliance with the standards will be subject to audit and scrutiny.

6.5 Designated professionals

6.5.1 Southport and Formby CCG is required to have in place arrangements to secure the advice of Designated Professionals for Safeguarding Children and Looked After Children (LAC) as well as advice for safeguarding vulnerable adults. Access to and support from such professionals will be through the shared Merseyside CCGs hosted team employed by Southport and Formby CCG. The Designated Professionals, including the lead for Safeguarding Adults, will:

- a) Provide strategic guidance on all aspects of the health service contribution to protecting children and vulnerable adults within Southport and Formby CCG and Southport and Formby LSCB and SAB area.
- b) Work closely in the discharge of their responsibilities – this may include the convening of professional advisory and support groups.
- c) Have enhanced Disclosure and Barring Scheme (DBS) clearance renewed every 3 years.
- d) Provide professional advice on safeguarding issues to the multi-agency network.
- e) Be a member of Southport and Formby LSCB, SAB and relevant sub-groups as required, delegating to other health professionals as appropriate.
- f) Be involved in the appointment of Named Professionals, providing support as appropriate.
- g) Provide professional safeguarding supervision and leadership to Named Professionals within the provider organisations.
- h) Take the strategic overview of safeguarding arrangements across Southport and Formby CCG and Local Authority area and assist in the development of systems, monitoring, evaluating and reviewing the health service contribution to the protection of children and adults at risk.
- i) Collaborate with the Director of Public Health, LSCB, SAB, Southport and Formby CCG Chief Nurse and Named Professionals in Provider Trusts in reviewing the involvement of health services in serious incidents which meet the criteria for serious case reviews.
- j) Advise on appropriate training for health personnel and participate where appropriate in its provision.
- k) Advise on practice policy and guidance ensuring health components are updated.
- l) Ensure expert advice is available in relation to safeguarding policies, procedures and the day to day management of safeguarding children and vulnerable adults issues.
- m) Liaise with other designated and lead professionals for safeguarding children, looked after children and vulnerable adults across the Merseyside area and beyond as required to do so
- n) Attend relevant local, regional and national forums.

- o) Take part in an annual appraisal process via the Chief Nurse from the employing CCG.
- p)

7.0 Management of Allegations Against a Southport and Formby CCG Employee

7.1 *Working Together to Safeguard Children* (2013) details the responsibility of all organisations to have a process for managing allegations against professionals who work with children. This requires Southport and Formby CCG to inform the Local Authority Designated Officer (LADO) of any allegations it becomes aware of within one working day. A parallel process will be followed regarding adults at risk. The Named Senior Manager / Officer will notify and access advice and guidance from the Safeguarding Adult Co-ordinator promptly as per LSAB Safeguarding Adult Policy and Procedures (2011).

8.0 Implementation

8.1 Method of monitoring compliance

8.1.1 Comprehensive service specifications for services for children and adults, of which child & adult protection / safeguarding is a key component, will be evident in all contracts with provider organisations. Service specifications will include clear service standards and KPI's (key performance indicators) for safeguarding Children & Adults and promoting their welfare, consistent with Southport and Formby LSCB/ SAB procedures.

8.1.2 The standards expected of all healthcare providers are detailed in the appendices. Compliance will be measured by annual audit – an audit tool will be made available to all providers to facilitate the recording of information. The audit tool should be completed using the RAG definitions outlined in the procedures for monitoring safeguarding children and vulnerable adults via provider contracts. This procedure was developed in order to standardise the monitoring and escalation approach across the North West.

8.1.3 Additionally a number of specific quality KPI's will be set for all providers which compliment a number of the existing standards in the afore mentioned audit tool, these will require a detailed response with data and achievements clearly evidenced in the returns. The quality and effectiveness of which will be monitored on a quarterly/ annual basis (dependent on the indicator).

8.2 Breaches of policy

8.2.1 This policy is mandatory. Where it is not possible to comply with the policy, or a decision is taken to depart from it, this must be notified to Southport and Formby CCG so that the level of risk can be assessed and an action plan can be formulated (see section 8 for contact details).

8.2.2 Southport and Formby CCG, as a co-ordinating commissioner, will notify collaborating commissioners of a providers' non-compliance with the standards contained in this policy, including action taken where there has been a significant breach.

9.0 Contact details

Designation	Contact Number
Chief Officer	01704 387028/0151 247 7009
Chief Nurse	01704 387028/0151 247 7252
Designated Nurse Safeguarding Children	0151 495 5469 or 5295
Designated Doctor Safeguarding Children	0151 228 4811 Ext 2287
Designated Doctor Looked After Children	0151 228 4811 Ext 2287
Community Paediatrician - CDOP	0151 228 4811 Ext 2287
Head of Safeguarding Adults	0151 495 5469 or 5295
Lead for the Mental Capacity Act	0151 495 5469 or 5295
Prevent Lead	0151 495 5469 or 5295

NB: The Shared Merseyside Safeguarding Service and Southport and Formby CCG work in conjunction with Sefton Borough Council to safeguard and promote the welfare of children, young people and adults from abuse or risk of abuse, i.e. through adherence to multi-agency policy, collaboration, information sharing and learning and representation at Sefton Safeguarding Children Board and Sefton Executive Board (Safeguarding Adult Board.)

10.0 References

The following statutory, non-statutory, best practice guidance and the policies and procedures of the Southport and Formby LSCB and Southport and Formby SAB have been taken into account:

10.1 Statutory Guidance:

- a) Department for Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice*. London: TSO
- b) Department of Health (2000) *Framework for the Assessment of Children in Need and their Families*. London: HMSO
- c) Department of Health, Home Office (2000) *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (issued under Section 7 of the Local Authority Social Services Act 1970)
- d) Department of Health et al (2009) *Statutory Guidance on Promoting the Health and Well-Being of Looked After Children*. Nottingham: DCSF Publications
- e) HM Government (2007) *Statutory guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004*. DCSF Publications
- f) HM Government (2008) *Safeguarding children in whom illness is fabricated or induced*. DCSF Publications
- g) HM Government (2009) *The Right to Choose: multi-agency statutory guidance for dealing with forced marriage*. Forced Marriage Unit: London
- h) HM Government (2010) *Working Together to Safeguard Children*. Nottingham: DCSF Publications
- i) HM Government (2013) *Working Together to Safeguard Children – a guide to interagency working to safeguard and promote the welfare of children*. DFE. www.education.gov.uk/aboutdfe/statutory
- j) Ministry of Justice (2008) *Deprivation of Liberty Safeguards Code of Practice to supplement Mental Capacity Act 2005*. London: TSO
- k) Home Office (2012) protecting the UK against terrorism. www.gov.uk/government/policies/protecting-the-uk-against-terrorism
- l) Care Quality Commission (2009) *Essential Standards of Quality and Safety*

10.2 Non-Statutory Guidance:

- a) Children's Workforce Development Council (March 2010) *Early identification, assessment of needs and intervention. The Common Assessment Framework for Children and Young People: A practitioner's guide*. CWDC
- b) Department of Health (June 2012) *The Functions of Clinical Commissioning Groups* (updated to reflect the final Health and Social Care Act 2012)
- c) Department of Health (March 2011) *Adult Safeguarding: The Role of Health Services*
- d) Department of Health (May 2011) *Statement of Government Policy on Adult Safeguarding*

- e) HM Government (2006) *What to do if you're worried a child is being abused*. DCSF Publications
- f) HM Government (2006) *Information Sharing: Guidance for practitioners and managers*. DCSF Publications
- g) Law Commission (May 2011) *Adult Social Care Report*
- h) www.justice.gov.uk/lawcommission/publications/1460.htm
- i) Royal College of Paediatrics and Child Health et al (2014) *Safeguarding Children and Young People: Roles and Competences for Health Care Staff*. *Intercollegiate Document*

10.3 Best Practice Guidance:

- a) Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services Standard 5* (plus including relevant elements that aren't contained in Core Standard 5)
- b) Department of Health (2009) *Responding to domestic abuse: a handbook for health professionals*
- c) Ending violence against women and girls. March 2014.
www.gov.uk/government/policies/ending-violence-against-women-and-girls-in-the-uk
- d) Department of Health (2010) *Clinical governance and adult safeguarding: an integrated approach*. Department of Health
- e) HM Government (2009) *Multi-agency practice guidelines: Handling cases of Forced Marriage*. Forced Marriage Unit: London
- f) National Institute for Health and Clinical Excellence (2009) *When to suspect child maltreatment*. NICE Clinical Guideline 89
- g) Department of Health (2006) *Mental Capacity Act Best Practice Tool*. Gateway reference: 6703

10.4 Sefton Local Safeguarding Children Board:

Sefton safeguarding children board policies, procedures and practice guidance are accessible at:

<http://www.liverpoolscb.org/>

10.5 Sefton Local Safeguarding Adult Board:

Sefton safeguarding adult board, policies, procedures and practice guidance are accessible at:

<http://liverpool.gov.uk/media/102189/safeguarding-policy-february-2013.pdf>

10.6 Disclosure and barring

The proposed changes to the vetting and barring scheme should become operational in December 2012. Until they become operational then the October 2009 regulations still apply. Further guidance is available at: www.homeoffice.gov.uk/crime/vetting-barring-scheme/

11. Glossary

CAF	Common Assessment Framework
CCGs	Clinical Commissioning Groups
DCSF	Department for Children, Schools and Families
DH	Department of Health
LAC	Looked After Children
LSAB	Local Safeguarding Adult Board
LSCB	Local Safeguarding Children Board
MCA	Mental Capacity Act
NCB	National Commissioning Board
SUI	Serious Untoward Incident

11.1 Categories of child abuse as per *Working Together to Safeguard Children* (HM Government 2013).

Abuse: A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or an institutional or community setting, by those known to them or, more rarely, by a stranger (eg via the internet). They may be abused by an adult or adults, or another child or children.

Physical abuse: A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Emotional abuse: The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual abuse: Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact,

including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Neglect: The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- Protect a child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care givers); or
- Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

11.2 Abuse of adults at risk: For safeguarding adults, the definitions of abuse have been taken from *No Secrets* (DH and the Home Office 2000).

Abuse: Abuse is a violation of an individual's human and civil rights by another person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm, or exploitation of, the person subjected to it. Of particular relevance are the following descriptions of the forms that abuse may take:

Physical abuse: Including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions.

Sexual abuse: Including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, could not consent, or was pressured into consenting.

Psychological abuse: Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

Financial or material abuse: Including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Neglect and acts of omission: Including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating. Neglect also results in bodily harm and/or mental distress. It can involve failure to intervene in behaviour which is likely to cause harm to a person or to others. Neglect can occur because of lack of knowledge by the carer.

NB: Self neglect by an adult will not usually result in the instigation of the adult protection procedures unless the situation involves a significant act of omission or commission by someone else with responsibility for the care of the adult. Possible indicators of neglect include:

- a) Malnutrition
- b) Untreated medical problems
- c) Pressure ulcers (Bed Sores)
- d) Confusion
- e) Over-sedation

Discriminatory abuse: Including racist, sexist, that based on a person's disability; and other forms of harassment, slurs or similar treatment.

Neglect and **poor professional practice** also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as **institutional abuse**.

APPENDIX 1: Authorisation Criteria for Safeguarding

<p>Domain 4: Proper constitutional and governance arrangements, with the capacity and capability to deliver all their duties and responsibilities including financial control, as well as effectively commissioning all the services for which they are responsible.</p>
<p>Criteria: 4.2 Able to deliver all their statutory functions, including strategic oversight, quality improvement, financial control and probity, innovation and managing risk.</p>
<p>Threshold for authorisation: 4.2.3 CCG has systems and processes in place to fulfil its specific duties of cooperation and partnership, including:</p> <ul style="list-style-type: none"> • Reducing inequalities in access and to outcomes from healthcare • CCG can demonstrate that it meets best practice in relation to safeguarding.
<p>Evidence for authorisation: D. CCG has established appropriate systems for safeguarding. E. CCG has established plan to train staff in recognising and reporting safeguarding issues.</p>
<p>Domain 5: Collaborative arrangements for commissioning with other CCGs, local authorities and the NHSCB as well as the appropriate commissioning support.</p>
<p>Criteria: 5.3 Strong arrangements for joint commissioning and cooperation with local authorities to enable integration, deliver shared outcomes and fulfil statutory responsibilities, drawing on public health advice.</p>
<p>Threshold for authorisation: 5.3 Appropriate arrangements are in place to safeguard and promote welfare of children and vulnerable adults.</p>
<p>Evidence for authorisation: B. Clear line of accountability for safeguarding is reflected in CCG governance arrangements, and CCG has arrangements in place to co-operate with the local authority in the operation of Local Safeguarding Children Board and the Safeguarding Adults Board. C. CCG has secured the expertise of a designated doctor and nurse for safeguarding children and for looked after children, and a designated paediatrician for unexpected deaths in childhood. D. CCG has a safeguarding adults lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.</p>

APPENDIX 2: What to do if you are worried a child is being abused.

For advice and support from the Designated Nurse for Southport and Formby CCG within the Shared Merseyside Safeguarding Service please ring the main contact numbers: 0151 495 5469

Any member of staff who believes or suspects that a child may be suffering or is likely to suffer significant harm should always refer their concerns to Children's Social Care. Never delay emergency action to protect a child whilst waiting for an opportunity to discuss your concerns first.

Are you concerned a child is suffering or likely to suffer harm ? eg

- You may observe an injury or signs of neglect
- You may be given information or observe emotional abuse
- A child may disclose abuse
- You may be concerned for the safety of a child or unborn baby

Step 1

Inform parents/ carers that you will refer to Children's social care UNLESS

The child may be put at increased risk of further harm (eg suspected sexual abuse, suspected fabricated or induced illness, female genital mutilation, increased risk to child, forced marriage or there is a risk to your own personal safety)

Step 2

Make a telephone referral to Sefton's Children's Services on 0845 140 0845 (8 a.m. – 6 p.m.) or for out of hours 0151 920 8234 (Mon – Thurs 5.30 p.m, Friday after 4 p.m and weekends)

- Follow up in writing within 48 hours
- Document all discussions held, actions taken, decisions made, including who was spoken to and who is responsible for undertaking actions agreed.
- For physical abuse document injuries observed

Step 3

Children's Social Care acknowledges receipt of referral and decides on next course of action. If the referrer has not received an acknowledgement within 3 working days contact Children's Social Care again for an update.

Step 4

You may be requested to provide further reports / information or attend multi-agency meetings

Other important numbers
Police - emergency 999

Police - non-emergency 101

APPENDIX 3: Possible signs and indicators of child abuse and neglect

Possible signs and indicators of child abuse and neglect

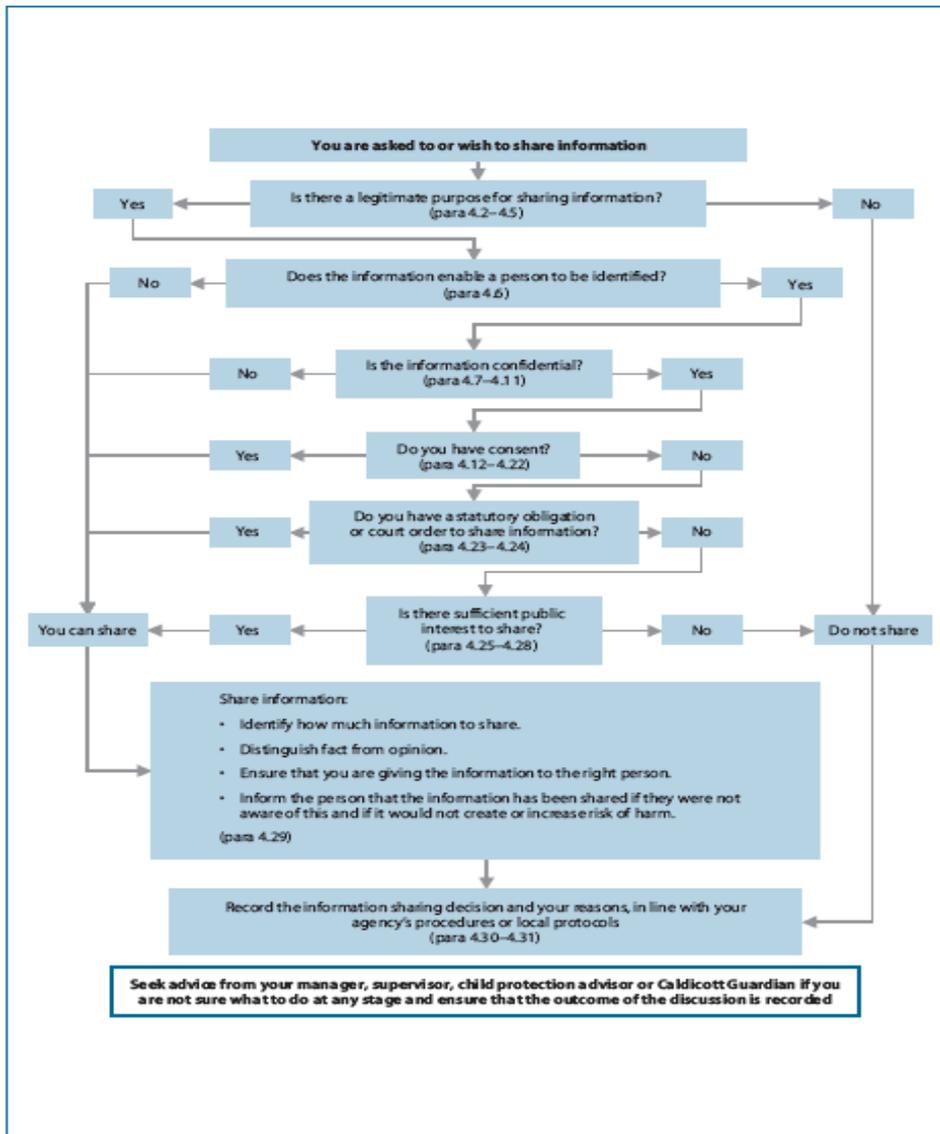
Physical Abuse		Emotional Abuse		
Actions and behaviour of adult/ carer	<ul style="list-style-type: none"> Minor injuries Various types of injuries eg. those resulting in fractures of head injuries Premeditated sadistic injuries Burns and scalds Bites Repeated abuse resulting from lack of control Injury resulting from physical chastisement 	<ul style="list-style-type: none"> Shaking Belittling Physical assaults regarded as bullying Suffocating Fabricated or induced illness Female circumcision Death/murder 	<ul style="list-style-type: none"> Rejection Lack of praise and encouragement Lack of comfort and love Lack of secure attachment Lack of continuity of care eg. frequent moves Serious over protectiveness Inappropriate non-physical punishment eg. locking in bedroom, cold water in bath, frequent shouting at a child Humiliating and degrading behaviour, including bullying and racial abuse 	
Physical signs on child/ young person	<ul style="list-style-type: none"> Disorientation Unexplained bruising/marks or injuries Injuries of different ages Adult bite marks Outline bruising eg. belt, hand print Bruises to eyes, ears, finger tips Burns and scalds on hands, feet, buttocks, groin, cigarette burn 	<ul style="list-style-type: none"> Difficulty in reading books Blood in white of eyes, small bruises on head, bruise on rib cage—may be associated with shaking injuries Injuries and/or fractures in babies and children who are not mobile Drowsiness eg. from head injury or poisoning Female genital mutilation Genital/anal area injuries 	<ul style="list-style-type: none"> Self harm behaviour, eg. scratching, self-harm, suicide attempt Developmental delay Eating disorder 	<ul style="list-style-type: none"> Exposure to repeated incidents of abuse Age or developmentally inappropriate expectations being imposed on the child Making the children feel frightened or in danger
Behaviour and emotional state of child/ young person	<ul style="list-style-type: none"> Aggressive Withdrawn or watchful Low self-esteem Poor concentration Fear self image 	<ul style="list-style-type: none"> Flinching when approached or touched 	<ul style="list-style-type: none"> Aggressive Withdrawn Repetitive comfort behaviour eg. rocking or hair twisting Swallow spoon incidents 	<ul style="list-style-type: none"> no sense of achievement Lack of confidence, lack of positive identity Inability to play Failure to thrive Severe behaviour problems
Sexual Abuse		Neglect		
Actions and behaviour of adult/ carer	<ul style="list-style-type: none"> Inappropriate fondling Moral masturbation Digital penetration Oral/genital contact Anal or vaginal intercourse Sexual exploitation Exposure to pornography 	<ul style="list-style-type: none"> Encouraging children/young people to become prostitutes Encouraging children to witness intercourse or pornographic acts Leaving a child in the care of a known sex offender Internet child pornography 	<ul style="list-style-type: none"> Abandonment or desertion Leaving alone Malnourishment, lack of food, inappropriate food or erratic feeding Lack of warmth Lack of adequate clothing Lack of protection or lack of supervision appropriate to child's age and developmental stage Persistent failure to attend school 	<ul style="list-style-type: none"> Leaving child alone to care for younger siblings Lack of appropriate stimulation Lack of protection from dangerous substances eg. fire, drugs, chemicals Lack of appropriate medical care Lack of secure attachment
Physical signs on child/ young person	<ul style="list-style-type: none"> Injuries to the genital/anal area Sexually transmitted diseases Pregnancy Bruises, scratches, burns or bite marks Gating disorders 	<ul style="list-style-type: none"> Self harm eg. suicide, self-mutilation, substance misuse Bleeding from vagina or anus Pain in passing urine or faeces Persistent discharge Warts in genital or anal area 	<ul style="list-style-type: none"> Delayed physical development: underweight and small of stature Hands and feet which are cold and puffy Chronic nappy rash Slow growth in both weight and height Frequently soiled Persistently dirty, unkempt appearance 	<ul style="list-style-type: none"> Persistently hungry Non-organic failure to thrive Impairment of health Death
Behaviour and emotional state of child/ young person	<ul style="list-style-type: none"> Highly aware and disturbed sleeping patterns Persistent offending, non-school attendance, running away Wetting, soiling, smearing excreta Significant changes in child's behaviour Depression 	<ul style="list-style-type: none"> Sexual awareness which is inappropriate to child's age and developmental stage Sexually aggressive towards other children Low self-esteem Limited attention span Unexplained aggression or withdrawn behaviour. 	<ul style="list-style-type: none"> Low self-esteem Destructive tendencies Neurotic behaviour Running away Stealing or hiding food 	<ul style="list-style-type: none"> Inappropriately seeking affection from unfamiliar adults Impairment of intellectual behaviour Long-term difficulties with social functioning

Common sites for accidental injury	Common sites for non-accidental injury	Be alert to the possibility of child abuse
		<ol style="list-style-type: none"> 1. What is the injury? Does it appear accidental? 2. Where is the injury? Is it in an unusual site? 3. Does the explanation of the injury fit with the presentation? 4. When was it caused? Is the age of the injury right? 5. How was it caused? (Don't believe and suspect) 6. Who caused it? (both stated and suspected) 7. Witnesses? Do stories tally? 8. What action was taken afterwards by the family?

Implications for practice - signs and symptoms of abuse should never be interpreted in isolation and must always be assessed in the context of the child's medical and social history, developmental stage and explanation given

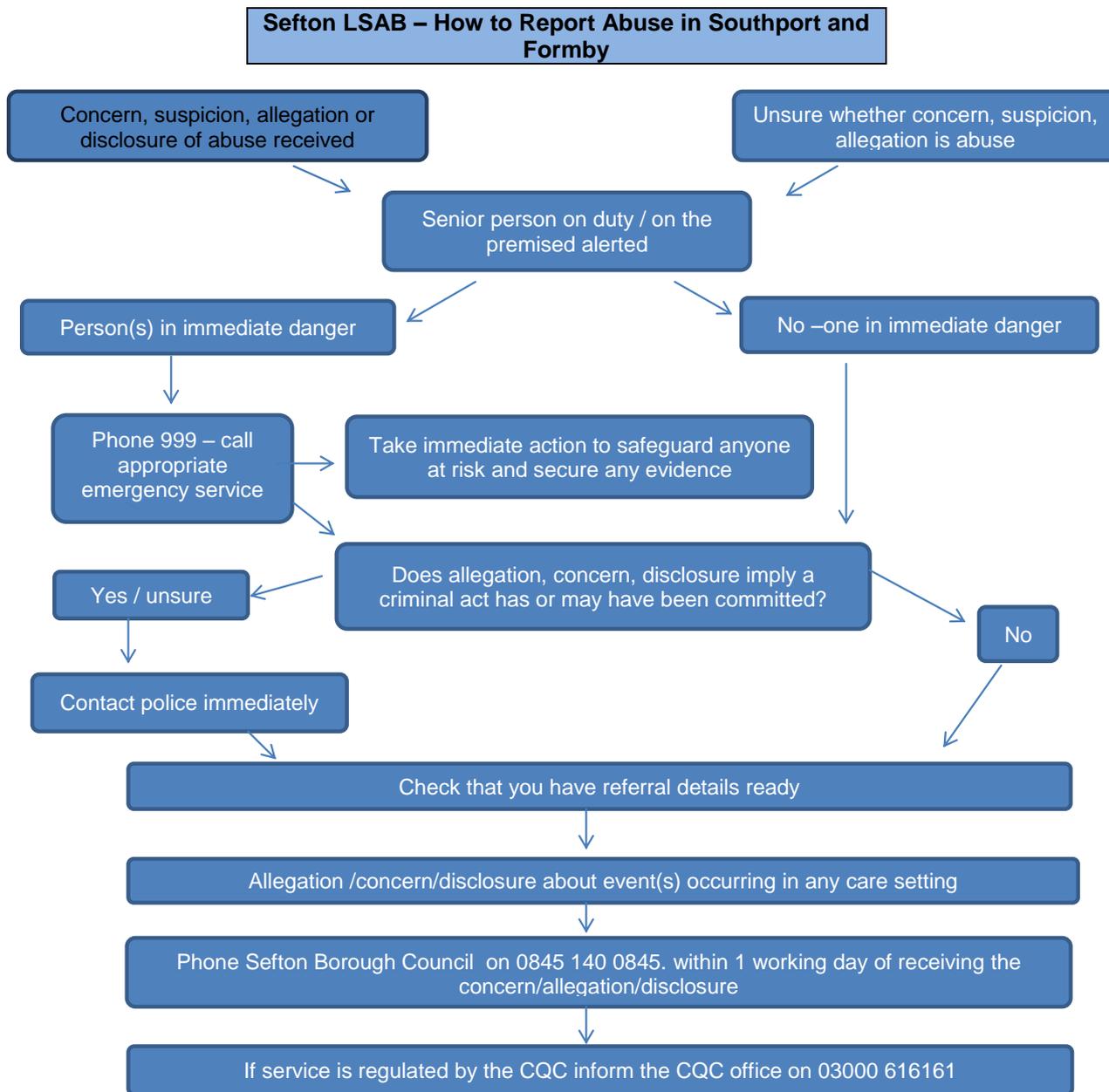
APPENDIX 4: Information Sharing Guidance

Sefton LSCB – Information Sharing Flowchart



For advice and support from the Designated Nurse for Southport and Formby CCG within the Shared Merseyside Safeguarding Service please ring the main contact numbers: 0151 495 5469 or 5295

APPENDIX 5: What to do if an adult is at risk of abuse



To discuss your concerns with the safeguarding adult lead for Southport and Formby CCG ring 0151 495 5469 or 5295.

APPENDIX 6: Safeguarding Best Practice Standards for GP member practices



Audit Tool to Monitor Safeguarding Best Practice Standards for GP Practices

RAG Rating Key:

	Green	Fully compliant (remains subject to continuous quality improvement)
	Amber	Action plans in place to ensure full compliance and progress is being made within agreed timescales
	Red	Non-compliance against standards and actions have not been completed within agreed timescales

Standard	Guidance and links to relevant LSCB/LSAB policies	Evidence	RAG
1. Clear lines of accountability for safeguarding children and vulnerable adults			
1.1	There is a named lead for safeguarding children and vulnerable adults - Must be included in job description/job plan		
1.2	All staff should know how to act on concerns that a child and or a vulnerable adult may have been abused, or is at risk of abuse or neglect in line with local guidance. Local Safeguarding Adult policies can be accessed at: http://liverpool.gov.uk/media/102189/safeguarding-policy-february-2013.pdf Local Safeguarding Children policies can be accessed at: http://www.liverpoolscb.org/		
2. Governance arrangements / Quality Assurance			
2.1	An incident reporting system is in place which identifies circumstances/incidents which have compromised the	- All serious untoward Incidents (SUI) compromising the safety and welfare of children and vulnerable adults are to be reported to insert contact details	

	safety and welfare of children and or vulnerable adults.	- All complaints that refer to the safety of children and vulnerable adults are referred and investigated thoroughly		
2.2	The Practice regularly reviews cases where there are safeguarding concerns (for both children and vulnerable adults)	- GP will meet regularly with health visitor/midwife/school nurse/district nurse as appropriate to discuss vulnerable families /adults to see how they can be best supported.		
3. Safeguarding policies, procedures and systems				
3.1	Staff have access to safeguarding policies and procedures for both children and vulnerable adults: these policies must be easily accessible by staff at all levels and be consistent with statutory, national and local guidance.	- All policies and procedures must be reviewed at a minimum 2 yearly to evaluate their effectiveness and to ensure they are up to date and working in practice.		
3.2	Safeguarding policy clearly states with whom staff should discuss and to whom staff should report any safeguarding concerns			
3.3.	Safeguarding policy/procedures includes guidance on complaints and whistle blowing policies which offers a guarantee to staff and service users that using these procedures will not prejudice their own position or prospects.			
3.4	Safeguarding policy/procedures includes guidance on how to respond			

3.10	There is a process for following up children who do not attend appointments.			
4. Parents/carers experiencing personal problems				
4.1	GPs and their practice staff in working with parents or carers who are experiencing personal problems (including substance misuse, mental health issues, domestic abuse and learning disabilities) must give consideration to the needs of the children and where necessary ensure that they are assessed and appropriate referrals are made.	<ul style="list-style-type: none"> - Where there are concerns in relation to a client's vulnerability that may impact on their parenting capacity it is advisable that discussions take place with the health visitor/school nurse/midwife as appropriate. Outcome of discussions to be recorded in clients record 		
5. Sexually Active Young People Under 18yrs				
5.1	Staff working in contact with children and young people will adhere to the LSCB procedure for Working with Sexually Active Young People under 18, which can be accessed at: [insert local link]	<ul style="list-style-type: none"> - Whilst this procedure applies to all sexually active young people under 18, it is essential that all cases involving under 13s should always be discussed with [insert local information]. However due consideration should be given to children 13-16 years in line with local guidance. - All cases involving under 13s must be fully documented in the clinical record, including detailed reasons where a decision is taken not to share information 		
6. Domestic violence (including Honour Based Violence and Forced Marriage)				
6.1	Information about local services on domestic violence is available to all women whether they are	insert local links		

	affected by domestic violence or not. This information should include Forced Marriage and Honour Based Violence.		
7. Information sharing			
7.1	Information sharing protocols in line with national and local guidance are in place within the practice.	Information sharing: <i>Guidance for practitioners and managers</i> (HM Government 2008) accessed at: https://www.education.gov.uk/publications/eOrderingDownload/00807-2008BKT-EN-March09.pdf	
8. Inter-agency working			
8.1	The Practice has access to staff who are competent to complete a CAF in their work with children and families; and the single assessment process when working with vulnerable adults	Insert local links	
8.2	The Practice establishes and maintains effective working relationships with health visiting, school nursing, midwifery services, district nurses and other applicable community health staff.		
8.3	GP's works with partners to protect children and vulnerable adults and participates in reviews as set out in statutory, national and local guidance. This includes Serious Case Reviews; Child Death Overview Processes; MARAC; MAPPA		
8.4	GP's invited to attend a multi-agency meeting in relation to		

	safeguarding a child or vulnerable adult must make every effort to attend. But in all cases GPs must make available information to inform decision making at child/adult protection conferences. Information provided to consist of a chronology of their involvement with the child and family/adult, analysis of information and recommendations for action.		
9. Safer Working practices			
9.1	For staff working with children and or vulnerable adults references are always verified, a full employment history is always available with satisfactory explanations for any gaps in employment history, qualifications are checked and the appropriate CRB check is undertaken in line with national and local guidance.	Insert Local Links	
9.2	General guidance is provided to staff on appropriate behaviours when working with children and young people in line with national and local guidance.	Detailed guidance on safe working practices for adults who work with children is available on the DCSF website at http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00311/	
10. Looked After Children			
10.1	Account is taken of local and statutory guidance when	Note best possible medical care requires access to relevant medical records. This is best achieved by accepting the child as a registered	

	<p>working with children who are 'looked after'</p> <ul style="list-style-type: none"> - clinical record makes the 'looked after' status of the child clear, so that their needs can be acknowledged - ensure that referrals made to specialist services are timely, taking into account the needs and high mobility of children looked after - provide, when requested, summaries of the health history of children looked after, including their family history where relevant and appropriate, subject to appropriate consent - make sure the GP held clinical record is maintained and updated: it is a unique health record and can integrate all known information about health and health events during the life of the child; - regularly review the clinical records of looked after children who are registered with the practice, and make it available for each statutory review of the health plan <p>(Reference: Promoting the Health and Well-being of Looked After Children (DH 2009))</p>	<p>patient and seeking urgent transfer of medical records. Treating as a temporary resident is not ideal and is only intended for those who are to be in an area for less than three months therefore where there is any doubt of the potential length of stay it is advisable to opt for full registration.</p>		
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12. Supervision and support to staff working with children, parents and carers and vulnerable adults			
12.1	Staff working directly with children and vulnerable adults have access to advice and support	- Advice on the most appropriate methods of advice, support and supervision can be sought from the lead GP for safeguarding	
13. Staff training and continuing professional development			
13.1	Staff in contact with children, adults who are parents/carers and vulnerable adults in the course of their normal duties are trained and competent to be alert to the potential indicators of know how to act on those concerns in line with local guidance.	<p>- Information on training requirements is available from the lead GP for safeguarding.</p> <p>- as per CQC guidance, it is required that at least 80% of staff undertake appropriate training relevant to their role. This is a minimum standard. [PCT to insert % level of training required for their provider]</p>	
Standard 13.2 (is relevant to GPs only)			
13.2	GPs maintain their skills in the recognition of abuse, and are familiar with the procedures to be followed if abuse is suspected.	GPs take part in training about safeguarding and promoting the welfare of children, and have regular updates (at least every 3 yrs) as part of their post-graduate educational programme.	

Practice Name:

Name of person in practice that can be contacted:

Contact details:

Date audit tool completed:

APPENDIX 7: Core safeguarding standards for all NHS acute, community, mental health and independent sector hospitals

AUDIT TOOL TO MONITOR SAFEGUARDING STANDARDS BASED ON CQC ESSENTIAL STANDARD 7 FOR SAFEGUARDING CHILDREN AND VULNERABLE ADULTS AND SECTION 11 OF THE CHILDREN ACT 2004 (2014/15)

PART 1: MINIMUM DATA SET TO BE SUBMITTED ON A QUARTERLY BASIS

RAG RATING KEY:

	Significant (Green) – evidence to validate a ‘significant’ rating assessed submission of evidence e.g. policy, procedures, documents, audits where processes, policies and systems meet fully compliant criteria, to mitigate a corporate or strategic risk.
	Reasonable (Amber) – Reasonable ratings in the context of assurance on controls are clear documented processes and systems which are evidenced by receipt and oversight through internal governance systems (e.g. Clinical Governance Committee minutes received by the Board). For example using an action plan e.g subject to progress through a formal committee for and approval as mitigating a corporate or strategic risk.
	Limited (Red) – Limited assurance is usually gained from draft plans, strategies and policies are yet to go through formal ratification, risk assessment or dissemination. These tend to be control documents which spell out what will happen, when things will happen and what resources are needed but do not carry any weight due to the lack of sign off.

PART 2: ANNUAL AUDIT TOOL TO BE SUBMITTED JULY 2014

Standard	Components of standard	Evidence for Children	Evidence for Vulnerable Adult	RAG Children	RAG Adults
1. Leadership					
1.1	There is a board lead for safeguarding children and vulnerable adults (these roles can be combined)	- Their job description clearly identifies their safeguarding responsibilities	Submission of the name of the lead and a copy of their job description.		
1.2	The organisation is linked into the Local Safeguarding Children Board (LSCB) and Local Safeguarding Adult Board (LSAB)	- There is representation at a senior level - The organisation contributes to the work of the Safeguarding Boards, including that of its sub groups	Submission of safeguarding organisation chart which clearly denotes who is responsible for attendance at the LSCB / LSAB. Submission of attendance chart to sub groups.		
1.3	There is a named lead for safeguarding children and a named lead for vulnerable adults.	- Roles and responsibilities for the named doctor and nurse for safeguarding children are in line with the Intercollegiate document, Safeguarding children and Young people: <i>Roles and Competencies for Health Care Staff</i> (2010) and Working Together to Safeguard Children 2013 - Safeguarding adult lead must have expertise in adult safeguarding and understand the nature of abuse and neglect, adult health services and the local arrangements for safeguarding vulnerable adults.	Submission of the name of the Named Lead for safeguarding Children and a copy of their job description. Submission of the name of the Named Lead for safeguarding Vulnerable Adults and a copy of their job description.		
2. Governance arrangements / Quality Assurance					
2.1	The Provider board regularly reviews safeguarding across the organisation.	- The board should receive regular reports on their arrangements for safeguarding. At a minimum an annual report should be presented at board level with the expectation that this will be made public.	Evidence of safeguarding with provider governance arrangements. E.g. Safeguarding Assurance Groups to communication at board level. Submission of CQC declaration – declaration is published on intra and internet of Provider Organisation		

			<p>Submission of annual report to the Safeguarding Service (Q2)</p> <p>Submission of board minutes which denote when the annual report has been presented.</p>	<p>Submission of annual report to the Safeguarding Service (Q2)</p> <p>Submission of board minutes which denote when the annual report has been presented.</p>	
2.2	<p>An adverse incident reporting system is in place which identifies circumstances/incidents which have compromised the safety and welfare of children and or vulnerable adults</p>	<ul style="list-style-type: none"> - Commissioners provided with a regular report (interval to be agreed between the provider and the commissioner but be at least annually) of key themes/learning from STEIS that involve safeguarding children and vulnerable adults. - All complaints that refer to the safety of children and vulnerable adults are referred and investigated thoroughly 	<p>Submission of annual report which will include section on incident reports Q2</p> <p>Submission of safeguarding assurance group minutes where outcomes of audits have been discussed. Q2</p>	<p>Safeguarding incidents themes and trends to be reported on a quarterly basis at Safeguarding Assurance Meetings – submission of minutes of these meetings.</p> <p>Quarterly reporting of the number of complaints raised relating to safeguarding adult concern. Q1, Q2, Q3, Q4.</p>	
2.3	<p>A programme of internal audit and review is in place that enables the organisation to continuously improve the</p>	<p>Audits of safeguarding arrangements to include progress on action to implement recommendations from:</p>	<p>Submission of annual audit plan.</p> <p>Submission of progress</p>	<p>Submission of annual audit plan.</p> <p>Submission of progress</p>	

<p>protection of all service users from abuse or the risk of abuse.</p>	<ul style="list-style-type: none"> - Serious Case Reviews - Internal management reviews as a consequence of SUJ's compromising the safety/welfare of service users - Reports from national bodies e.g. Ofsted, Care Quality Commission. - Domestic Homicide Reviews 	<p>reports against Serious Case Review Action Plans Quarterly.</p> <p>Submission of final RCA reports relating to Safeguarding incidents. Quarterly.</p> <p>Submission of action plan from external audits e.g Ofsted, CQC, MIAA. Quarterly.</p> <p>Submission of audit report pertaining to effective implementation of routine enquiry – Maternity and Community Providers Only (Q3)</p> <p>Additional audit reports for submission in Q3 (see 3.7 and 5.1)</p>	<p>incidents Q1, Q2, Q3, Q4.</p> <p>Quarterly submission of data related to number of new Serious Case reviews in quarter Q1, Q2, Q3, Q4.</p> <p>Quarterly submission of progress reports against Serious Case Review Action Plans, Q1, Q2, Q3, Q4.</p> <p>Quarterly submission of data in relation to number of new DHR's in quarter Q1, Q2, Q3, Q4.</p> <p>Quarterly submission of data in relation to number of new in quarter external audits completed e.g. Ofsted, CQC, MIAA Q1, Q2, Q3, Q4.</p> <p>Quarterly submission of action plan from external audits e.g. Ofsted, CQC, MIAA. Q1, Q2, Q3, Q4.</p> <p>Quarterly- Numbers of adult safeguarding incidents quarterly count required Q1, Q2, Q3, Q4.</p>	
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3. Safeguarding policies, procedures and systems	
<p>3.1</p> <p>Staff at all levels, have easy access to safeguarding children and vulnerable adult policies and procedures. These policies and procedures must be consistent with statutory, national and local guidance. Please refer to Appendix 1 for details of the core requirements of the safeguarding policy</p>	<p>- Policies and procedures are updated regularly to reflect any structural, departmental and legal changes</p> <p>- All policies and procedures must be audited and reviewed at a minimum 3 yearly to evaluate their effectiveness and to ensure they are working in practice.</p> <p>- Policies and procedures to specifically consider children and vulnerable adults in special circumstances, e.g. those with a disability, those who do not speak English as their first language, etc.</p> <p>- Policies take account of the Mental Capacity Act.</p> <p>LSCB policies can be accessed at: [insert link]</p> <p>LSAB policies can be accessed at: [insert link]</p> <p>This includes identifying a Senior Officer who has overall strategic responsibility for ensuring the organisation operates the procedures; and a nominated Senior Manager to whom all allegations or concerns are reported; and a deputy in his/her absence. The procedure must be followed when there are concerns that any person in a position of trust (whether paid or unpaid) has:-</p> <ul style="list-style-type: none"> - behaved in a way that has harmed a child and or vulnerable adult, or may have harmed a child and or vulnerable adult - possibly committed a criminal offence against or related to a child or vulnerable adult - behaved towards a child or vulnerable adult in a
	<p>Submission of a copy of Safeguarding Policy and procedures.</p>
	<p>Submission of a copy of Safeguarding Policy and procedures. Q2</p> <p>Policy is current and reviewed in line with trust compliance</p>
	<p>Submission of a copy of the Allegations against Professionals policy procedure / highlighted copy of Safeguarding Policy with appropriate reference to section relating to allegations against professionals Q2</p> <p>Types of evidence-</p> <p>Submission of final RCA reports in relation to any StEIS reported allegations against</p>

		<p>way that indicates s/he is unsuitable to work with children or vulnerable adults</p> <p>All cases will be reported through [to be determined locally] and must follow the LADO process for children.</p> <p>All cases will be reported through to the appropriate local authority and must follow the multi-agency adult safeguarding procedures.</p> <p>All substantiated cases to be reported to the CCG [insert contact details of the person in the commissioning organisation] in addition to other regulatory bodies, including professional bodies.</p> <p>- A guarantee is provided to staff and service users that using the procedures appropriately will not prejudice their own position or prospects.</p>	<p>Submission of LADO meeting minutes indicating that cases have been discussed in this forum.</p> <p>Evidence of involvement of appropriate regulatory bodies: i.e. DBS and professional bodies.</p>	<p>professionals.</p> <p>Submission of the minutes from local authority safeguarding adult strategy meetings.</p> <p>Evidence of involvement of appropriate regulatory bodies: i.e. DBS and professional bodies.</p>	
3.3	<p>Robust complaints and whistle blowing policies/procedures are in place</p>		<p>Submission of a copy of the whistle blowing policy.</p>		
3.4	<p>There is a process for ensuring that patients are routinely asked about dependents such as children, or about any caring responsibilities</p>		<p>Submission of relevant protocol that highlights this practice. Q2</p> <p>Submission of audit results which assess whether this has been implemented in practice. Q2</p>		
3.5	<p>There is evidence of the implementation of the national Prevent strategy in protecting vulnerable people from being drawn into terrorism.</p>	<p>There are clear procedures in place on the implementation of Prevent that identifies children and vulnerable adults at risk of radicalisation who may be drawn into terrorist activity.</p>	<p>Submission of policy and procedures which reference Prevent strategy Q2</p> <p>Identification of a Prevent Lead in place. Q2</p> <p>Submission of a training strategy to deliver HealthWRAP programme. Q2</p> <p>Quarterly submission of training compliance to HealthWRAP programme</p> <p>Comply with the monthly submission of training data of HealthWRAP programme to the regional prevent</p>		

			Co-ordinator - NHS England. Quarterly- Submission of data in relation to percentage of staff completed Prevent training in line with TNA & policy (to include denominator and numerator) Q1 = Submission of training needs analysis, Q2 = count & % trained, Q3 count & % trained Q4 target 40%		
The following policies, procedures and systems apply only to providers of services to children and young people					
3.5	There is a system for flagging children for whom there are safeguarding concerns	- Consideration should be given to Looked After Children.	Submission of protocol / policy which states how the flagging system is implemented.		
3.6	When it is known that a child is not accessing education a referral will be made to the Local Authority in which the child lives.	Where it is discovered a child is not receiving any form of education the Children Missing Education Officer is to be notified. Information on missing education is available at: [insert link]	Submission of protocol/policy which highlights how this is implemented within the organisation. Submission of audit results demonstrating that this system has been tested.		
3.7	There is clear guidance in relation to LAC as to the requirements necessary for the completion of health action plans, including regular health assessments, medicals and reviews. (as per guidance Promoting the Health and Well being of Looked after Children 2009)	Clear protocols and procedures should be in place for LAC demonstrating the interface with the LA and other partner agencies. Clear arrangements in place to support the provision of care for children living in another area/out of Borough.	Submission of protocol/policy for LAC. Submission of annual audit relating to the quality of health assessments that have been completed (in Borough and out of Borough) with particular reference to the voice of the child. Annual audit of the above to be submitted with Q3 KPI's Submission of data returns relating to %of health assessments / medicals that have been completed and within what timescale. Submission of annual data set relating to number of children leaving care who have a comprehensive		

			health summary completed.	
4. Information sharing				
4.1	<p>There are agreed systems, standards and protocols for sharing information within the service and between agencies in accordance with national and local guidance</p>	<ul style="list-style-type: none"> - Staff understand what to do and the most effective ways of sharing information if they believe a child / vulnerable adult may require particular services in order to achieve their optimal outcomes; - staff understand what to do and when to share information if they believe a child may be at risk of significant harm or an adult is at serious risk of harm; - agency-specific guidance is produced to complement guidance issued by central government and training is made available to existing and new staff as part of their induction programme and ongoing training; - managers are fully conversant with the legal framework and good practice guidance issued for practitioners 	<p>Submission of policy / protocol highlighting information sharing arrangements. Q2</p>	
			<p>Submission of audit of information sharing arrangements.</p> <p>Submission of training matrix / packages that highlight information sharing arrangements and standards.</p>	<p>Submission of compliance against statutory training. Q2</p>
5. Inter-agency working				
5.1	<p>The organisation embeds the locally agreed assessment process e.g. Common Assessment Framework (CAF) / single assessment processes , within its existing systems and processes</p>	<ul style="list-style-type: none"> - The principles of early help should be embedded within practice - 	<p>Submission of policy that highlights CAF procedures.</p> <p>Submission of data relating to the</p> <ul style="list-style-type: none"> - Number of CAF's that have been initiated - Of those, the number initiated by the health provider organisation - Number of continuing CAFs within the organisation. - Analysis of outcomes resulting from CAF process (i.e. reduction in escalation of cases to CSC etc.) <p>Annual audit of outcomes following CAF initiation demonstrating the above to be submitted with Q3 KPI's</p>	

5.2	The organisation works with partners to protect children and vulnerable adults and participates in reviews as set out in statutory, national and local guidance	<ul style="list-style-type: none"> - Staff to provide, when requested, information on their involvement with a child and or family to inform the case discussion in relation to Serious Case Reviews, Domestic Homicide Reviews, Child Death Overview Processes, MARAC, MAPPA - Professionals who are invited to attend a multi-agency meeting in relation to safeguarding a child or vulnerable adult must make every effort to attend and will submit a written report if they cannot attend or where requested to do so. The report will include a chronology of their involvement, assessment and analysis of the capacity of parents/carers to meet the needs of the child/vulnerable adult and recommendations for action. 	Submission of quarterly data in relation to <ul style="list-style-type: none"> Attendance at Child Protection conferences and reviews Attendance at LAC reviews Attendance at MARAC / MAPPA meetings 	<p>Quarterly- submission of data in relation to:</p> <p>Strategy Meetings invited and attended (to include denominator and numerator – target 95% attendance) quarterly count Q1, Q2, Q3 Q4</p> <p>Multi- Agency Risk Assessment Conferences invited and attended (to include denominator and numerator. Quarterly count Q1, Q2, Q3 Q4</p>		
6. Supervision and support						
6.1	Staff working directly with children and vulnerable adults have access to advice support and supervision. This includes clinical and safeguarding supervision.	<ul style="list-style-type: none"> - Access to advice / support is available to all staff working with children and vulnerable adults - For front line practitioners working directly with children, young people and vulnerable adults where there are concerns about harm, self-harm or neglect this will include the supervisor regularly reading the case files to review and record in the file whether the work undertaken is appropriate to the child's/adults current needs and circumstances, and is in accordance with the agency's responsibilities. - Frontline staff to follow their organisation's supervision policy [insert policy link], which should clearly outline those cases that need to be reviewed by the supervisor. - Community staff requirements – case supervision 	<ul style="list-style-type: none"> Submission of supervision policy / protocol Submission of audit of supervision policy / protocol Submission of quarterly data relating to the number of cases that have been supervised. Submission of data relating to the qualifications held by the named supervisor. Can this be more specific to 	<p>Provide evidence of safeguarding adult supervision framework. E.g. group supervision, individual supervision, reflective case discussions, audits re: PDR process evidencing safeguarding Q2</p>		

		for both CP and LAC / pre-school and school age. - Acute staff (including MH services) evidence of a framework/ flowchart ensuring appropriate supervision arrangements with safeguarding leads are in place.	children only.		
6.2	Named professionals, including MCA leads, seek advice and access regular formal supervision from designated professionals for complex issues or where concerns may have to be escalated.		Submission of minutes of Named Nurse forum demonstrating attendance for supervision. Q2	Submission of minutes of Safeguarding Adult Lead Forum demonstrating attendance for supervision. Q2	
7. Staff training and continuing professional development					
7.1	There is a training strategy and operational model for safeguarding children and adults	<ul style="list-style-type: none"> - Training must reflect statutory and local guidance such as Working Together to Safeguard Children; <i>Intercollegiate Document Safeguarding Children and Young People: Roles and Competencies for Health Care Staff</i> (2010), Bournemouth: National Competence Framework for Safeguarding Adults (2010) and the LSCB /LSAB training strategies - Training must be audited to ensure its effectiveness and quality assured - Training takes account of emerging messages from national and local reviews of safeguarding - as per CQC guidance, it is required that at least 80% of staff undertake appropriate training relevant to their role. This is a minimum standard. [CCG to insert % level of training required for their provider] 	Submission of training strategy. Evidence that there has been approval of training packages by the LSCB. Submission of quarterly data in relation to percentage of staff that have been trained.	Submission of training strategy. Q2 Evidence that there has been approval of training packages by the LSAB and compliance Bournemouth: National Competence Framework for Safeguarding Adults (2010). Quarterly submission of data for safeguarding adult training levels: 1,2,3 against Bournemouth: National Competence Framework for Safeguarding Adults (2010)	

			<p>Level 1 Adult Safeguarding Training Quarterly-</p> <p>Percentage of overall staff who have had training within the past 3 years (to include denominator and numerator) target 90% Q1, Q2, Q3, Q4.</p> <p>Level 2 Adult Safeguarding Training-</p> <p>Q1 = Submission of training needs analysis, Q2 = count & % trained, Q3 count & % trained. Q4- target 90%</p> <p>Level 3 Adult Safeguarding Training-</p> <p>Q1 = Submission of training needs analysis, Q2 = count & % trained, Q3 count & % trained. Q4- target 90%</p> <p>Domestic Abuse Training-</p> <p>Percentage of clinical staff completed domestic abuse training in line with Training Needs Analysis (to include denominator and numerator) measured by an end of year count in Q4</p>		
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8. Applies only to healthcare providers offering in-patient facilities to children under 18 years only			
8.1	There is clear guidance as to the discharge of children for whom there are child protection concerns.	<ul style="list-style-type: none"> - No child about whom there are child protection concerns is discharged from hospital without a documented plan for the future care of the child. This plan must include follow up arrangements and involve partner agencies as required. - The need to safeguard a child should always inform the timing of their discharge, so that the likelihood of harm can be assessed while he or she is in hospital. 	<p>Submission of safeguarding policy which contains the guidance.</p> <p>Submission of audit data of children who have been discharged with safeguarding concerns.</p>
8.2	Specialist paediatric advice is available at all times		
8.3	The child's GP and health visitor/school nurse is notified of admissions/discharges	<ul style="list-style-type: none"> - Where a child is not registered with a GP the parent/carer should be advised to register the child with a local GP practice. - Where the child has no parents in attendance and/or the child is not registered with a GP, it is the provider's responsibility to ensure GP allocation via the locally agreed arrangements with either the CCG or LAT. 	<p>Copy of service specification highlighting arrangements that are in place for paediatric advice.</p> <p>Submission of policy that highlights this area of work.</p>
9. Applies only to A&E Departments, ambulatory care units, walk in centres and minor injury units			
9.1	All attendances for children under 18 years to A&E, ambulatory care units, walk in centres and minor injury units should be notified to the child's GP. Attendances at A&E will also be copied to the health visitor and or school nurse depending on the age of the	<ul style="list-style-type: none"> - Where a child is not registered with a GP the parent/carer should be advised to register the child with a local GP practice. - Where the child has no parents in attendance and/or the child is not registered with a GP, it is the provider's responsibility to ensure GP allocation via the locally agreed arrangements with either the CCG or LAT. 	<p>Submission of service specification for urgent care services.</p> <p>Submission of quarterly data returns stating the number of referrals that have been made for safeguarding children.</p>

	child.				
10. Applies only to community providers offering services to children / families and adults					
10.1	Community health practitioners should have a clear means of identifying in records those children (together with their parents and siblings) who are subject to a child protection plan			Submission of policy / protocol which states that this needs to take place. Submission of audit data relating to record keeping audit.	
10.2	There is good communication between GPs, community nursing services (i.e. health visiting, school nursing and community midwifery services) in respect of children for whom there are concerns.	<ul style="list-style-type: none"> - Each GP practice should be informed of who their 'named' health visitor / school nurse / community midwife is and how they can be contacted. - This may include evidence of regular Primary care team meetings/ communication, any child protection referrals should be shared with the GP. 		Submission of minutes of meetings with primary care.	
11. Voice of the Child					
11.1	There is evidence that the voice of the child is incorporated within all routine and targeted health assessments, with particular focus on LAC, CPP and CIN/CAF assessments	<ul style="list-style-type: none"> - A systematic process should be implemented to review the quality of assessments (particularly in relation to listening to the voice of the child), both routine and targeted 		Submission of assessment tools used and policy supporting implementation	
11.2	Evidence that the child's voice is heard and has an impact on service development and improvement	<ul style="list-style-type: none"> - A clear strategy for engaging the views of children should be embedded - Analysis of findings should inform service development proposals 		Submission of an annual summary report outlining the organisation engagement strategy and the impact made by listening to the voice of the child on service delivery	
12. applies to NHS commissioned organisations and hospitals providing care for adults					
12.1	There are clear procedures on the implementation and	<ul style="list-style-type: none"> - Managing authorities, i.e. hospitals providing in-patient facilities for adults, must have in place a 		Submission of Deprivation of Liberty policy / procedures. Q2	

	<p>management of Deprivation of Liberty Safeguards in line with the Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice.</p>	<p>procedure that identifies whether a deprivation of liberty is or may be necessary; what steps are taken to assess whether to seek an authorisation; whether all practical and reasonable steps have been taken to avoid a deprivation of liberty; what action they should take if they do need to request an authorisation; how they review cases; and who should take the necessary action;</p> <ul style="list-style-type: none"> - Managing authorities must have in place a procedure that identifies what actions should be taken when an urgent authorisation needs to be made; who should take that action; and within what timescales. - Managing authorities must have in place processes for reviewing deprivation of liberty and reducing the levels of restriction where reasonably possible 	<p>Submission of a framework for assessing mental capacity. Q2</p> <p>Submission of a framework for conducting Best Interest Meetings. Q2</p> <p>Quarterly submission of the number of referral for Independent Mental Capacity Advocacy under MCA and DoLS, Q1, Q2, Q3, Q4</p> <p>Quarterly- submission of data in relation to Deprivation of Liberty Authorisation requests (DoLs) (Hospitals, Mental Health Services, Intermediate Care) submission of quarterly count, Q1, Q2, Q3, Q4</p>		
12.2	<p>Staff required to use restrictive physical interventions have received specialist training. Specialist training should include the legal duties enshrined in the Mental Capacity Act 2005 (including the law relating to assault against a person) and national guidance on consent for examination or treatment.</p>	<ul style="list-style-type: none"> - Staff understand when different types of restraint are or are not appropriate, prioritizing de-escalation or positive behaviour support over restraint where possible - Know whether and what type of restraint should be used in a way that respects dignity and protects human rights where possible - Understand that restraint should only be used as a last resort where it is necessary and proportionate, and that restraint used should be the least restrictive and for the minimum amount of time to ensure that harm is prevented and that the person, and others around them are safe. - Where restraint is used it is documented and followed by an assessment of the person restrained and others involved in the restraint for 	<p>Submission of a restraint policy / procedures Q2</p> <p>Evidence of approved training in place.</p> <p>Quarterly- Submission of data in relation to percentage of identified staff that have been trained in approved physical intervention techniques of identified cohort.</p> <p>Q1 = Identify those who need training within each quarter, submission of TNA Q2= 90% Q3 90%, Q4 90%</p>		

		<p>signs of injury and any emotional or psychological impact.</p> <ul style="list-style-type: none"> - There is clear guidance on the use of rapid tranquilisation in line with NICE clinical guidance on Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments (2005) - There are clear procedures in place that identifies what actions should be taken when a Vulnerable adults requires assessment under the Mental Act (2005) - Training must reflect statutory and local guidance such as National Standards Framework for Safeguarding Adults (2005) and the LSAB training strategies 	<p>Submission of a rapid tranquilisation policy / procedures Q2</p>		
12.3	<p>Rapid tranquilisation will only be used in accordance with NICE clinical guidelines on Violence. Applicable to A&E departments and Mental Health Trust only</p> <p>There are clear procedures on the implementation and management of Mental Capacity Act 2005.</p>		<p>Submission of policy / procedure re assessing mental capacity Q2</p> <p>Evidence of approved training in place</p> <p>Quarterly- submission of data in relation to percentage of staff completed MCA/DoLS training in line with policy requirements (to include denominator and numerator) threshold- 90% Q1, Q2, Q3, Q4.</p> <p>Quarterly- Submission of data in relation to number of Independent Mental Capacity Advocate (IMCA) requests Q1, Q2, Q3, Q4.</p>		
12.4					

NB all quarterly identified submissions relate to the required KPI data sets.

Appendix 1:

Policies required by all Provider Organisations (the policy can be provided via a link to local LSCB and ASB policies

Ratification of all Provider Organisation Safeguarding Policies should include consultation with Designated Safeguarding Service Professionals

Policy	National / Local Policy / Standards Reference where available	Date Reviewed and comments	Expiry Date
<p>Safeguarding Adults Policy</p> <p>Including guidance on:</p> <ul style="list-style-type: none"> - Abuse and neglect - Female Genital Mutilation - Forced Marriage - Mental Capacity - Deprivation of Liberty Safeguards - Domestic Violence - Human Rights - Terrorism and Radicalisation 	<p>No Secrets guidance (2000), Safeguarding Vulnerable Adults Act (2006), LSAB multi agency policy and procedures</p> <p>Multi-Agency Practice Guidelines: Female Genital Mutilation (2011) HM Government</p> <p>The Right to Choose: Multi-Agency statutory guidance for dealing with forced marriage (2008) HM Government</p> <p>Merseyside Forced Marriage Protocol 2013</p> <p>Mental Capacity Act (2005)</p> <p>Deprivation of Liberty Safeguards (2007)</p> <p>Domestic Violence, Crime and Victims Act (2013)</p> <p>Human Rights Act (1998)</p> <p>PREVENT strategy</p>		
<p>Safeguarding Children Policy</p> <p>Including guidance on:</p> <ul style="list-style-type: none"> • Fabricated Illness 	<p>Fabricated or induced illness a rare form of child</p>		

<ul style="list-style-type: none"> • Forced Marriage • Disabled Children • E-Safety • Sexually Exploited Children / CSE Strategy • Female Genital Mutilation • Working with sexually active young people under the age of 18 • Domestic abuse (inclusive of children who are the victims of domestic abuse) • Early help • The voice of the child 	<p>abuse? (2011) NSPCC Safeguarding children in whom illness is fabricated or induced. (2008) HM Government</p> <p>The Right to Choose: Multi-Agency statutory guidance for dealing with forced marriage (2008) HM Government Merseyside Forced Marriage Protocol 2013</p> <p>Safeguarding disabled children: practice guidance (2009) Department for Education.</p> <p>LSCB E-Safety Standards</p> <p>LSCB CSE Strategy Safeguarding Children and Young People from Sexual Exploitation (2009) HM Government</p> <p>Multi-Agency Practice Guidelines: Female Genital Mutilation (2011) HM Government</p> <p>Safeguarding Children and Young People from Sexual Exploitation (2009) HM Government. LSCB Procedures</p> <p>Domestic Violence and Abuse – Professional Guidance (2013) Department of Health. Responding to domestic abuse: a handbook for health professionals (2005) Department of Health. Striking the balance: practical guidance on the application of Caldicott Guardian Principles to Domestic Violence and MARACs (2012) Department of Health. NICE Public Health Guidance. Domestic violence and abuse: how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse (2013).</p>		
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	Working Together to Safeguard Children (2013)		
	Working Together to Safeguard Children (2013)		
Whistle Blowing Policy	LSCB Procedures		
Managing allegations of abuse against a person who works with children or vulnerable adults	Information sharing: Guidance for practitioners and managers (2008) HM Government		
Information sharing	LSCB Procedures		
Safe recruitment, including CRB checks where required and taking up of references	Protection of Freedoms Act 2012		
Appropriate behaviours by staff towards vulnerable adults and children	Disclosure and Barring Scheme		
Supervision Policy	LSCB Procedures		
Mental Capacity Act – Deprivation of Liberty Safeguards	Mental Capacity Act (2005)		
	Deprivation of Liberty Safeguards (2007)		

APPENDIX 8: Standards for voluntary, community and faith sector (VCFS) organisations / non-health care providers



Audit Tool to Monitor Standards for Voluntary, Community & Faith Sector (VCFS) Providers

RAG Rating Key:

- Green Fully compliant (remains subject to continuous quality improvement)
- Amber Action plans in place to ensure full compliance and progress is being made within agreed timescales
- Red Non-compliance against standards and actions have not been completed within agreed timescales

	Standard	Guidance and links to relevant LSCB/LSAB policies	Evidence	RAG * (see key below)
1. Clear lines of accountability for safeguarding children and vulnerable adults				
1.1	A safeguarding policy is in place which demonstrates commitment to safeguarding children and vulnerable adults (this may be combined into one overarching policy)	<ul style="list-style-type: none"> - The policy makes it clear who has overall responsibility for the contribution to safeguarding children and vulnerable adults including lines of accountability though to the person with ultimate accountability - The policy sets out key out clear priorities for safeguarding line with those of the local safeguarding boards. [insert link] - The policy clearly states with whom staff should discuss and to whom staff should report any safeguarding concerns in relation to children and vulnerable adults 		
1.2	There is a named lead within the			

	service /organisation for safeguarding children and vulnerable adult and arrangements for cover when this person is not available		
1.3	All staff (paid and volunteers) should know how to act on concerns that a child and or a vulnerable adult may have been abused, or is at risk of abuse or neglect in line with local guidance.	Local Safeguarding Adult policies can be accessed at: [insert link here] Local Safeguarding Children policies can be accessed at: [insert link here]	
2. Governance arrangements / Quality Assurance			
2.1	An incident reporting system is in place which identifies circumstances/incidents which have compromised the safety and welfare of children and or vulnerable adults.	<ul style="list-style-type: none"> - All serious untoward Incidents (SUI) compromising the safety and welfare of children and vulnerable adults are to be reported to [insert link] - All complaints that refer to the safety of children and vulnerable adults are investigated thoroughly 	
2.2	The service/organisation regularly reviews cases where there are safeguarding concerns (for both children and vulnerable adults)		
3. Safeguarding policies, procedures and systems			

3.1	All staff (paid and volunteers) have access to safeguarding policies and procedures for both children and vulnerable adults: these policies must be easily accessible by staff at all levels and be consistent with statutory, national and local guidance.	<ul style="list-style-type: none"> - All policies and procedures must be reviewed at a minimum 2 yearly to evaluate their effectiveness and to ensure they are up to date and working in practice. - There should be local determination whether inclusion of the Mental Capacity Act is applicable to the provider. 		
3.2	Safeguarding policy/procedures includes a process for recording and reporting concerns, suspicions and allegations of abuse or harm in line with LSCB and LSAB	[insert links]		
3.3	Safeguarding policy/procedures includes guidance on complaints and whistle blowing policies which offers a guarantee to staff and service users that using these procedures appropriately will not prejudice their own position or			

	prospects.			
3.4	Safeguarding policy/procedures includes guidance on how to respond to a disclosure from a child or a young person and or vulnerable adult.			
3.5	Safeguarding policy/procedures includes clear guidance on managing allegations against staff and volunteers working with children and vulnerable adults in line with policies and procedures of LSCB / LSAB.	[insert links]		
3.6	When it is known that a child is not accessing education a referral will be made to the Local Authority in which the child lives.		Information on missing education is available at: [insert link]	
4. Sexually Active Young People Under 18yrs (this standard relates only to those providing services to young people under 18 years)				
4.1	There is clear guidance for practitioners working with sexually active	[insert links]		

	children under 18 years which is in line with that of LSCB		
5. Domestic violence (including Honour Based Violence and Forced Marriage)			
5.1	The service/organisation takes account of national and local guidance to safeguard those children and adults experiencing domestic abuse.	[insert links]	
6. Information sharing			
6.1	Information sharing protocols in line with national and local guidance are in place within the practice.	- National guidance on information sharing can be accessed at: http://www.dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/informationsharing/informationsharing/	
7. Inter-agency working			
7.1	The service/organisation works with partners to protect children and vulnerable adults and participates in reviews as set out in statutory, national and local guidance	- the service will provide, when requested, information on their involvement with a child, family and adult at risk of abuse to inform the case discussion in relation to child /adult protection processes, Serious Case Reviews; Child Death Overview Processes, MARAC and MAPPA - the service contributes to the Common Assessment Framework (CAF) as required to do so and with the consent of the individual and or parent/carer.	
8. Safer Working practices			

8.1	Robust recruitment and vetting procedures are in place to help prevent unsuitable people from working with vulnerable adults and children.		
8.2	General guidance is provided to staff on appropriate behaviours when working with children and vulnerable adults in line with national and local guidance	- Detailed guidance on safe working practices for adults who work with children is available on the DCSF website at http://www.dcsf.gov.uk/everychildmatters/resources-and-practice/IG00311/	
9. Record keeping			
9.1	Staff who work with children and vulnerable adults record their work with the child and family in accordance with statutory and best practice guidance.	- All staff maintain an accurate, clear record of their involvement with the child and their family and vulnerable adults on a routine basis. - Where there are concerns about a child's welfare, all concerns, discussions about the child, decisions made and the reasons for those decisions must be recorded in writing in the child's /vulnerable adults records.	
10. Supervision and support to staff working with children, parents and carers and vulnerable adults			
10.1	Staff working directly with children and vulnerable adults have access to advice and support		
11. Staff training and continuing professional development			

11.1	Paid staff and volunteers in contact with children, adults who are parents/carers and vulnerable adults are trained and competent to be alert to the potential indicators of know how to act on those concerns in line with local guidance.	<ul style="list-style-type: none"> - The level of training an individual requires is dependent on their roles and responsibilities. For this reason training needs should be informed by training strategies of the LSCB / LSAB. [insert link] - Refresher training is undertaken at regular intervals (at a minimum 3 yearly) 	
12. Proving safer activities and trips			
12.1 12.1 Cont	All service users are protected when taking part in activities and trips	<p>The service organisation ensures that:</p> <ul style="list-style-type: none"> - Paid staff and volunteers undertaking specialist roles (e.g. taking children, young people and vulnerable adults off site on trips) are provided with appropriate training; - All activities are risk assessed to ensure that all reasonable steps are taken to prevent children, young people and vulnerable adults being harmed whilst participating in the organisations/services activities; - Takes out employers' liability and public liability insurance to ensure that all activities and services and all people taking part are covered; - All activities being provided are properly planned and organised; - Checks the driver holds the correct driving licence, the vehicle has the correct insurance, tax, MOT, seats, seatbelts and a first aid box; - All computers used by young people are equipped with 'parent controls' to ensure safe internet use; - Staff are equipped to understand, identify and mitigate the risks of new technology 	

Name and address of organisation:

Name of person completing audit tool:

Contact details:

Date audit tool completed

APPENDIX 9: Standards for care homes



Audit Tool to Monitor Safeguarding Standards for Care Homes
RAG rating Key:

- Green Fully compliant (remains subject to continuous quality improvement)
- Amber Action plans in place to ensure full compliance and progress is being made within agreed timescales
- Red Non-compliance against standards and actions have not been completed within agreed timescales

	Standard	Guidance and links to relevant policies	LSCB/LSAB	Evidence	RAG
1. Clear lines of accountability for safeguarding adults at risk and children					
1.1	A safeguarding policy is in place which demonstrates commitment to safeguarding	<ul style="list-style-type: none"> - The policy makes it clear who has overall responsibility for the contribution to safeguarding including lines of accountability though to the person with ultimate accountability - The policy sets out key out clear priorities for safeguarding line with those of the LSAB. - The policy clearly states with whom staff should discuss and to whom staff should report any safeguarding concerns 			
1.2	There is a named lead for safeguarding. Arrangements for cover are in place when this person is not available	<ul style="list-style-type: none"> - named lead must have had sufficient training and time to undertake this task, role to be covered in job description, and a clear understanding of the Safeguarding Adult Board procedures 			

1.3	All staff (paid and volunteers) should know how to act on concerns that a vulnerable adult may have been abused, or is at risk of abuse or neglect in line with local guidance.	- All staff working under the auspices of the home must have safeguarding adults training and have a training update not less than every three years		
2. Governance arrangements / Quality Assurance				
2.1	The home is registered with the CQC	- The home is fully compliant with outcome 7 'Safeguarding people who use services from abuse': Essential standards for Quality and Safety (CQC 2010). Where a home is not compliant they will notify [insert contact] and inform them of agreed action plans in place		
2.2	The home regularly reviews safeguarding arrangements			
2.3	An incident reporting system is in place which identifies circumstances/incidents which have compromised the safety and welfare of patients /residents.	- All serious untoward incidents (SUI) compromising the safety and welfare of a patient funded by NHS Southport and Formby CCG is to be notified to [insert contact]. - All complaints that refer to the safety of patients are referred and investigated thoroughly		
2.4	A programme of internal audit and review is in place that enables the organisation/home to continuously improve the protection of all service users from abuse or the risk of abuse.	Audits of safeguarding arrangements to include progress on action to implement recommendations from: - Serious Case Reviews; Internal Management Reviews as a consequence of SUI's compromising the safety/welfare of service users; reports from national bodies e.g. Care Quality Commission		
2.5	Residents are aware of the procedures for reporting abuse and neglect	- The procedure is publicized in appropriate ways e.g. in resident induction, welcome packs, handbooks, notice boards, etc.		
3. Safeguarding policies, procedures and systems				

3.1	All staff (paid and volunteers) have access to safeguarding policies and procedures. Policies must be easily accessible by staff at all levels and be consistent with those of the LSAB	<ul style="list-style-type: none"> - Policies and procedures are updated regularly to reflect any structural and legal changes - Policies and procedures undergo an equalities impact assessment - Policies and procedures must be audited and reviewed at a minimum 2 yearly to evaluate their effectiveness and to ensure they are working in practice. - Policies and procedures to specifically consider adults in special circumstances, e.g. those with a disability, those who do not speak English as their first language - Policies should take account of the Mental Capacity Act <p>[Insert link to LSAB policies]</p>		
3.2	Safeguarding policy/procedures includes a process for recording and reporting concerns, suspicions and allegations of abuse or harm in line with those of LSAB			
3.3	Safeguarding policy/procedures includes guidance on how to respond to a disclosure of abuse.			
3.4	Safeguarding policy/procedures includes clear guidance on managing allegations against staff and volunteers			
3.5	There are robust complaints and blowing whistle policies/procedures in place	<ul style="list-style-type: none"> - A guarantee is provided to staff and service users that using the procedures appropriately will not prejudice their own position or prospects. 		
3.6	There are clear procedures on the implementation and management	<ul style="list-style-type: none"> - Care Homes must have in place a procedure that identifies whether a deprivation of liberty is 		

	of Deprivation of Liberty Safeguards in line with the Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice	<p>or may be necessary; what steps are taken to assess whether to seek an authorisation; whether all practical and reasonable steps have been taken to avoid a deprivation of liberty; what action they should take if they do need to request an authorisation; how they review cases; and who should take the necessary action;</p> <ul style="list-style-type: none"> - Care Homes must have in place a procedure that identifies what actions should be taken when an urgent authorisation needs to be made; who should take that action; and within what timescales. - Care Homes must have in place processes for reviewing deprivation of liberty and reducing the levels of restriction where reasonably possible 		
3.7	The use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual	<ul style="list-style-type: none"> - The use of restraint should be discussed, agreed and documented in advance wherever possible; is used as a last resort and is the minimum response necessary for the shortest possible time, to make the individual and others as safe as possible. - Where restraint is used it is documented and followed by an assessment of the person restrained and others involved in the restraint for signs of injury and any emotional or psychological impact 		
4. Information sharing				
4.1	There are agreed systems, standards and protocols for sharing information within the service and between agencies in accordance with national and local guidance	<ul style="list-style-type: none"> - staff understand what to do and when to share information if they believe a vulnerable adult is at risk of harm; - agency-specific guidance is produced to complement guidance issued by central government and training is made available to existing and new staff as part of their induction programme and ongoing training; 		

			managers are fully conversant with the legal framework and good practice guidance issued for practitioners	
5. Inter-agency working				
5.1	The organisation/home works with partners to protect vulnerable adults and participates in reviews as set out in local guidance		<ul style="list-style-type: none"> Staff to provide, when requested, information on their involvement with a vulnerable adult to inform the case discussion in relation to multi-agency meetings including Serious Case Reviews; Professionals who are invited to attend a multi-agency meeting in relation to a vulnerable adult must make every effort to attend and will submit a written report where requested to do so. 	
6. Safer recruitment practices				
6.1	Robust recruitment and vetting procedures are in place to help prevent unsuitable people from working with vulnerable adults and children.			
6.2	Safeguarding responsibilities are reflected in all job descriptions relevant to role and responsibilities			
6.3	Staff involved in employing staff are trained in the processes of 'safer recruitment'			
7. Record keeping				
7.1	Staff working record their work in		All staff maintain an accurate, clear record of	

	accordance with statutory and best practice guidance.	<p>their involvement on a routine basis. The record is clear, accessible, comprehensive and contemporaneous with both judgments made and decisions taken carefully recorded. The record is dated, signed and the persons name legibly written at the end of the record entry;</p> <ul style="list-style-type: none"> - Where there are concerns about an individuals welfare, all concerns, discussions held and decisions made and the reasons for those decisions must be recorded in writing in the individuals records; 		
8. Supervision and support				
8.1	Staff working directly with vulnerable adults have access to advice support and supervision to enable them to manage the stresses inherent with this work			
9. Staff training and continuing professional development				
9.1	Paid staff and volunteers in contact with vulnerable adults and children are trained and competent to be alert to the potential indicators of abuse and neglect know how to act on those concerns in line with local guidance.	<ul style="list-style-type: none"> - The level of training an individual requires is dependent on their roles and responsibilities. For this reason training needs should be informed by Safeguarding Training Strategy of Southport and Formby Safeguarding Adult Board. - Records are kept of those accessing training - Refresher training is undertaken at regular intervals (at a minimum 3 yearly) - Staff understand when different types of restraint are or are not appropriate, prioritizing de-escalation or positive behaviour support over restraint where possible 		
9.2	Staff required to use restrictive physical interventions have received specialist training. Specialist training should include the legal duties enshrined in the			

9.2 cont	Mental Capacity Act 2005 (including the law relating to assault against a person) and national guidance on consent for examination or treatment.	<ul style="list-style-type: none"> - Know whether and what type of restraint should be used in a way that respects dignity and protects human rights where possible - Understand that restraint should only be used as a last resort where it is necessary and proportionate, and that restraint used should be the least restrictive and for the minimum amount of time to ensure that harm is prevented and that the person, and others around them are safe - Clinical holding policy in place and should take account of what is expected in terms of risk assessment. 		
10. Proving safer activities and trips				
10.1	All service users are protected when taking part in activities and trips	<p>The organisation ensures that:</p> <ul style="list-style-type: none"> - Paid staff and volunteers undertaking specialist roles (e.g. taking vulnerable adults off site on trips) are provided with appropriate training - all activities are risk assessed to ensure that all reasonable steps are taken to prevent adults being harmed whilst participating in the organisations activities - takes out employers' liability and public liability insurance to ensure that all activities and services and all people taking part are covered - that all activities being provided are properly planned and organised - checks that the driver holds the correct driving licence, the vehicle has the correct insurance, tax, MOT, seats, seatbelts and a first aid box. 		

Name and address of Care Home:

Name of person completing audit tool:

Contact details:

Date audit tool completed:

Key Issues Quality Committee

Meeting Date May 2014

Chair Helen Nichols

Key Issues	Risks Identified	Mitigating Actions
1. Provider performance reports <ul style="list-style-type: none"> • Southport & Ormskirk • Liverpool Community Health • Mersey Care • Mersey Providers 	<ul style="list-style-type: none"> • Scrutiny of providers' quality and performance given by CCG Quality Committee 	<ul style="list-style-type: none"> • Relevant providers to provide clarity and commentary on areas raised by Quality Committee • Areas requiring further clarification for providers where SF CCG are not lead commissioners, the CCG has consulted with other CCGs
2. Serious Incident Update	<ul style="list-style-type: none"> • Nil 	<ul style="list-style-type: none"> • The CCG have in place robust mechanisms to manage ongoing Serious Incidents involving SF CCG providers and patients through strong collaborative arrangements. The Quality Committee is assured of these processes
3. GP Quality Lead Report <ul style="list-style-type: none"> - Dr Callow reported the GP Operational Forum was revitalised with the appointment of Rob Gillies - The Forum had discussed the introduction of a pre-referral check lists 	<ul style="list-style-type: none"> • West Lancs CCG were not represented at a recent meeting but their presence had been requested. Want to keep numbers small but want to use soft intelligence regarding the localities. 	<ul style="list-style-type: none"> • Nil

to avoid duplication of tests			
4. NHSE 2013/14 annual complaints by CCG - It was noted the CCG appeared comparable with other CCGs	• Nil	• Nil	• Nil
5. Locality Update	• It was noted that if the committee had to have a chair from a GP locality the criteria was not currently being fulfilled. Dr Callow and Dr Scholtz could no longer fulfil that role as they were on the board	• A meeting had been arranged to discuss the roles of clinical leads at various committees and a report would be submitted to the Governing Body that would rectify the situation.	• Dr Cauldwell would take over as Chair and future meetings
6. Any other business	• Miss Nichols informed the committee she would be standing down as Chair but would continue to attend meetings		

Recommendations to the Governing Body

1. The Governing Body is asked to receive this key issues log as an assurance that the CCG Quality Committee has oversight and assurance that the population the CCG serves is receiving safe, harm free and quality care in provider organisations, and where issues have been raised the Quality Committee has put in place appropriate mitigating actions.

Key Issues Report to Governing Body July 2014

Audit Committee Meeting held on 3 rd June and 9 th July 2014	Chair: Helen Nichols
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Key Issue	Risk Identified	Mitigating Actions
Consultation on Auditor Appointment	Potential for different external auditors to be appointed to each CCG	<ul style="list-style-type: none"> FLC has written to Audit Commission requesting that both CCGs have the same External Auditor.

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

• Annual Governance Statement signed off
• Annual Accounts signed off
• Annual Report signed off
• External Audit Report
• Received Annual Audit Committee Letter
• SIRO Briefing Report received

**Key Issues
Finance and Resource Committee**

Meeting Date 21 May 2014 and 18 June 2014

Chair Mrs Helen Nichols

Key Issues	Risks Identified	Mitigating Actions
1. No issues to report	•	•
2.	•	•
3.	•	•

Information update to Audit Committee
1. The CCG has sufficient reserves in place to achieve the planned £1.700m surplus at the end of the year.
2. Annual IFR Report received – current approval rate of 19%.
3. Quality Premium Dashboard - Southport & Formby CCG should receive a payment in Q3 of 2014/15 of £111,638 against a total possible payment (if all indicators were within tolerance) of £595,400
4. PMO Programme Update – all programmes on target.

Audit Committee Minutes

Wednesday 30th April 2014, 10.00am to 12.00pm
Family Life Centre Southport

Attended		
Helen Nichols	Lay Member (Chair)	HN
Roger Pontefract	Lay Member	RP
Paul Ashby	Practice Manager	PA
Colette Riley	Practice Manager	CR
In Attendance		
Martin McDowell	Chief Finance Officer	MMD
Debbie Fagan	Chief Nurse	DF
Ken Jones	Chief Accountant	KJ
Roger Causer	Local Counter Fraud Specialist, (MIAA)	RC
Adrian Poll	Audit Manager, MIAA	AP
Rachael McIlraith	Audit Manager, Price Waterhouse Coopers	SB

	Item	
A14/19	<p>Apologies for absence</p> <p>Apologies for absence were received from Tracy Jeffes. DF notified late arrival.</p>	
A14/20	<p>Declarations of interest</p> <p>Declarations of interest were made by CCG Officers who hold dual posts at both South Sefton and Southport and Formby CCGs. HN noted that she is a shadow Governing Body Member at Southport and Ormskirk NHS Trust.</p>	
A14/21	<p>Advance Notice of items of other business</p> <p>There was no advance notice of other items of business.</p>	
A14/22	<p>Minutes of the Previous Meeting</p> <p>The minutes of the previous meeting were approved as a true and accurate record pending to minor amendments.</p>	
A14/23	<p>Action Points from Previous Meeting</p> <p>The action notes from the previous meeting were closed as appropriate.</p>	
A14/24	<p>Review of Conflicts of Interest Register</p>	D Fairclough

	<p>The Chair referred the committee to the register of conflicts of interest. The committee noted that the register requires updating to include new Governing Body members and the removal of family link for Dr Simmonds to LCH. HN noted that her position as shadow board member at Southport and Ormskirk NHS Trust had been omitted from the register.</p> <p>The Audit Committee noted the Conflicts of Interest Register.</p>	
A14/25	<p>Unaudited Annual Accounts (Draft)</p> <p>KJ presented the unaudited Annual Accounts and invited the Audit committee to comment as desired.</p> <p>RP requested clarification in relation to the absence sickness absence statistics. KJ responded that this information which will be submitted by NHS England on 9th May 2014.</p> <p>HN requested confirmation of performance in relation to payment of invoices in line with the Better Payment Practice code for the six months preceding year end.</p> <p>KJ and MMcD confirmed that the finance team have ensured the appropriate payment runs have continued during the year end close down. KJ will provide performance information to HN.</p> <p>RP requested clarification in relation to the absence of PFI assets. KJ explained that this is now the responsibility of NHS Property Services.</p> <p>KJ drew attention to Note 42. This note will be appropriately highlighted in the Annual Report.</p> <p>HN thanked MMcD, KJ and the Finance Team for their work on the annual for his work and detailed report.</p> <p>MMcD advised the Committee that if they wanted to make any amendments to the Annual Report these should be submitted via Lyn Cooke to maintain version control.</p> <p>The Audit Committee noted the Unaudited Annual Accounts (Draft).</p>	KJ
A14/26	<p>Local Counter Fraud Annual Report</p> <p>RC presented summary of the Annual Report and asked the committee to note the work in the initial year which has focused on the establishment of a sound platform to secure a strong anti-fraud culture.</p> <p>RC updated the committee as to completed actions including reinforcing the counter fraud message to all staff.</p> <p>The Committee noted that there have been no fraud investigations to date.</p> <p>RP noted that the review of Conflicts of Interest Register had been completed; this will be circulated to all members of the committee.</p> <p>The Audit Committee noted the Local Counter Fraud Report.</p> <p>Local Counter Fraud Work Plan 2014-2015</p> <p>RC presented the Local Counter Fraud Work Plan for 2014-15 and noted the four key areas.</p> <p>The Committee noted that the Local Counter Fraud Team would be following up on advice given to ensure appropriate action had been taken.</p> <p>The Committee noted that the plan allowed for flexibility in the event that the Crime Standards proposed by NHS England are published. Amendments to the plan will be brought to Audit Committee for</p>	MMcD

	<p>approval.</p> <p>The Audit Committee noted that CHC is considered to be a significant risk for fraud particularly in the light of the CSU merger.</p> <p>RP commented that the committee should consider if eight days per year was sufficient to protect the CCH from fraud risks. MMcD responded that the CCG could respond quickly if it is identified that further resource is required.</p> <p>MMcD thanked RC and the Local Counter Fraud Team for their work to date, the annual report and the draft work plan for 2014/15.</p> <p>The Audit Committee noted the content of the Local Counter Fraud Annual Report.</p> <p>The Audit Committee approved the 25 days Local Counter Fraud Work Plan and approved the fee of £8,000.</p>	
A14/27	<p>Internal Audit</p> <p>AP presented the Internal Audit reports as listed below.</p> <p>a. MIAA Progress Report</p> <p>AP noted that all audits had proceeded in line with plan and had achieved significant assurance. Action plans have been drafted as appropriate and these will be monitored by the Audit on a composite report compiled by D Fairclough.</p> <p>The Audit Committee noted the MIAA Internal Audit Progress Report</p> <p>b. MIAA Draft Audit Opinion</p> <p>AP presented the Draft Audit Opinion and noted that overall Significant Assurance can be given and that there is a generally sound system of internal control designed to meet the organisation's objectives and that controls are generally being applied consistently. However, some weaknesses in design or inconsistent application of controls put the achievement of particular objective at risk.</p> <p>The Audit Committee noted the MIAA Draft Audit Opinion.</p> <p>c. MIAA Draft Plan 2014/15</p> <p>AP presented the draft work plan for 2014/15 and noted the key areas. The committee were advised by AP that the plan is flexible and that MIAA Internal Audit is able to respond quickly as required.</p> <p>The Audit Committee approved the MIAA Draft Plan for 2014/15 and the fee of £24,000.</p> <p>MMcD commented that this was pleasing outcome for the CCG with significant assurance ratings for all audits. The Committee were assured that any issues identified will be addressed.</p> <p>MMcD thanked AP and his team for their work over the past year, and the reports submitted.</p> <p>AP thanked the CCG for accommodating the Audit Team so readily and providing their co-operation. AP further noted that in terms of degree this is a "high-end" significant assurance.</p> <p>HN commented that to achieve high end significant is a great achievement and congratulated MMcD and his team. These sentiments were supported by Audit Committee who noted that they very assured by these reports.</p> <p>RP noted his concern in relation to issues around CHC and requested clarification that the CCG are evaluating claims on a comparable basis with other CCGs. He further commented that the CCG should take</p>	

	<p>note that we treating patients with physical illness in a comparable way to patients with mental illness.</p> <p>The Audit Committee approved the draft MIAA Internal Audit Work Plan and approved the fee of £24,000.</p>	
A14/28	<p>External Audit Progress Report</p> <p>RMcl gave a verbal progress update in relation to external audit.</p> <p>The Committee noted that PWC officers were currently on site at the CCG. The Audit is currently progressing and is expected to result in a satisfactory outcome.</p> <p>The Audit Committee noted the External Audit Progress Report</p>	
A14/29	<p>Legacy Balances – Update</p> <p>KJ updated the committee in relation to legacy balances.</p> <p>The committee noted that there are a small number of fixed assets. CHC restitution payments are currently being dealt with by NHS England and will be resolved as appropriate from a central funding pool.</p> <p>MMcD updated the Audit Committee on the current situation and will continue to update the Governing body.</p> <p>The Audit Committee noted the verbal update on Legacy Balances.</p>	
A14/30	<p>2014/15 Committee Work Schedule – revised</p> <p>The Chair of Audit Committee referred the committee to the revised Committee Work Schedule circulated in advance.</p> <p>HN requested clarification if the Audit Committee has the overarching responsibility for Risk Registers and the Assurance Framework. MMcD will liaise with D Fairclough.</p> <p>The Audit Committee noted the revised Committee Work Schedule.</p>	MMcD
A14/31	<p>2014/15 Meeting Dates – revised</p> <p>The Chair of Audit Committee referred the committee to the revised meeting dates circulated in advance.</p> <p>The Audit Committee noted the revised meeting dates.</p>	
A14/32	<p>Information Governance Toolkit</p> <p>MMcD presented this report to the committee. Based on the assurance received from CMCSU, MMcD and HN have to sign off the IG Toolkit.</p> <p>HN noted that MIAA had reported some difficulty in securing evidence to support some areas of the Information Governance Audit. AP responded that all evidence had now been submitted.</p> <p>The Audit Committee noted the CCG compliance with Level 2 of the IG Toolkit.</p>	
A14/33	<p>CMCSU Report</p> <p>KJ/MMcD presented this report.</p> <p>The Committee noted the report in relation to CMCSU readiness to provide the services that it is contracted to do. The committee raised concerns in relation to a number of outstanding actions and the timeframe for resolution, and the merger with Manchester CMCSU.</p> <p>RMcl noted External Audit are not reliant on this report for assurance</p>	

	<p>and will carry out appropriate audit activity to provide the necessary assurance for the CCG and Audit Committee</p> <p>The Audit Committee requested the MMcD advise the relevant parties at the CSU of their concerns in relation to the report.</p> <p>The Audit Committee noted the CMCSU Report which raised a number of concerns. MMcD, KJ and TJ will consider this through the performance meeting with CMCSU.</p>	MMcD/KJ/TJ
A14/34	<p>Annual Audit Committee Report</p> <p>The Chair presented the Annual Audit Committee report which is included in the CCG Annual Report and will be submitted to the Governing Body.</p> <p>The Audit Committee noted the Annual Audit Committee Report.</p>	
A14/35	<p>Self-assessment of committee effectiveness</p> <p>HN referred the committee to the National Audit Office Self-Assessment of Effectiveness. All members of the committee are requested to complete the survey which should be submitted to KL by 30th May 2014. The results will be compiled into a report to be brought to committee in July 2014.</p> <p>The Audit Committee noted the self-assessment of committee effectiveness.</p>	All
A14/36	<p>Review of losses and special payments, tender waivers, aged debt and declarations of interest</p> <p>KJ referred the committee to the nil return report circulated in advance.</p> <p>KJ advised the committee that there are some claims in the system in relation to CHC including some claims for mal administration. The CCG has been recommended to make some small payments in relation to two of these claims for less than £500. Appropriate legal advice is being sought and followed.</p> <p>The Audit Committee noted that there were no losses, special payments, tender waivers, aged debt or declarations of interest to report.</p>	
A14/37	<p>Changes to Standing Orders, SFI's, Accounting policies.</p> <p>MMcD referred the committee to the draft accounting policies that had been previously approved in conjunction with the Chair of the Audit Committee.</p> <p>The amended policies will form part of the annual accounts.</p> <p>The Audit Committee noted the draft accounting policies</p>	
A14/38	<p>Receive updates of other committees and review business inter-relationships Finance & Resources Committee</p> <p>The Audit Committee noted the key risks and issues log from Finance and Resource Committee.</p> <p>Quality Committee</p> <p>The Audit Committee noted the key risks and issues log from Quality Committee.</p> <p>HN/DF noted the absence of risk and issue logs for March and April 2014 and gave a verbal update.</p> <p>The Committee requested that the Francis Action Plan including current status of actions should be presented to the Governing Body in</p>	

	May 2014.	
A14/39	<p>Any other business</p> <p>There were no other items of other business.</p>	
A14/40	<p>Review of meeting</p> <p>The committee reviewed the meeting and noted that</p>	
	<p>Date and time of next meeting:</p> <p>Tuesday 3rd June 2014</p> <p>9.00am – 11.00am 3rd floor Merton House</p>	

Southport and Formby Clinical Commissioning Group

Audit Committee

Minutes

Tuesday 3 June 2014, 9.00am to 11.00am
Boardroom Merton House

Attended		
Helen Nichols	Lay Member (Chair)	HN
Roger Pontefract	Lay Member	RP
Paul Ashby	Practice Manager	PA
Dr Jeff Simmonds	Secondary Care GP	JS
In Attendance		
Fiona Clark	Chief Officer	FC
Martin McDowell	Chief Finance Officer	MMD
Debbie Fagan	Chief Nurse	DF
David Bacon	Interim Deputy Chief Finance Officer	DB
Ken Jones	Chief Accountant	KJ
Rachael McIlraith	Audit Director, PricewaterhouseCoopers LLP	RMcl
Elizabeth Tay	Audit Manager, PricewaterhouseCoopers LLP	ET
Pippa Scarrett	Audit Lead PricewaterhouseCoopers LLP	PS

	Item	Lead
A14/41	Apologies for absence Apologies for absence were received from Tracy Jeffes and Colette Riley.	
A14/42	Declarations of interest Declarations of interest were made by CCG Officers who hold dual posts at both Southport and Formby and South Sefton CCGs.	
A14/43	Advance Notice of items of other business There was no advance notice of other business.	
A14/44	Minutes of the Previous Meeting The minutes of the previous meeting were approved pending one minor amendment – job title for Rachel McIlraith.	
A14/45	Action Points from Previous Meeting Action points from the previous meeting were deferred until the meeting in July 2014.	
A14/46	Approval of Annual Report An extensive discussion took place in relation to the Annual Report and Annual Accounts. A number of amendments to the text of the Annual	

	<p>Report were agreed and will be implemented prior to sign off.</p> <p>RMCl was invited to comment on amendments which were unanimously agreed by the committee.</p> <ol style="list-style-type: none"> 1. Annual Governance Statement The Audit Committee approved the signing of the Annual Governance Statement. 2. Annual Accounts The Audit Committee approved the signing of the Annual Accounts. 3. Annual Report The Audit Committee approved the signing of the Annual Report. 	
A14/47	<p>PWC ISA 260 Report</p> <p>RMCl presented the ISA 260 Report and noted that</p> <p><i>“We have completed our audit of the CCG’s accounts in accordance with auditing standards, subject to the following outstanding matters:</i></p> <ul style="list-style-type: none"> • <i>approval of the financial statements and letters of representation;</i> • <i>evidence to support the statement that payments to GP members are not pensionable;</i> • <i>receipt of CSU ISAE 3402 report;</i> • <i>related parties note; and</i> • <i>completion procedures, including going concern and subsequent events review and completion of director and manager file reviews.</i> • <i>Subject to the satisfactory resolution of these matters, the finalisation of the financial statements and their approval by those charged with governance, we expect to issue an unqualified audit opinion”</i> <p>In addition RMCl noted that</p> <p><i>“On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission on 15 October 2013, we have no matters to report with respect to whether, Southport and Formby CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014”.</i></p> <p>The Committee were further advised by RMCl that in relation to GP Pension disclosure the CCG has chosen to interpret the relevant guidance as not requiring disclosure. PWC are comfortable with this interpretation, however, cautioned the Audit Committee that this guidance may be more explicit next year and may require full disclosure.</p> <p>RMCl thanked MMcD and the team at the CCG for their continued co-operation during the audit.</p> <p>The Audit Committee noted the content of the External Audit Report.</p>	
A14/48	<p>Letter of Representation</p> <p>The Committee noted one amendment to be made to the draft letter of representation circulated to the Audit Committee and authorised the Chief Finance Officer to sign the letter.</p>	
A14/49	<p>Any other business</p>	

	There were no items of other business.	
	Date and time of next meeting: 9.30am – 11.00am 9 th July 2014 Family Life Centre Southport	

Quality Committee Minutes

23 April 2014, 3.00pm to 5.00 pm
Family Life Centre, Southport

Present		
Helen Nichols	Chair and Lay Member	HN
Dr Doug Callow	GP Quality Lead S&F	DC
Dr Rob Caudwell	GP Governing Body Member	RC
Dr Kati Scholz	GP Locality Lead - North	KS
Debbie Fagan	Chief Nurse	DF
Malcolm Cunningham	Head of Primary Care & Corporate Performance	MC
Billie Dodd	Joint Head of CCG Development	BD
In attendance		
James Hester	Programme Manager Clinical Quality & Safety	JH
Apologies		
Fiona Clark	Chief Officer	FLC
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Martin McDowell	Chief Finance Officer	MMcD
Ann Dunne	Deputy Designated Nurse Safeguarding Children	AD
Tracy Forshaw	Deputy Head of Adult Safeguarding	TF
Karen Garside	Deputy Designated Nurse Safeguarding Children	KG
Minutes		
Jayne Byrne	Office Manager/PA to Chief Nurse	

	Item	Action
14/40	Apologies for absence were noted as above.	
14/41	Declarations of interest Officers holding dual roles in both South Sefton and Southport and Formby CCGs declared their interest.	
14/42	Minutes of the previous meeting The minutes were accepted as an accurate record of the previous meeting.	
14/43	Matters arising/action tracker <i>13/132 DNAR</i> – should say March. Has been passed through the LMC and the referral form is being updated and will be circulated to practices shortly. This will be brought back to this meeting for approval in May.	JH

	Item	Action
14/43	<p>14/17 Chief Nurse to circulate revised Alder Hey Action Plan on receipt from NHSE – not yet done as date for next QSG is 24 April (day after QC) so DF will circulate updated information when available - carry forward to May's meeting.</p> <p>14/18 Francis Action Plan – remove from tracker.</p> <p>14/28 Stroke/TIA – MC to meet with Sharon Forrester who was due to feedback to the Committee in May on clinical pathway.</p> <p>14/33 reporting of serious incidents – a meeting had been arranged with Merseycare/RGP clinical leads/CCG to discuss SI reporting within the Trust.</p> <p>14/40 looked after children medicals – Miss Fagan had informed the Corporate Parenting Board this was not a problem.</p>	<p>DF</p> <p>MC/SF</p>
14/44	<p>Chief Nurse Report</p> <p>p20 of 167 – Section 3 Research - the Deputy Chief Nurse had completed the draft of the Research Strategy which will be presented to the Quality Committee in June.</p> <p>p22 of 167 – Section 8 Sefton Corporate Parenting Board – Miss Fagan presented a paper on CAMHS to the Corporate Parenting Board, which was in the process of completing a service specification for Tier 3 and the children's element of the Sefton mental health strategy jointly with the Council.</p> <p>p22 of 167 Section 12 – CMCSU provision of commissioning support re CHC – Miss Fagan reported NHSE were launching a draft assurance framework around CHC that they wanted to pilot within one area team. The CCG will have to provide evidence back to NHSE around assurance in relation to CHC and Miss Fagan had been in contact with CMCSU colleagues.</p> <p>Miss Fagan had spoken to Tina Wilkins whose team had done some process mapping/service transformation around CHC and she was hoping to hold a joint event between the Council and the CCG in the next 6 weeks or so regarding the integration agenda and future local pathways.</p>	
14/45	<p>HCAI Action Plan</p> <p>The Committee was asked to receive the Action Plan which had been updated with local developments and be used as evidence for Q4 checkpoint assurance meeting.</p> <p>It was noted that Aintree would not be adhering to the Department of Health guidance for C-Diff as it believed the targets were clinically unjustifiable and had set their own internal targets.</p>	
14/46	<p>Safeguarding Report</p> <p>Miss Fagan had included an update within the Chief Nurse Report.</p>	

14/47	<p>Francis Action Plan</p> <p>Mr Hester presented an updated version of the action plan and directed the Committee to p45 of 167, the report's 9 recommendations from the Government's report.</p> <p>All outstanding actions have been moved to green unless they are to be dealt with in future and remain amber.</p> <p>The complaints policy would be presented at the next Quality Committee meeting. Sallyanne Hunter currently ratifying.</p> <p>It was agreed the plan would be re-presented every 4 months or sooner if required.</p>	
14/48	<p>Corporate Risk Register</p> <p>Miss Fagan presented the register in Mrs Jeffes' absence.</p> <p>The register had been reviewed by the CCG Senior Management Team and also the Corporate Governance Support Group.</p> <p>11 risks were scored as high and one new risk ID26 had been added for the Q4 update.</p> <p>Mr Gillespie commented there appeared to be one extreme risk and all others seemed reasonable with progress being made.</p> <p>Miss Fagan explained the extreme risk regarding safeguarding had been identified in Q3. She was not happy reducing the risk until all actions introduced were having effect and information from providers had been received in Q4.</p> <p><i>p63 of 167</i> - the Committee received the report and approved the recommendation to remove risks ID9, ID13, ID16 and ID19 from the Register.</p>	
14/48	<p>Governing Body Assurance Framework Update Q4</p> <p>The risk status was considered reasonable, however, the different format of the corporate risk register and the governing body assurance framework documents had caused some confusion and it was suggested the author should be invited to the next meeting to explain the format. The Committee received the report.</p>	TJ
14/49	<p>Commissioner Assurance – provider cost improvement plans 2014/15</p> <p>NHSE(M) wrote to the CCG asking to see processes by way of assurance. JH was working with Karl McCluskey to develop internal processes and this paper highlighted that process. The appendices showed draft measures which had been put in place so the provider could be monitored throughout the year as an early warning dashboard for GP clinical leads. It was intended the paper should be presented to the Quality Committee on a quarterly basis. No questions or comments were received. The process was approved.</p>	
14/50	<p>Corporate Governance Support Group – Key Issues Report</p> <p><i>p99 of 167</i> – this paper was disregarded as it referred to Southport and Formby. It was noted the Corporate Risk Register had been approved without the support of this document.</p>	
14/51	<p>EPEG – Key Issues Report</p> <p>EPEG met w/e 11th April, but due to timescales April's meeting wasn't recorded. Providers as well as NHSE would be attending EPEG meetings in the future so information was received and could be used immediately.</p>	

14/52	The Committee were asked to approve the following standardised policies in accordance with the CCG's Constitution.	
14/52	Equality and Diversity Policy Approved subject to minor amendment to p6 – the yellow highlighted text should read "Finance & Resource Committee".	
14/53	Harassment Policy Approved subject to minor amendment to p117 – the yellow highlighted text should read "Chief Officer".	
14/54	Retirement Policy Approved.	
14/55	Secondment Policy Approved subject to minor amendment to Appendix 1 points 1 and 3 – change "host organisation" to "South Sefton CCG." Mr Driver asked what had been agreed at the Southport and Formby CCG Quality Committee meeting. Miss Fagan confirmed a decision would be made at the next meeting on Wednesday 23rd April.	
14/56	Travel Expenses Policy Approved.	
14/57	Any Other Business It was noted that several Leads were missing and the Chair asked for a deputy to be nominated for future meetings. Miss Fagan informed the Committee that Bernie Cuthel, Chief Executive of Liverpool Community Health NHS Trust and Helen Lockett, Director of Operations/Executive Nurse were leaving. An interim Chief Executive, Sue Page, had been appointed pending the recruitment of a permanent new Chief Executive and an interim Director of Operations/Executive Nurse would be appointed within the next two weeks. Meanwhile, Marie Crofts, Deputy Director of Operations/Executive Nurse would take over lead responsibility for Operations and Nursing. Patient Safety Incident – Fri 11 th – an action plan had been asked for.	
14/58	Date of next meeting Thursday 22 nd May 2014 3.00pm – 5.00pm Boardroom Merton House	

Quality Committee Draft Minutes

Date: Wednesday 21 May 2014, 3.00pm to 5.00 pm
Venue: Family Life Centre, Southport

Present		
Helen Nichols	Chair and Lay Member	HN
Dr Doug Callow	GP Quality Lead S&F	DC
Dr Kati Scholz	GP Locality Lead - North	KS
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
Also in attendance		
James Hester	Programme Manager – Quality	JH
Minutes		
Jayne Byrne	Office Manager/PA to Chief Nurse & Quality Officer	JB
Apologies		
Dr Rob Caudwell	GP Governing Body Member	RC
Fiona Clark	Chief Officer	FLC
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Billie Dodd	Head of CCG Development	BD
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Ann Dunne	Designated Lead Nurse for Safeguarding Children	AD
Tracy Forshaw	Designated Lead Nurse for Safeguarding Adults	TF

No	Item	Action
14/63	Apologies for absence were noted as above.	
14/64	Declarations of interest regarding agenda items Members holding dual roles in both South Sefton and Southport & Formby CCGs declared their interest.	
14/65	Minutes of the previous meeting <i>Page 3 of 99 - 3rd paragraph from bottom of page. The 2nd sentence should read “Serious Incidents subject to aggregated review will be closed.”</i> <i>Page 5 of 99 – 14/51 - delete reference to Dr Gillespie.</i>	
14/66	Matters arising/action tracker <i>14/28 Stroke/TIA – carried forward to next meeting.</i> <i>14/30b Access to Community Respiratory Services - still awaited – carry forward.</i> <i>14/30e format of ‘other providers’ report – on agenda.</i> <i>14/33 Closing of Serious Incidents – on agenda.</i> <i>14/34a Locality meetings – quality and re-design now a standard agenda item for locality meetings – take off tracker.</i>	MC/SF BD

14/66	<p><i>14/34b Unsatisfactory discharge letters</i> – Mrs Dodd’s team will be the Managerial lead for discharge letters.</p> <p>Care Home report - needs to be picked up with Gordon. Whether on framework or not. Jo Simpson to pick up – carry forward</p> <p>Whistleblowing – just ccg staff or provider staff - sh relates to both – although provider need it so do ccg for staff and members of the public. DF suggested referring to Operational Gov Gp – JH to spk to TJ. To update whistleblowing policy and advise how we can achieve that . JH to report back in a qtrs. Time august internal meeting when it’s been to Op Gov Gp. (mtg 8th jul?)</p> <p>MM thought it should also go to EPEG PALS/Complaints – system in place. Logged through CSU onon behalf. Whether or not we differentiate between members of staff or public.</p> <p>JS believed it was a contract requirement for 2014/15 duty of candour – consitiute £10K fine.</p> <p>NICE – Annie Coppel – will attend June’s QC meetings unless we can get all 4 GP quality leads together before hand.</p> <p>14/50 – fap – jh done. Seems to be a standard line but needs to be more specific ie what we want providers so – explains in FAP. Below that need to look at in contract. Going to this months gb. JH to action.</p> <p>14/53 – actioned – circulated by JB.</p>	<p>JH</p> <p>JH</p>
14/67	<p>Planned content of future provider performance reports – HN not quite hit the mark. Assurance from other providers. Disregard paper. Hn spoken to DF. DF to formalise conversation in writing. Come back to internal meeting (June). Avoid wading through data.</p> <p>DF will flag in Chief Nurse report and CG SSQC chair had proposed GP quality leads should attend meetings and lead their hospital’s dashboard and CCG there from a managerial perspective.</p> <p>DC MSA breaches – cross boundaries – other providers getting data?</p>	DF

<p>14/68</p>	<p>Provider performance reports –std csu report – under new regime would n konger come to meeting as it covers lots of providers and is too detailed. Any queries? Otherwise skip to p59 – concentrating on S&O (2 page report new style).</p> <p>JS do by exception or discuss issues raised at CQPG.</p> <p>Around cancer measures S&O underperforming but lots of small nos largely down to patient choice. For more in depth info CSU have asked providers if they want risk cause analysis for all breaches. Providers already felt they do their own internal RCA so additional not needed.DC believed survey was too narrow. Look at whole numbers and provide written report.</p> <p>KS ok to review 6 patients but what happened to rest too? JS could propse looking at cancer pathways at next CQPG. Better pathway around bowel cancer, radiology delays, etc. All interconnected – friends and family not doing so well.</p> <p>DF suggested speaking to Trust – could invite them to speak to next ext meeting to ezplain what theyre doing with other patients.</p> <p>Koti believed this would be better after report received – only invite if unsatisfactory report.</p> <p>Smoking – all Trust seem to be underperforming – can sk for more ifno at CQPG. Doing more than report says just not being recorded. HN how important is this – not very important from a clinical point of view s already known in primary care. Review when new system in place end of Q2 or Q3 – check with Debbie.</p> <p>SABreaches – COO not happy with DF! At CQPG. Addressed at last meeting . March due to C-Diff see p59 of 99.</p> <p>Can't ignore NHS Constitution persons right even though trust take decision to close wards. Not happy but aware that any penalties need to go back to the Trust.</p> <p>They're claiming that other trusts are gaining. Other element is social services delays. Majority of MSA breaches in April are S&F not SS patients. Care Closer to Home 12 months but it was urgent care network before then definitely work in progress so funding there.</p> <p>Requested remedial action plan but won't; give csu access – expecting feedback today. On next CQOG agenda. CSU have asked for data delayed discharge to see how it correlates.</p> <p>The day before is the first mention of discharge should hjappen as soon as they are in hospital.</p> <p>JS also spoken to Aintree how they collect their MSA breaches. Can demonstrate how they've dealt with it. CSU to do some work around it?</p> <p>ACTION chase on action plan they been asked for. Someone will make enqs about other providers (discretely). DC or DF. Where they think it's happening.</p> <p>Choose and Book Slot Utilisation – S&O can't understand why. Lot of fax appts no direct appts – repeatedly failed referrals – can't use software? Is CB priority of discharge letters?</p> <p>We will not worry about this for 6 months let GP OP forum run with it.</p> <p>Kati commented that cb stops working at 7pm in evening. From Oct surgey have to do extended hours so cb needs to be extended. National issue martin to raise.</p> <p>Ambulance handovers – 34 to 37 all decline are be Ue should be red? JS to check. Within 15 mins fine? Nos above problem? Both seem to be getting worse to HN but not being flagged up. JS to raise with DM. If it is a problem to be raised at next meeting (CQPG or QC??). MM asked JS to find out what criteria is for hernia ops – 6% fig is it worth doing?</p> <p>Prophylaxis – just a blip in the month – data collection issue. JS fairly confident but will keep an eye on it.</p> <p>CQUINS – national for S&O – dementia underperforming in line with other trusts s&f more elderly patients. Lookng at all mside and nw health economy meeting to be arranged re bestpractice with sth&k hospital trust.</p> <p>Friends and family – still issues around a&e</p>	<p>JS</p> <p>MMCD</p> <p>JS</p>
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14/68	Other providers struggling on friends and family – texting service improving figures.	
14/68	CQUIN is scored on response rate, not response itself – so could have 100% response rate but content not great. No guidelines on what's deemed to be a good score. Action: lets see if we can get them texting and see if theres an improvement. EPEG all over it.how our score compares to other providers in the area. In terms of test score.p56 of 99.shows this.looking at profile of patient to see why not responding ie drunk/drugs/elderly, etc. HN more concerned about inpatient scores than A&E.F believed it was good that data coujld be triangulated and the CCG could work with Trusts to improve.	
14/68	HN how do we as commissioners use that info to drive quality up in S&O? can we go back to trust re friends and family breakdown per ward and what is coming onlone from jun july in contract re staffing levels and triangulate it. JH will pick up as he has links with trust and EPEG and can more data about complaints etc. Let them focus on response rate. We can focus on quality that test scores are v poor compared to other providers and why is it and what are they going to do about it? Get comparative data. They are focussing on scores and that's not what's important. Advance in Quality (AQuA) – lag in timeline of data. More info needs to be requested for next meeting. JS Domain 5 C-Diff – remedial action plan in place. at sub comm of board. Trust and CCG breached full year objective and have commenced health economy work S&O proactive in organising workshop and input on day. CQC intell tool – replaces qua risk profiles in transition at mo. JS to provide latest info following meeting. Elevated whistleblowing rate – prob based on policies that have been updated. Safety thermometr – final data expected nationally soon. Updated version in next report. Merseycare dashboard to be set up based on NHSE. Get up and running then LCH as separate topic. Karl lead on primary care will report back next time.	JH
14/69	GP quality lead report – DC GP Operational forum revitalised Rob Gillies making right noises west lancs not represented but presence requested. Want to keep numbers small but want to use soft intelligences re the localities. Rob is enforcing profess mandatory standards. Like QC to think a pre referral check lists to avoid duplication of tests. Kati believed there were factors like docs test then hospital specialist test which incl stand which mean duplication – ESYS??? (software) could rectify a lot of these issues. S&O would like a list of necessary phone calls ie death, own discharge, safeguarding, etc. V keen on std quality item of locality agendas. Info to refer raised at AQC last week. All localities informed not NICE compoliant and to use their own judgement. Mortality data – hmsr and shim increased over 12 months. The Trust have are issues with coding and increased costs. NHSE have asked them to concentrate on months where data is high. SHK and RL came in and did peer review on case notes which didn't show bad. Curetly on low assurance and will be reviewed. Breast biopsies – ccg been present at 2 internal sis not just breast cancer patients regarding depth of biopsy. Robust procedure and Rob attending meetings and feeding back. 14 patients 2 recalled no patients come to harm. Ifnot seen someone now can they know its urgent – based on info niot judgement.	

14/70	<p>Serious incidents and never events update - s&o latest data april 14 and changes daily. Current position as it stand 29 sis open relating to S&O major s&f patients. AS a CCG we have 5 of those 29 sitting with S&F either response to RCA or review auditors or governance structures. WLCCG have 5 did have 10 but 5 are ok to close. Issue with chief nurse not being in post but 5 comments have been sent back to Trust/CSU. HN why staying open so long. Trust have 15 of 15 3 arent due to be reported yet. 5 identified as going on forward plan one have 3 and 1 for csu. DC and JH going to stat less formal meetings to keep up to date. Also practice nurses need to be involved in si discussions.</p> <p>5 info governance Alison Johnston has meetingon Monday with ???</p>	
14/71	<p>NHSE 2013/14 annual complaints by CCG – first report. P75 of 99 knowsley area but there is another sheet of paper detailing Knowsley complaints – need to clarify with NHSE. We appear to be comparable with other ccgs.</p>	DF
14/72	<p>Go To Doc complaints (referred by EPEG) – complaints on Go to doc service – p86 of 99 complaint 2 needs a clinical opinion concern over end of life care. Complaint 3 misinformation provided to a patient need to clinical opinion. Wider paper has been shared with MC leading the gotodoc. Dc would like to see localities contribute. Trying to dissuade minor illness reporting. Why won't docs turn up between 6 and 8am and therefore result in a visit to A&E. Are they contracted to do urgent visits between those hours? They will be doing contracted hours. Needs to be raised with MC to review from contract perspective. Reviewed quarterly. RC to provide written clinical response to complaint 2 to EPEG and Craig Gillespie deal with Complaint 3 as SS issue.</p> <p>Bank Hol Monday advice line was incorrect messaging went wrong and said contact surgery. MMcD asked for that to be reviewed. Can we check contractual situation between 6 and 8am. From 1st april all docs have contractual responsibility to report on Ooh service.</p> <p>Query how extra landscape paper goes into report? JH to ask MC. DF or DC to list key issues at board next week as HN is away</p> <p>Corp Support Group – meeting in April and at Aprils internal qc dfairclough had reported boxes anyway.Need to get in sync. Jh to query wth Cathy L.</p>	MMcD DF/MC
14/73	Minutes of Corporate Governance Support Group meeting 3rd April 2014	
14/74	Locality update – not fulfilling criteria one of the clinicians has to be gp locality chair dc and ks used to be but cant now on board. If this committee has to hav a chair from a gp locality we're not fulfilling that criteria. Meeting this morning re roles of clinical leads at various committees. Report going to Governing Body that will rectify the situation.	
14/76	<p>Any other business</p> <ol style="list-style-type: none"> 1 HN extremely bad from governance that HN chairing everything – HN to stand down from QC chair although will still attend. RC to take over as Chair but the meeting will move to 0930 hrs before F&R committee at 1130 hrs from next month. DC to check whether OK. December meeting Tuesday? JB to email everypon to confirm dates look at August and December. 2 Presebtatuob of porovider quality accounts dual response with west lancs next week. 3 Ahch – action from tracker – df to present action plan – it's the cqc action plan. Agreement trust they could have further time to prepare due to issues.] 4 Further single item qsg from nhse more issues from whistleblowing around theatre at ahch were systematic. Nothing done here at CCG because CQC due to gon in and inspect in next few weeks. Claire Henegahn wrote to Trust to highlight concerns and a plan of action foing fowrad that would include CQC visit. SSSCG attend ahchcqp so Brendan is attending meetings going forward and also single itemd qsg. Wendy Hewitt is gp clinical lead and is also involved. 5 Aintree – cted as follow up to risk summit. Notifying trust that we are cancelling contract query around rtt missed one, but mortality will stay. Trust performance around A&E as been red rag rated Steve Astles reviewing. CQC rated overall hospital as good with exception of leadership with impovemetn required. Good news story to be reported back. <p>KS thanked HN for her input into the QC metings.</p>	JB
14/77	<p>Date of next meeting Wednesday 18th June 2014 3.00pm – 5.00pm Family Life Centre, Southport</p>	

Quality Committee Minutes

Date: 18 June 2014, 9:30am to 11:30am

Venue: Family Life Centre, Southport

Present		
Dr Rob Caudwell	Chair & GP Governing Body Member	RC
Dr Doug Callow	GP Quality Lead	DC
Helen Nichols	Chair and Lay Member	HN
Paul Ashby	Practice Manager	PA
Debbie Fagan	Chief Nurse & Quality Officer	DF
Martin McDowell	Chief Finance Officer	MMcD
In attendance		
James Hester	Programme Manager - Quality	JH
Brendan Prescott	Deputy Chief Nurse & Quality Officer	BP
Linda Williams	Safeguarding Clinical Lead (Edge Hill University)	LW
Apologies		
Dr Kati Scholz	GP Locality Lead - North	KS
Fiona Clark	Chief Officer	FLC
Billie Dodd	Head of CCG Development	BD
Karen Garside	Deputy Designated Nurse Safeguarding Children	KG
Tracey Forshaw	Designated Lead Nurse for Safeguarding Adults	TF
Tracy Jeffes	Chief Corporate Delivery & Integration Officer	TJ
Malcolm Cunningham	Head of Primary Care & Contracting	MC
Minutes		
Melanie Wright	Business Manager	

Membership Attendance Tracker

Name	Membership	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr Rob Caudwell	GP Governing Body Member (Chair as of Jun 2014)	A	√	√									
Dr Doug Callow	GP Quality Lead	√	√	√									
Dr Kati Scholtz	GP Locality Lead – North	√	√	A									
Helen Nichols	Governing Body and Lay Member	√	√	√									
Fiona Clark	Chief Officer	A	A	A									
Malcolm Cunningham	Head of Primary Care and Contracting	√	A	A									
Billie Dodd	Head of CCG Development	√	A	A									
Debbie Fagan	Chief Nurse and Quality Officer	√	√	√									
Martin McDowell	Chief Finance Officer	√	√	√									

- √ Present
- A Apologies
- L Late or left early

No	Item	Action
14/77(a)	The meeting was preceded by a presentation by Linda Williams of Edge Hill University on the recent Safeguarding Review that the CCG had commissioned.	

No	Item	Action
	<ul style="list-style-type: none"> • “Miss Nichols” to be referred to “Mrs Nichols” throughout. • The spelling of Dr Caudwell’s name to be corrected. • At 14/68, update to read “wanted root cause analysis for all breaches” in paragraph 2. • At 14/70, to note that Mr Hester has been in contact with the Trust to progress this. • Miss Fagan provided amended wording at 14/76 (Alder Hey) – should read in its entirety for Alder Hey ‘DF informed the Committee that NHSE had agreed with the Trust prioritisation linked to the development of the required action plans as a result of the CQC visit and the Risk Summit. This was the rationale behind action plans not being presented to the CCG Quality Committee as they were being further developed and amalgamated so there was one overarching plan. The CCG are represented at the CPQG (Quality Contract Meeting) were this is discussed and also contribute to the Quality Review process for the purposes of assurance. The CCG are working closely with Liverpool CCG as co-ordinating commissioner and NHSE(Merseyside & Cheshire, Warrington & Wirral) in their role as commissioners of specialist services by way of mutual assurance’. Aintree – amended to add ‘ the contract query for Health Care Acquired Infections has been closed. 	
14/80	<p>Matters arising/action tracker</p> <p>All actions to remain on the tracker to be considered at the next available meeting, except where detailed within the following points.</p> <p>13/132 <i>DNAR</i> – rolled out to practices and being implemented, but this does not appear to be in evidence at practice level. Mr Hester agreed to look into this and respond to Drs Caudwell and Callow out with this meeting. This item can then be removed from the tracker.</p> <p>14/69(c) <i>Stroke/TIA</i> – Mr Hester circulated a detailed written update. It was felt that insufficient progress has been made and this item to be included on the agenda for the next external meeting. Sharon Forrester to be invited to the next meeting, along with the Stroke lead at the ICO: Miss Fagan to facilitate for July 2014.</p> <p>14/30(b) <i>Access to Community Respiratory Services</i> – Dr Caudwell to liaise with Dr Scholtz.</p> <p>14/30(d) <i>Dashboard for Mental Health Services</i> – <i>Jamie Hester has been progressing this with Gordon Jones and Jo Simpson from CSU..</i> This can now be moved from the Tracker.</p> <p>14/36 <i>Care Home Report</i> – the Quality Committee received an update and were happy to close the action.</p> <p>14/37 <i>Primary Care Update</i> – dashboard being presented to SLT next week.</p> <p>14/50 <i>NICE</i> – actioned, can be closed down.</p> <p>14/68(b) <i>Choose and Book</i> – the system times out on an individual basis if the system is inactive. Issues to be directed to i-Merseyside from practices. Can be removed from the tracker.</p>	JB/DF
14/81	<p>Chief Nurse report</p> <p>Miss Fagan advised that had been a joint workshop with the Local Authority to consider the integrated approach to Continuing Healthcare and some process mapping had taken place. A follow up session in July will consider packages of care, before a further workshop which will include provider colleagues.</p> <p>There was some discussion around the national publication of live nursed staffing data being available in the public domain on NHS Choices and via Trust websites. Dr Caudwell felt that this issue must not distract from the community nursing issues with the</p>	

No	Item	Action
	live national data being in relation to in-patient services.	
14/82	<p>Safeguarding service quarterly assurance report</p> <p>The CCG Safeguarding Service were not present at the meeting and Miss Fagan presented the Safeguarding Report in the absence of the team. The committee considered the assurance ratings of providers and Miss Fagan advised that although there is a red rating at S&O, the Safeguarding Service are reporting an upward trajectory and this will be considered further at the next CPQG meeting. Miss Fagan stated that she has asked the Safeguarding Service to meet with the Trust to gain necessary clarity regarding expectation in what the service require to see by way of evidence from the Trust for the purposes of assurance. The meeting will also enable the service to further support the Trust for the purposes of improvement,</p> <p>Actions</p> <p>7. To be reviewed at the next meeting CPQG and discussed at the July Quality Committee meeting with a view to issuing a contract query, if sufficient assurance is not gained.</p>	DF
14/83	<p>Mental Capacity Act, Deprivation of Liberties report</p> <p>Paper was presented by Miss Fagan in the absence of the Safeguarding Service. The content and recommendations were considered by the Committee</p> <p>Actions</p> <p>8. To be considered as part of ongoing safeguarding training for both the Governing Body and the wider membership.</p>	DF
14/84	<p>CQC-style safeguarding peer review reports and action plan</p> <p>Considered at the commencement of the meeting with Ms Williams' presentation.</p>	
14/85	<p>Commissioner assurance report</p> <p>Miss Fagan presented the Commissioner Assurance Report. The committee discussed the way provider assurance would be presented going forward with a differentiation between > /< 5% spend which is reflective of the rationale utilised for the CCG Checkpoint assurance meeting with NHSE(M).</p> <p>Dr Caudwell highlighted private providers who must not be overlooked as part of this process.</p>	
14/86	<p>Research strategy report</p> <p>Mr Prescott presented the CCG Research Strategy for approval to the committee. Dr Callow queried whether we are exploiting the research opportunities around managing an elderly frail population. Mr Prescott responded that there is a network opportunity. Dr Callow also felt that research opportunities would increase the region's attractiveness in terms of employment. This could be considered at a locality level.</p> <p>Actions</p> <p>9. The strategy was approved.</p>	
14/87	<p>National audit of child health information system</p> <p>The communication was received and the contents acknowledged. Miss Fagan will keep the Committee apprised of developments once the outcome of the national audit is</p>	DF

No	Item	Action
	known.	
14/88	<p>Complaints policy</p> <p>The Committee noted that the appropriate scrutiny has taken place at the Operational Support Group.</p> <p>Actions</p> <p>10. The policy was approved.</p>	
14/89	<p>Any other business</p> <p><i>Primary Care Quality Board</i></p> <p>Care should be taken to avoid duplication between the work of the Primary Care Quality Board and the Quality Committee. The dashboard should be reviewed at this Committee. There was a discussion about the actions to be taken upon the identification of issues on the dashboard.</p> <p>The minutes of this Committee and brief key issues report should be considered at the Quality Committee internal meeting.</p> <p>Mrs Nichols stated that the Committee were expecting to see the Primary Care Quality Dashboard at this meeting but its development had been delayed. Mrs Nichols had agreed with Karl McCluskey that the dashboard would be presented to the August meeting of the Quality Committee.</p>	
	<p>Actions</p> <p>11. Minutes of the Primary Care Quality Board to be presented to the Quality Committee</p> <p>12. Primary Care Dashboard to be presented to August 2014</p>	JH
	<p><i>Alder Hey Quality Review Meeting</i></p> <p>Miss Fagan referred to this meeting held last week and support being offered to the Trust by NHS England.</p> <p>The CQC have revisited the Trust and the report is due in July. A meeting will be reconvened at the end of July to consider the outcome.</p>	
14/90	<p>Date and time of next meeting</p> <p>Wednesday, 23 July 2014 at 09:30am to 11:30 am at the Family Life Centre, Southport.</p> <p>Dr Caudwell asked if the meeting timing could be switched with the timings of the Finance and Resource Committee. This to be considered by the Jayne Byrne/Karen Lloyd. Helen Nichols to raise at Finance & Resource Committee.</p>	JB/KL

Finance & Resource Committee Minutes

Date: Wednesday 19 March 2014 11.00am – 1.00pm

Venue: Family Life Centre, Ash Street, Southport.

Attended		
Helen Nichols(Chair)	Lay Member (Vice Chair)	HN
Dr Martin Evans	GP Governing Body Member	ME
Dr Hilal Mulla	GP Governing Body Member	HM
Colette Riley	Practice Manager	CR
Martin McDowell	Chief Finance Officer	MMD
Debbie Fagan	Chief Nurse	DF
Jan Leonard	Head of CCG Development	JL
Tracy Jeffes	Head of Delivery and Integration	TJ
In attendance		
James Bradley	Head of Strategic Financial Planning	JB
Becky Williams	Chief Analyst	BW

No	Item	Action
FR14/39	Apologies for absence Apologies for absence were received from: Fiona Clark, Roy Boardman, Roger Pontefract, Malcolm Cunningham, Brendan Prescott, Karl McCluskey, Tracy Jeffes.	
FR14/40	Declarations of interest regarding agenda items The Officers of the CCG who hold joint posts declared their potential conflicts of interest.	
FR14/41	Minutes of the previous meeting The minutes of the previous meeting were approved as a true and accurate record of the meeting, pending one minor amendment.	
FR14/42	Action points from the previous meeting Action points of the previous meeting were closed as appropriate:	
FR14/43	Month 11 Finance Report JB and MMcD presented this report which gave the Committee an overview of the financial position for Southport and Formby CCG as at month 11. The CCG has sufficient reserves in place to achieve the planned £1.700m surplus at the end of the year.	

No	Item	Action
	<p>The Resource allocation has reduced by £0.162m to £171.880m in Month 11 as a result of the following transfers to NHS England:-</p> <ul style="list-style-type: none"> • Southport & Ormskirk Trust - a reduction of £0.106m relating to the GA Dental contract where the CCG incorrectly retained this budget in the baseline • Royal Liverpool University Hospital (RLUH) - £0.086m reduction in relation to specialised services provided by RLUH • Additional funding of £0.030 to all CCGs to support the Personal Health Budget rollout and for general planning support. <p>JB noted an increase in the costs attributed to high cost drugs at RLBUHT. The CCG has received credit notes which have processed, however funding has been transferred to Specialised Commissioning. JB will investigate which high cost drugs have been used.</p> <p>JB drew attention to the increases in CQUIN related activity at Renacres and Spire Hospitals. The committee noted that this could be due to a change in referral practice. JL will investigate if there has been a corresponding decrease at Southport and Ormskirk Hospital.</p> <p>The Committee were advised that an accrual has been made in relation to CHC to support the management of uncertainty in this area.</p> <p>The Committee received the finance update and noted in particular that:</p> <p>The CCG remains on target to deliver its financial targets for 2013/2014</p> <p>The greatest area of risk is costs associated with Continuing Healthcare. The costs have risen significantly compared to 2012/2013.</p>	
FR14/44	<p>Strategic Financial Plan Update (includes QIPP update).</p> <p>MMcD updated the committee in relation to the Strategic Financial Plan and noted that this would be presented to the Governing Body in May 2014.</p> <p>The Committee received the verbal Strategic Finance Plan update.</p>	MMcD
FR14/45	<p>IFR Update Report</p> <p>MMcD and JL presented this report for information. The Committee noted that JL has met with the CSU and that new procedure for the approval of IFRs is currently being drafted.</p> <p>The Committee received the Southport and Formby CCG IFR report and noted the content.</p>	
FR14/46	<p>Better Care Fund</p> <p>MMcD presented this verbal update and noted that integration work is ongoing with the council.</p> <p>The committee noted that collaborative working will be key to the success of the Better Care Fund.</p> <p>The Committee received the verbal update regarding Better Care Fund.</p>	

No	Item	Action
FR14/47	<p>Quality Premium Dashboard</p> <p>BW presented this report and noted that based on the year to date performance (April 2013 – January 2014), Southport & Formby CCG would receive a payment in 2014/15 of £111,638 against a total possible payment (if all indicators were within tolerance) of £595,400</p> <p>The Committee received the Quality Premium Dashboard.</p>	
FR14/48	<p>Southport and Formby PMO programme update and exception report – M11</p> <p>BW presented this report on behalf of FD</p> <p>The committee noted that the IT issues in relation to the ophthalmology service are now resolved.</p> <p>The committee noted that all schemes are on schedule as per case for change.</p> <p>The Committee received the PMO programme update and exception report.</p>	
FR14/49	<p>Summary of main requirements of Annual Report</p> <p>MMcD presented this report and asked the committee to note the requirements and agreed approach in relation to the first Annual Report and Annual Accounts for Southport and Formby CCG.</p> <p>The committee noted that the final content of the report would be decided by governing body members.</p> <p>The Committee received the summary of the main requirements of the Annual Report.</p>	
FR14/50	<p>Prescribing Q3 report</p> <p>The committee were advised that Actual Cost growth in Q3 showed a 4.7 % increase compared with the previous year with a spend of £5,153,236 compared to £4,922,635. This corresponded with an increase of 3.7 % of items dispensed with 743,049 items dispensed in Q3 2013-14 compared with 716,631 items in Q3 2012-13. There has been a continuing promotion in practice work of moving items to be prescribed over a 28 day period rather than 56 or 72 days.</p> <p>In relation to level 3 QIPP areas for cost improvement, there has been a reduction of £184,052 in spend with a reduction from £5,082,084 in Q3 2011-12 to £4,898,032 in Q3 2012-13.</p> <p>One area to note is the reduction in spend of statins with a patent expiry having a significant impact in year. Areas for cost improvement will inform work plans in 2013-14.</p> <p>The Committee received the Q3 prescribing report.</p>	
FR14/51	<p>Any other business</p> <p>There was one item of other business.</p> <p>MMcD requested suggestions from GP colleagues on how to utilise potential additional funding. Suggestions included the potential for setting up a walk in centre in Southport, GP/Nurse representation in A & E departments to divert patients to appropriate provision and the CCG assuming management of A & E departments.</p> <p>MMcD requested that colleagues continue to seek innovative solutions to healthcare provision in Southport and Formby.</p>	

No	Item	Action
FR14/52	<p style="text-align: center;">Date and Time of Next meeting Wednesday 21 May 2014 11.00am – 1.00pm Family Life Centre Southport</p>	

Southport and Formby Clinical Commissioning Group

Finance & Resource Committee Minutes

Date: Wednesday 21st May 2014 11.00am – 1.00pm

Venue: Family Life Centre, Ash Street, Southport.

Membership		
Helen Nichols(Chair)	Lay Member (Vice Chair)	HN
Dr Martin Evans	GP Governing Body Member	ME
Roger Pontefract	Lay Member	RP
Colette Riley	Practice Manager	CR
Martin McDowell	Chief Finance Officer	MMD
Debbie Fagan	Chief Nurse	DF
Jan Leonard	Head of CCG Development	JL
Tracey Jeffes	Head of Delivery and Integration	TJ
In attendance		
David Bacon	Interim Deputy Chief Finance Officer	DB
Brendan Prescott	CCG Lead for Medicines Management	BP
James Bradley	Head of Strategic Financial Planning	JB
Becky Williams	Chief Analyst	BW

No	Item	Action
FR14/53	Apologies for absence Apologies for absence were received from Dr Hilal Mulla, Fiona Clark, Malcolm Cunningham, Ken Jones, Fiona Doherty, Karl McCluskey.	
FR14/54	Declarations of interest regarding agenda items The CCG Officers who hold dual roles declared their potential conflict of interest. Martin Evans declared his interest in the proposed prescribing quality scheme.	
FR14/55	Minutes of the previous meeting The minutes of the previous meeting were approved as a true and accurate record.	
FR14/56	Action points from the previous meeting Actions from the previous meeting were closed as appropriate.	

No	Item	Action
FR14/57	<p>Year End Finance Report</p> <p>JB presented the Finance & Resource Committee with an overview of the financial position for Southport and Formby Clinical Commissioning Group for the 2013/14 Financial Year.</p> <p>The committee noted the changes to the financial allocation of the CCG, and the financial performance of the CCG at month 12, reflecting the full 2013/14 financial year. At the end of the 2013/14 financial year, the CCG was £3.684m (Month 11 £3.177m) over-spent prior to the application of reserves.</p> <p>After the application of reserves, the CCG has delivered its target surplus of £1,750k for 2013/14</p> <p>MMcD noted that a key priority for the team is to model the impact of a hypothetical 2% increase in expenditure and the potential CCG response to this.</p> <p>The team will also look ahead to the next financial year, and continue to monitor a number of risks. The committee noted that Southport and Ormskirk Trust are reporting 100,000 new contacts in the community. This information requires validation and analysis.</p> <p>The Committee noted that the Chair will take part in a finance team away day on 9th June 2014.</p> <p>The Committee noted the Year End Finance Report.</p>	
FR14/58	<p>Strategic Financial Plan Update (includes QIPP update).</p> <p>MMcD presented this verbal update and advised the committee that the Finance Team have revisited the planning assumptions and revised the Strategic Financial Plan which will be circulated with the Governing Body papers. A public facing document will be drafted in due course.</p> <p>The Committee noted the verbal Strategic Financial Plan update.</p>	
FR14/59	<p>IFR Update Report</p> <p>MMcD presented this report for information.</p> <p>CSU will provide a full Annual IFR report for the next meeting in June 2014.</p> <p>The Committee noted the content of the IFR Update Report.</p>	TJ
FR14/60	<p>Better Care Fund</p> <p>MMcD noted that the CCG continues to meet with Sefton MBC. The Committee noted that a challenge from HM Treasury to the Department of Health has raised issues of credibility in relation to the plans in general.</p> <p>Going forward there is likely to be a more defined assessment criteria.</p> <p>The Committee noted the verbal update in relation to the Better Care Fund.</p>	

No	Item	Action
FR14/61	<p>Quality Premium Dashboard</p> <p>BW presented this preliminary month 12 report, this is based on locally produced data, however payment will be based on national measures. The indicators show that the payment currently stands at £111,638 Public Health England continue to support the team in trend analysis for some of the indicators.</p> <p>Month 12 end of year report will be available for the June meeting. BW further noted that some indicators were missed by a small margin and in these cases the data will be rechecked.</p> <p>HN requested that thought is given to incentivising the relevant parties to improve performance in some of these areas. JB will review this.</p> <p>The committee noted the content of the Quality Premium Dashboard.</p>	JB
FR14/62	<p>Southport and Formby PMO programme update and exception report – M12</p> <p>BW presented the PMO programme update and noted that all cases for change are on track in relation to milestones.</p> <p>The Committee noted the content of the PMO Programme update.</p>	
FR14/63	<p>Capital Plans and Updates</p> <p>MMcD reported that access to capital is extremely limited. The CCG has a bid lodged with NHS England for consideration in relation to IM&T.</p> <p>The Committee noted the verbal update in relation to capital plans.</p>	
FR14/64	<p>Review of Annual Work plan</p> <p>The Committee reviewed the annual work plan. Any comments in relation to revisions should be sent to Karen Lloyd.</p> <p>The Committee noted the content of the annual work plan.</p>	
FR14/65	<p>GP Framework Report</p> <p>JL presented this summary for the end of the year. The committee noted that this is a legacy issue from the PCT. The scheme had been intended to end on 31 March 2014, however, there was a requirement for this to be extended into quarter 1 of 2014/15.</p> <p>The Committee noted the content of the GP framework report.</p>	
FR14/66	<p>Gateway 1 Cases for Change</p> <p>MMcD presented this verbal report and noted that there were no cases for change to be reviewed at this meeting. The committee noted that the new Service Improvement Review Committee will have the responsibility for review and approval of business cases going forward.</p> <p>The Committee noted the update on review of approval for cases for change.</p>	

No	Item	Action
FR14/67	<p>Area Prescribing Committee recommendations</p> <p>BP presented this report and noted that the Pan Mersey Area Prescribing recommends the commissioning of Aflibercept (Eylea®▼) as a treatment option for treating visual impairment caused by macular oedema secondary to central retinal vein occlusion only by ophthalmologists in accordance with NICE TA305. The annual resource impact for Southport and Formby CCG is circa £2,400</p> <p>The committee approved the Pan Mersey recommendation.</p> <p>It was proposed that going forward the Chief Finance Officer and the Head of Medicines Management would review any recommendations requiring resource of <£5k across the CCG and approve as appropriate bringing a retrospective report to the committee.</p> <p>The committee approved the establishment of a £5k resource impact threshold for future recommendations coming to the committee for approval</p>	
FR14/68	<p>Proposed Prescribing Quality Scheme</p> <p>BP presented this report which provides the committee with the proposed content of the Prescribing Quality Scheme (PQS) for NHS Southport and Formby CCG to help performance manage prescribing across constituent practices.</p> <p>The committee noted that the scheme aims to provide incentives to practices to maintain financial balance and optimise prescribing outcomes across NHS Southport and Formby CCG. In total there are 50 points available under the scheme worth £6,100 for an average sized Southport and Formby practice of 6,100 patients. The maximum pay out under the scheme would be £122,358.</p> <p>The committee reviewed the proposed scheme, the allocation of points and granted approval.</p>	
FR14/68	<p>AOB meeting with external auditors</p> <p>MMcD advised the committee that at an update meeting with the External Auditors he had been assured that the audit was progressing as per plan. There are a number of technical issues in relation to disclosure; however, these are expected to be satisfactorily resolved.</p>	
FR14/69	<p>Date and time of next meeting</p> <p>11.30am Wednesday 18th June 2014 (Please note new start time).</p> <p>Family Life Centre Southport.</p>	

Attendance Tracker

Finance and Resource Committee

Committee Member	May 2014	June 2014	July 2014	September 2014	October 2014	November 2014	January 2015	February 2015	March 2015
Helen Nichols (Chair) Lay Member	Yes								
Dr Martin Evans, GP Board Member	Yes								
Dr Hilal Mulla, GP Board Member	Apols								
Roger Pontefract , Lay Member	Yes								
Paul Ashby Practice Manager	Yes								
Colette Riley Practice Manager	Yes								
Fiona Clark, Chief Officer	Apols								
Martin McDowell, Chief Finance Officer	Yes								
Debbie Fagan Chief Nurse	Yes								
Suzanne Lynch Head of Medicines Management	Apols								
Billie Dodd, Head of CCG Development	Apols								
Tracy Jeffes, Head of CCG Delivery	Yes								
Malcolm Cunningham, Head of CCG Performance & Outcomes	Apols								
Jan Leonard Chief redesign and Commissioning Officer	Yes								

Southport and Formby Clinical Commissioning Group

Finance & Resource Committee Minutes

Date: Wednesday 18 June 2014 11.30am – 1.00pm

Venue: Family Life Centre, Ash Street, Southport.

Attended		
Helen Nichols(Chair)	Lay Member (Vice Chair)	HN
Dr Hilal Mulla	GP Governing Body Member	HM
Colette Riley	Practice Manager	CR
Fiona Clark	Chief Officer	FLC
Martin McDowell	Chief Finance Officer	MMD
Debbie Fagan	Chief Nurse	DF
Jan Leonard	Head of CCG Development	JL
Tracy Jeffes	Head of Delivery and Integration	TJ
In attendance		
David Bacon	Interim Deputy Chief Finance Officer	DB
James Bradley	Head of Strategic Financial Planning	JB
Becky Williams	Chief Analyst	BW

No	Item	Lead
FR14/70	Apologies for absence Apologies for absence were received from Suzanne Lynch, Dr Martin Evans, Roger Pontefract, Paul Ashby, Fiona Doherty, Ken Jones, Karl McCluskey	
FR14/71	Declarations of interest regarding agenda items The CCG Officer who hold joint posts at both NHS Southport and Formby and NHS South Sefton CCGs declared their potential conflicts of interest.	
FR14/72	Minutes of the previous meeting The minutes of the previous meeting were approved as an accurate record pending	
FR14/73	Action points from the previous meeting The action points from the previous meeting were closed as appropriate.	

No	Item	Lead
FR14/74	<p>Finance Reports</p> <p>a) Month 2 Finance Report</p> <p>JB presented the Finance and Resource Committee with an overview of the financial position for NHS Southport and Formby CCG as at Month 2 and outlined the key financial risks facing the CCG. The CCG has sufficient reserves in place to achieve the planned £1.700m surplus at the end of the year.</p> <p>The Resource Allocation of £170.270m is the Allocation currently recorded by NHS England for Southport and Formby CCG. There are a number of adjustments required to this figure which have been agreed in principle with NHS England and will be corrected through allocation transfers in Month 3.</p> <p>JB drew attention to a number of risks and opportunities including:</p> <ul style="list-style-type: none"> • Continuing Healthcare • Overspends on Acute cost per case contracts • Continuing Healthcare restitution claims • Estates • Prescribing and Drug costs. <p>DF noted that the CCG did not have a cap in place on the maximum payment that the CCG will provide going forward and is investigating national model.</p> <p>HM requested that the Finance Team could model the costs associated with CHC going forward. MMcD is investigating national uplift in relation to CHC.</p> <p>HN requested clarification that appropriate funding had been reserved to settle outstanding CHC claims.</p> <p>MMcD noted that appropriate funding had been reserved as per current national guidance.</p> <p>HN requested clarification as to why a lower multiple had been applied to the independent sector as opposed to NHS spend. MMcD responded that this is in response to remodelling of profile.</p> <p>National monies have been announced, CCG has received £900k which has been invested into the Trust. There is currently £450k outstanding to be allocated following consultation.</p> <p>The Finance and Resource Committee noted the contents of the Finance Report, in particular that the CCG remains on target to deliver is financial targets for 2013/14.</p> <p>b) Quarter 4 Contract Performance Report</p> <p>JB presented this report which described the financial performance against contracts in 2013/14 and the operational performance of the main provider, Southport and Ormskirk NHS Trust.</p> <p>JB drew attention to pressures at The Royal Liverpool and Broadgreen Hospital. This has been built into the budget at 2013/14 level.</p> <p>Southport and Ormskirk NHS Trust have had an increase in activity in Month 12 which has resulted in an overspend which has been discussed with the Trust and risks are being monitored.</p> <p>JB further noted that the NWAS contract has a lower contract value this year.</p> <p>MMcD commented that the performance at Southport and Ormskirk Trust appears to be offering a more resilient service.</p> <p>HN requested clarification if the trends reported represented an exposure to the CCG going forward. JB will model this for the next meeting</p>	MMcD

No	Item	Lead
	<p>HN requested clarification if the trends reported represented an exposure to the CCG going forward. JB will model this for the next meeting.</p> <p>The Finance and resource Committee noted the contents of the Quarter 4 Contract Performance Report.</p>	JB
FR14/75	<p>Annual IFR Update Report</p> <p>JL presented the Annual IFR update report from which the committee noted that between March 2013 and April 2014 a total of 97 requests were received. Of these 17 were approved and 72 declined providing a current approval rate of 19%, this figure will be reviewed when the final eight requests have been resolved.</p> <p>JL will discuss potential specialised commissioning issues and signposting of requests with Sally Anne Hunter at CSC.</p> <p>The Finance and Resource Committee noted the content of the Annual IFR Report.</p>	JL
FR14/76	<p>Better Care Fund</p> <p>MMcD presented a verbal update on the Better Care Fund and noted that the CCG is awaiting a criteria based assessment and prescriptive guidance. Initial modelling has begun with the Sefton MBC.</p> <p>The Finance and Resource Committee noted the contents of the verbal update in relation to the Better Care Fund.</p>	

No	Item	Lead
FR14/77	<p>Quality Premium Dashboard</p> <p>BW present the Quality Premium Dashboard Annual Report and advised the committee that the quality premium is intended to reward clinical commissioning groups for improvements in the quality of the services they commission and for associated improvements in health outcomes and reducing inequalities.</p> <p>Based on local data performance for the confirmed indicators for 2013/14 (April 2013 – March 2014), Southport & Formby CCG should receive a payment in Q3 of 2014/15 of £111,638 against a total possible payment (if all indicators were within tolerance) of £595,400. This is due to underperformance in a number of areas which have been described in the previous month's report. However, data is still awaited for two further indicators, which may increase this amount to £279,094 should they be at or below target.</p> <p>The final payment is expected to be received in September 2014.</p> <p>There have been changes to a number of indicators for the 2014/15 financial year, which are also described in this report, and a draft dashboard to display performance. Data to populate the dashboard is expected for the July committee. The Committee noted that the population has increased slightly which will have the potential to increase the achievable payment.</p> <p>FLC will discuss ownership of the indicators at Leadership team.</p> <p>FLC requested that JL investigate if any of the 62 day cancer waits relate to Specialised Commissioning.</p> <p>In relation to the 2014/15 indicator:</p> <ul style="list-style-type: none"> • Years of Life Lost – this is not within the influence of the CCG. • IAPT – New IAPT service will be tendered for 15% prevalence as opposed to the previous 12% prevalence. Having bought out the waiting list last year there is capacity for referral including self-referral. Current waiting times are less than 4 weeks. The CCG is likely to achieve this target. HM will meet with current provider to encourage referral rates. • Avoidable emergency admissions. The Committee noted that this indicator can be influenced by actions in Primary Care. This needs to be reflected to the clinical leads, where possible this data can be investigated at record level. BW noted that data should be available for July 2014 committee and then roll out to localities in August 2014. HM requested clarification in relation to benchmarking the CCG in terms of unplanned admissions. FLC and JL assured HM that elective care is being monitored equally with non-elective. • A & E Attendance and Inpatient experience of hospital care - providers have a standing invitation to EPEG and are offering peer support. JH will have discussions with NHS England (Mersey) to request further resource. • Reporting of medication errors. BP is making enquiries in relation to this. • Local Measure Diabetes Care – CCG should be able to achieve this. • 14 day cancer referral – FLC will review issue with network. MMCD suggested that at the first sign of risk this should be submitted as an escalated contract query. • Ambulance response times – same measure as last year. <p>The Finance and Resource Committee noted the content of the Quality Premium Dashboard.</p>	<p>FLC JL</p> <p>JH</p> <p>BP/SL</p> <p>FLC</p>

No	Item	Lead
FR14/78	<p>Southport and Formby PMO programme update and exception report – Annual Report</p> <p>BW presented the Southport and Formby PMO programme update and exception report and reminded the committee that these programmes are being measured against the 2013/14 objectives as per the original business cases.</p> <p>All cases for change are on track in relation to original milestones, waiting times have been reduced and diversions from secondary care as appropriate have been achieved.</p> <p>The Finance and Resource Committee noted the contents of the Southport and Formby PMO programme update and exception report – annual report.</p>	
FR14/79	<p>Any Other Business</p> <p>There were four items of other business</p> <ol style="list-style-type: none"> 1. Annual Accounts and Report MMcD noted that The Annual Report and Accounts have been approved by the Audit Committee and have been uploaded to the intranet/internet. PWC have supplied an unqualified audit opinion. 2. Towards Excellence Quality Standard MMcD noted that the Finance Team are working towards the Towards Excellence Quality Standard and as part of this have attended their 2nd Team away day following which 3 key projects have emerged. <ul style="list-style-type: none"> • Improved financial awareness - Finance Training for Non-finance professionals. This has been project planned and will be brought to July meeting. • Production of Accounting Instruction Manual • Improved Information and reporting for external customers. 3. MMcD noted that this was David Bacon's final meeting prior to leaving and thanked him for his work and his support of the team and the committee. The Committee added their thanks and good wishes. 4. HN noted the potential requirement to move the Finance and Resource Committee meeting to 9.30am. JL will canvass GP availability. 	
FR14/80	<p>Date, Time and Venue of Next Meeting.</p> <p>Wednesday 23rd July 2014 11.30am – 1.30pm Family Life Centre Southport.</p>	

Merseyside CCG Network

Wednesday, 7 May 2014, 13.00 to 16.00 (lunch available from 12.30)
Meeting, Boardroom, Third Floor, Merton House, Bootle L20 3DL

Minutes

Present

Dr Rob Caudwell	Chair, S&FCCG
Dr Clive Shaw	Chair, SSCCG
Fiona Clark	CO, S&FCCG/SSCCG
Jan Snoddon	obo Simon Banks
Dr Nadim Fazlani	Chair, LCCG
Martin McDowell	CFO, S&FCCG/SS CCG
Tom Jackson	CFO, LCCG
Paul Brickwood	CFO, KCCG
Phil Thomas	obo Dianne Johnson
Dr John Caine	Chair, WLCCG
Dr Andy Pryce	Chair, KCCG

Apologies

Katherine Sheerin	CO, LCCG
Simon Banks	CO, HCCG
Mike Maguire	CO, WLCCG
Dr Steve Cox	CCO, StHCCG
Dianne Johnson	CO, KCCG
Sarah Johnson	Deputy CO, StHCCG
Paul Kingan	CFO, WLCCG
Dr Cliff Richards	Chair, HCCG
John Wicks	Interim CO, WCCG

In attendance

Clare Duggan	NHS England
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Minutes

Melanie Wright	SSCCG/S&FCCG
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No	Item	Action
14/46.	Welcome & Introductions were made.	
14/47.	<p>Strategic Planning</p> <p>The strategic session on 14 May will consider interdependencies across the system (in place of the Co-Commissioning Collaborative meeting).</p> <p><i>Specialised Commissioning</i> - it is hoped that key strategic aims will be available by the 20 June deadline for submission of 5-year plans, but it was acknowledged that these will still require further development at this time.</p> <p>The purpose at this point is to develop an understanding of the direction of travel for organisations, acknowledging that a high level of detail will not be available at that point. It will, however, enable some examination of possible avoidable outcomes.</p>	

No	Item	Action
	<p>Mrs Duggan described the methods utilised by The Boston Group when considering Specialised Commissioning. The task and finish session for Specialised Commissioning will take place on 27 May and a communication on this will follow shortly.</p> <p>Mrs Duggan also sought representation from each CCG to consider the options for a Major Trauma service in Cheshire and Merseyside, the time commitment is likely to be a meeting per month and the dates will follow. CCGs agreed to advise Mrs Duggan of representatives.</p> <p>It was agreed that providers would be invited to the July Co-Commissioning Collaborative.</p> <p>CCGs to provide a schedule of key dates to NHSE for future planning.</p> <p>There was a discussion around 4-hour targets for A&E and the Women's Hospital and it was agreed that Fiona Lemmens could pick this up at the Urgent Care Tripartite.</p>	<p>CCGs</p> <p>MW</p> <p>CCGs</p> <p>LCCG</p>
14/48.	<p>Recent Changes to the Area Team</p> <p>John Lawlor and Andy Buck, Area Team Directors, have resigned from Cumbria and Moira Dumma will take over in West Yorkshire. Alison Tonge will now act up into Moira's previous role. Gaynor Hales is supporting a piece of work to understand Specialised Commissioning. Further, Sue Page has taken over the role of Acting CEO to LCH, with the support by secondment of Johanna Reilly. The environment across NHSE is one of help and support to colleagues.</p>	
14/49.	<p>Assurance</p> <p>Mrs Duggan wanted the focus to move to joint collaborative work and delivery.</p>	
14/50.	<p>Annual Reporting Mechanisms</p> <p>To be considered at the session on 14 May.</p>	
14/51.	<p>Five Year Plan</p> <p>Discussed above.</p>	
14/52.	<p>Apologies for Absence were received.</p>	
14/53.	<p>Minutes from the previous meeting</p> <p>The Minutes were agreed as an accurate record.</p>	
14/54.	<p>Actions from the previous meeting</p> <p>Dr Liz Mears to be invited to respond/attend for the next meeting.</p> <p>CLARC – Katherine Sheerin to be invited to update the meeting,</p> <p>14/33 Dr Fazlani advised as to a meeting that took place last week with the Women's Hospital, together with LCCG and NHSE. The issues are one of finance around tariff and following the publication of the Royal College of Obs and Gynae framework, it has been identified that the hospital is an outlier in terms of outcomes which may impact upon service delivery. A public consultation will be necessary and will require tie-in with the Healthy Liverpool programme.</p> <p>There is a meeting to develop a Clinical Reference Group and terms of reference will be agreed on 23 May.</p> <p>It was acknowledged that there will be other outliers on the patch.</p>	<p>MW</p> <p>MW</p>

No	Item	Action
	<p>The two major risks for the Women's was the paucity of the tariff and the CNST and claims around a previous consultant. NHSLA have deferred the premium for CNST until next year, but this is unlikely to solve the problem in the longer term.</p>	
14/55.	<p>EPRR Update</p> <p><i>Surviving Public Enquiries</i> – all on-call staff are invited to attend, CCGs to proffer representation. This is required by on-call staff as per the NHSE guidance.</p> <p><i>Generic email addresses</i> – ratification given from CCGs. Emails will then be received by all staff who participate in the on-call service.</p> <p><i>Hillsborough Report</i> – from an EPRR perspective, is primary aimed at Safety Advisory Groups, which fall within the remit of NWAS. Ian Davies was due to respond to the LHRP on behalf of CCGs, ensuring that all providers are engaged in the process. Mr Booth agreed to chase Mr Davies for a progress report.</p> <p>Ms Clark asked whether the CCGs were clear what would happen should such an event happen again. Mr Booth advised Safety Advisory Groups are much more active now and how organisations feed in. The major football clubs in Liverpool also have Safety Advisory Groups.</p> <p>Mrs Snoddon asked whether the Creamfields event in Halton was covered as part of this; Mr Booth confirmed that it was and the Police had developed robust schemes in response thereto.</p> <p><i>Exercise Palladin</i> – a list of recommendations has been produced and NHSE/Public Health England will work through these. CSU will attend and understand expectations. A task and finish group will consider emergency communications issues. CCGs' participation in exercises is sought. Mr Booth to write with this request.</p> <p><i>Pandemic Flu Planning Group</i> – there is a discussion about whether providers' contracts need to be more detailed about actions in the event of a pandemic, although there is an argument about the level of detail to be included in the service description.</p> <p>Mr Booth asked CCGs to consider the kind of support required from CSU in relation to Emergency Planning generally. It was agreed that Mr Booth would write to the CCGs formally to generate this conversation. Mr Thomas agreed to raise this with Dianne Johnson.</p> <p><i>Resilience Direct</i> – organisations may express an interest in becoming part of Resilience Direct to access emergency planning documentation on a national basis and it is likely to become a tool for emergency planning. Mr Booth agreed to contact Dianne Johnson with a view to progressing this,</p> <p><i>Pandemic Flu Plans</i> – Mr Booth is in the process of reviewing these and will revert to organisations in due course.</p> <p><i>Business Continuity</i> – an annual review of plans for individual CCGs will be required. Mr Booth will send dates to CCGs to commence this process.</p>	<p>CCGs</p> <p>RB</p> <p>RB</p> <p>RB PT</p> <p>RB</p> <p>RB</p>
14/56.	<p>NWAS Reconfiguration and Service Reviews</p> <p>CCGs are asked to review from a Merseyside perspective and provide any comments to Simon Banks.</p>	CCGs
14/57.	Footprints for Urgent Care Networks	

No	Item	Action
	<p>Ms Clark drew the meeting's attention to John Wicks' recent communication (Warrington CCG) as CCG representative on the National Urgent Care Networks. It was felt that the local Urgent Care Networks are the proper venue for this discussion, however, Mr Thomas noted that these networks were not decision-making bodies.</p> <p>The group noted the principle and were happy for Urgent Care Networks to deal with this on behalf of the CCG Network.</p>	
14/58.	<p>Hillsborough Report</p> <p>Discussed under 14/55 above.</p>	
14/59.	<p>Maternity Network – Update</p> <p>Discussed under 14/54 above.</p>	
14/60.	<p>Any Other Business</p> <p>There was a general discussion around the CSU contract, which has not progressed any further.</p> <p>There was also a discussion on Primary Care Commissioning and Specialised Commissioning and the forthcoming deadline for expression of interest by CCGs of 20 June was noted.</p>	
14/61.	<p>Date of Next Meeting</p> <p>Wednesday, 4 June 2014, Boardroom, Merton House</p>	

HEALTH AND WELLBEING BOARD

**MEETING HELD AT THE TOWN HALL, BOOTLE
ON WEDNESDAY 18TH JUNE, 2014**

PRESENT: Councillor Ian Moncur (in the Chair)
Dr. Janet Atherton, Dr. Rob Caudwell, Fiona Clark,
Councillor Paul Cummins, Dwayne Johnson,
Councillor John Joseph Kelly, Maureen Kelly,
Colin Pettigrew and Dr. Clive Shaw

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr. Niall Leonard, Peter Morgan and Phil Wadson.

2. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the Minutes of the meeting held on 19 March 2014 be confirmed as a correct record.

3. DECLARATIONS OF INTEREST

No declarations of pecuniary interest were received.

**4. CONSOLIDATED CLINICAL COMMISSIONING GROUPS
STRUCTURES AND UPDATE**

The Board received a presentation "Driving Strategy into Delivery" from Fiona Clark, Chief Officer for South Sefton Clinical Commissioning Group (CCG) and Southport and Formby Clinical Commissioning Group that updated on the Consolidated Clinical Commissioning Groups Structures. The presentation provided information on the following:-

- The three strategic priorities of frail elderly, unplanned care and primary care transformation
- The strategic plan engagement relating to additional programme areas, adult and children mental health services review, the Better Care Fund, the Community Services Review and enhanced primary care
- The organisational structures of the wider constituent CCG and the Medicines Management Team
- The accountability and performance structures of the Southport and Formby and South Sefton CCG's
- The roles and responsibilities of the Southport and Formby and South Sefton CCG governing bodies and clinical leads/locality lead GPs

RESOLVED:

That Fiona Clark be thanked for her informative presentation.

5. REFRESH OF THE HEALTH AND WELLBEING STRATEGY AND SEFTON STRATEGIC NEEDS ASSESSMENT

The Board considered the report of the Head of Business Intelligence and Performance seeking the Board's views and agreement regarding:-

- the process and timetable for refreshing the Sefton Health and Wellbeing Strategy and the Sefton Strategic Needs Assessment as outlined in the report;
- the draft Strategy and high level Needs Assessment, attached to the report; and
- the Better Care Fund Plan.

The report set out the background to the matter together with details of the Sefton Health and Wellbeing Strategy 2013 – 2018; the Sefton Strategic Needs Assessment (SSNA); the context of the review of the Health and Wellbeing Strategy; the Better Care Fund Plan; the Annual Review Process undertaken; inter-connectivity to other Strategies and Plans; the Outcomes Framework and Performance Dashboard; and conclusions reached.

Copies of the revised Health and Wellbeing Strategy 2014-20, Better Care Plan for Sefton and the Sefton Strategic Needs Assessment 2014/15 High Level Summary were attached to the report.

RESOLVED: That

- (1) the draft iteration of the Health and Wellbeing Strategy, as attached to the report, be approved and that further refinement take place over coming months, with a view to the Strategy being resubmitted to the Board in September 2014 and progressed to the Cabinet and Council and Clinical Commissioning Group (CCG) Governing Bodies in the Autumn of 2014;
- (2) the content of the report and the context within which the refresh of the Strategy and the Strategic Needs Assessment is taking place, as described in the report, be noted;
- (3) the process for further refreshing the Strategy and Strategic Needs Assessment, as described in the report, be endorsed and the full review of the Sefton Strategic Needs Assessment be published in 2014;
- (4) the Celebration Event planned to take place in July 2014 be noted and the publication of an annual report alongside the final version of the next iteration of the Health and Wellbeing Strategy be agreed;

- (5) the work being undertaken in developing a performance dashboard be endorsed and that this be discussed at the development workshop for the Health and Wellbeing Board in June 2014;
- (6) the second iteration of the Better Care Fund Plan, as attached to the report, be endorsed, the progress in developing a one year integrated transition plan be noted, and that further work on this be progressed by the Board at its development workshop in June, 2014;
- (7) subject to work progressing over the next two months through the Forums and Task Groups, the Cabinet and the Council, and the CCG Governing Bodies be recommended to agree that the Strategy becomes the overarching strategic outcomes framework for the Borough, to replace any previous versions of the Sustainable Community Strategy; and
- (8) the Council's Overview and Scrutiny Committees be requested to add the Health and Wellbeing Strategy and the Sefton Strategic Needs Assessment to their future work programmes once the documents are developed further over the coming months.

6. SEFTON PHARMACEUTICAL NEEDS ASSESSMENT

The Board considered the report of the Chief Officer for South Sefton Clinical Commissioning Group and Southport and Formby Clinical Commissioning Group summarising the findings of the Sefton Pharmaceutical Need Assessment (PNA) steering group's identification of changes to pharmaceutical services and changes in needs for pharmaceutical services since the publication of the last PNA in 2011. The report also proposed undertaking a revised assessment and publishing a supplementary statement.

The report set out the background to the matter; recent changes in pharmaceutical provision within Sefton; changes in need for pharmaceutical services within Sefton due to housing developments; changes in pharmaceutical and locally commissioned services delivered; and conclusions reached and recommendations made.

RESOLVED: That

- (1) a revised assessment is not required prior to publication of the next Sefton Pharmaceutical Needs Assessment (PNA), due by 1st April 2015; and
- (2) a Supplementary Statement be issued and uploaded to the Council website detailing changes in pharmacies and opening hours.

South Locality Meeting Minutes

Date and Time - Thursday, 24th April 2014, 12:30 – 13:30

Location - Ainsdale Village Surgery

Attendees

Dr Robert Russell (Chair) (RR)	Ainsdale Medical Centre
Paul Ashby (PA)	Practice Manager, Ainsdale Medical Centre
Sharon Forrester (SF)	Central Locality Manager
Anne Lucy (AL)	Locality Development Support
Rob Russell (RR)	GP, Ainsdale Medical Centre
Paul Smith (PS)	GP, Ainsdale Village Surgery
Nina Price (NP)	Practice Manager, Grange Surgery
Dr Ian Kilshaw (IK)	GP, The Grange Surgery
Dr Gladys Gana (GG)	GP, Lincoln House Surgery
Janice Lloyd (JL)	Practice Manager, Lincoln House Surgery
Kay Walsh (KW)	Medicines Management
Rachel Ogden (RO)	Practice Nurse, Ainsdale Village Surgery
Karen Ridehalgh (KR)	Practice Manager, Ainsdale Village Surgery
Dr Kebsi Naidoo (KN)	GP, The Family Surgery

Apologies

Carol Roberts (CR)	Practice Manager, The Family Surgery
Jane Uglow (JU)	South Locality Manager
Becky Williams (BW)	Public Health & Prescribing Analyst

Minutes

Sadie Rose (SR)	Administrator
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Southport and Formby Clinical Commissioning Group

No	Item	Action	Supporting Documents
	<p>patients. The CCG has £3 per head associated with the Primary Care Quality Strategy. In addition, the planning guidance issued by NHS England identified the need for CCGs to make available, on a recurrent basis, an additional £5 per head to support vulnerable people and reduce A&E attendances and emergency admissions. This is additional funding. SF informed the group of 2 meetings due to be held in May to communicate with all constituency members. The information for the meetings will be circulated as soon as confirmation is received. The intention of the meeting is to re-visit Primary Care Quality Strategy Money, discuss finances and discuss quality elements (e.g. opt in/opt out). The intention is to be signed up by the end of June to be ready for the 1st July.</p> <p>Action- SF to provide a breakdown of the different monies/budgets to clarify any confusion.</p>	SF	
14/29	<p>Finance and performance Quality Premium Dashboard report</p> <p>Due to apologies from BW this item on the agenda was not discussed. Subsequent to the meeting BW circulated the Quality Premium Dashboard report which has just been published (see supporting document).</p> <p>Action- Any questions regarding the report to contact BW directly.</p>	ALL	 Southport Formby April 2014 Quality P
14/30	<p>Medicines Management</p> <p><u>Prescribing Finance Report</u> KW advised that as at Month 10, all practices in the locality are overspent with the exception of Lincoln House. As stated previously, work is ongoing with Finance to look at a number of issues around budgets and there is still a realistic expectation that the 13-14 Prescribing Quality Scheme (PQS) will make payments.</p> <p><u>Co-amoxiclav Audit for 13-14 PQS</u> KW has reported back that all practices in the locality have achieved the target and that details are documented in the March locality minutes.</p> <p><u>14-15 PQS</u> KW advised that this is being finalised and is due for signing off at the Joint Medicines Operational Group (JMOG) on Friday, subject to any comments from the JMOG. KW has fed back re potential disparity between practice workloads around the proposed antimicrobials in Nursing Homes audit and the wording</p>		

Southport and Formby Clinical Commissioning Group

No	Item	Action	Supporting Documents
	<p>should be on it's way.</p> <p>The group discussed how this is more than unplanned admissions, and is more a holistic approach focusing on quality of life. SF added that the project is going to be as successful as clinicians make it.</p> <p><u>Housebound</u> Jane Uglow circulated an email prior to the meeting with considerations for the housebound scheme:</p> <ul style="list-style-type: none"> • Scope of service- Initially should all housebound patients receive an annual check and have a care plan put in place. What will annual check cover? • Skill mix required to deliver service- Practice nurse/prescribing nurse, meds management undertake medication review, GP input • Operational Issues- The locality will need to nominate/agree a practice to deliver the service on behalf of the other practices, the nominated practice will employ the associated skill-mix. With regard to the practice operational issues, we should be able to learn from the Formby locality in relation to their home visiting scheme on how best we may approach some of these issues. <p>The group noted that the housebound scheme was suggested in a locality meeting by one person, and they weren't aware of it being officially stamped. Jane Uglow had simply circulated the above list of questions for the group's consideration. The group also debated about this already being done in QOF and going around in circles when the funding could be used elsewhere. It was also noted about the difficulty around defining what constitutes as housebound.</p>	ALL	
14/33	<p>Any other business</p> <p><u>Plain film x-rays</u> Following a team meeting, SF was asked by Collette Page to ask around practices to see if anyone has noticed any improvements in reporting times in plain film x-rays. This received a mixed response for the group, some noting no improvements at all and still being generally disappointed with the service. One practice recently noticed a speedier x-ray referral turnover. Some other practices have noticed minor improvements but perhaps it is too early to tell.</p> <p><u>Potassium samples</u> An issue was brought up about the collection of potassium</p>	ALL	

Southport and Formby Clinical Commissioning Group

No	Item	Action	Supporting Documents
	<p>samples. There have been occurrences where samples have been done at 08:30 and have only been collected at 15:50. This breaches the 4-hour guidance time. The lab manager has been informed and been asked to readdress this. The manager admitted that it was a transport issue, as there is no funding available for extra transport. This has now been raised and is being looked into further.</p> <p><u>HCA Apprentice scheme</u> SF discussed the HCA apprentice scheme to see if any practices are interested. It is a 12 month education apprentice designed for HCAs. The CCG will pay for half of cost of HCA training. Action- SF to circulate details to practices.</p> <p><u>In-house spirometry training scheme</u> SF outlined a new in-house training scheme for practice nurses in spirometry as this was identified as an area that required more training. Details to follow. Action- SF to circulate details when they are confirmed.</p>	<p>SF</p> <p>SF</p>	
14/34	<p>Date and Venue for Next Meeting:</p> <p>Thursday 22nd May 2014, 12.30- 13.30, Ainsdale Village Surgery</p>		

South Locality Meeting Minutes

Date and Time: Thursday 22nd May 2014, 12:30 – 13:30
Location: Ainsdale Village Surgery

Attendees

Dr Robert Russell (RR)	(Chair) GP, Ainsdale Medical Centre
Paul Ashby (PA)	Practice Manager, Ainsdale Medical Centre
Jane Uglow (JU)	South Locality Manager, S&F CCG
Dr Paul Smith (PS)	GP, Ainsdale Village Surgery
Dr Gladys Gana (GG)	GP, Lincoln House Surgery
Dr Ian Kilshaw (IK)	GP, The Grange Surgery
Kay Walsh (KW)	Medicines Management
Dr Kebsi Naidoo (KN)	GP, Family Surgery
Carol Roberts	Practice Manager, Family Surgery

In attendance

Apologies

Nina Price (NP)	Practice Manager, The Grange Surgery
Rachael Ogden (RO)	Practice Nurse, Ainsdale Village Surgery
Karen Ridehalgh (KR)	Practice Manager, Ainsdale Village Surgery
Janice Lloyd (JL)	Practice Manager, Lincoln House Surgery
Penny Bailey (PB)	District Nurse Team Leader
Rob Caudwell (RC)	Chair, Southport & Formby CCG

Minutes

Sadie Rose (SR)	Administrator
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Southport and Formby Clinical Commissioning Group

Attendance Tracker

- ✓ Present
- A Apologies
- L Late or left early

Name	Practice / Organisation	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Dr G Gana	Lincoln House Surgery	✓		✓	✓	A	A	✓	✓	✓			
Dr I Kilshaw	The Grange Surgery	✓		✓	✓	✓	✓	✓	✓	✓			
Dr K Naidoo	The Family Surgery	✓		✓	✓	A	✓	✓	✓	✓			
Dr R Russell	Ainsdale Medical Centre	A		✓	✓	✓	✓	✓	✓	✓			
Dr S Bennett	Ainsdale Medical Centre	✓											
Dr P Smith	Ainsdale Village Surgery	✓		✓	✓	✓	✓	✓	✓	✓			

Southport and Formby Clinical Commissioning Group

No	Item	Action
14/35	<p>Apologies/Minutes</p> <p>The minutes from the previous meeting were agreed as an accurate record. KW noted an inaccuracy in the job title of Becky Williams on the front sheet of the previous minutes. Action: SR to amend accordingly.</p> <p>Apologies were noted for Nina Price, Karen Ridehalgh, Janice Lloyd, Rob Caudwell, Penny Bailey and Rachael Ogden. See attendance sheet below:</p> <div style="text-align: center;">  Attendance Sheet.pdf </div>	SR
14/36	<p>Matters Arising</p> <p>The group went through the matters arising from the previous meeting:</p> <p>Refer to 14/27- The practices that have not yet had meetings have been given dates.</p> <p>Refer to 14/28- RR emailed Joe Chattin re clarification on financial data (PMS and GMS baseline figures). RR is still awaiting a reply and will email group once reply is received.</p> <p>Refer to 14/31- Moira McGuinness has informed JU of a potential joint federation event to take place on 18th June. This is still to be confirmed.</p>	
14/37	<p>Chair's Update</p> <p>RR circulated the letters re the North's locality development budget expenditure. RR received a response from Dr Scholts and thanked her for her reply. The board have now noted the issue and have assured the same mistake won't happen again.</p> <p>RR attended the locality GP leads meeting on Tuesday 20th. The topics discussed were shared with the group:</p> <ul style="list-style-type: none"> • Agenda template- A generic agenda template is in the process of being created to ensure everything is covered at locality meetings. One of the localities have requested for medicines management to be reported on a quarterly basis. RR expressed how he is happy with medicines management attending on a monthly basis and feels it is useful. One of the risks involved with reporting quarterly is that there could be a build-up of information and also data could be out of date. RR also spoke about addressing AOB at the start of each locality meeting in order to prevent them becoming too lengthy. JU asked the group how soon they want to receive the papers before the meeting. The group agreed a week before the meeting would be sufficient. • Duties of locality leads/members- RR explained how this was one of the discussions at the locality leads meeting. It was discussed how locality meetings should be 2 hours minimum, however RR made the point of saying that it is quality not quantity. Locality leads are going to be required to attend locality lead meetings 	

Southport and Formby Clinical Commissioning Group

No	Item	Action
	<p>bi monthly and board meetings bi-monthly.</p> <ul style="list-style-type: none"> • Acute Visiting Service- The proposal of an Acute Visiting Service was discussed as a combined locality investment. There was also a suggestion from St Marks regarding the employment of medicines management technicians who perform medication reviews. It could be worth looking into this. • Statutory duties of localities- It was discussed that there are certain statutory duties for localities to look at certain issues in meetings (Quality, Finance, Performance etc.) 	
14/38	<p>Locality Development 2014/15</p> <p>JU spoke about a former email that came from James Bradley detailing the different funding streams available for 14/15. The group requested more clarification on this, so JU provided the following breakdown:</p> <p><u>Winter pressures</u> The CCG have winter pressure monies of £320K. £120K has already been invested into winter schemes that were seen as successful last year. This includes the CERT team (community emergency response team) which manages a range of community beds (both step up and step down) in local care homes. £200K still remains uncommitted and available for this coming winter. JU advised the group to start thinking about ideas for how to invest the money. This could be either as an individual practice or collectively as a locality.</p> <p>Separate to this, the CCG has invested in an Assisted Discharge Scheme; this is an 18 month scheme being run between the British Red Cross and the CCG. The scheme is focused on the transport and support of frail elderly back to their home. It has been noted that the scheme works particularly well in Blackpool, and the first planning meeting is scheduled for 17th June.</p> <p><u>Primary Care Quality/Vulnerable Patients</u> This has been invested in local quality contract- confirmed.</p> <p><u>Quality Premium Dashboard</u> This is uncommitted at present. Localities can put ideas forward on how the money should be invested. The amount currently stands at £112K but there is a chance this figure could change.</p> <p>JU summarised by advising the group to consider the locality development budget of £50K, Winter pressure (individual practice or collective) and Quality Premium. Group to have a think about ideas on how to invest these budgets.</p> <p>Two suggestions put forward regarding supporting the housebound patients and ensuring care plans are fully implemented for the over 75s. It was considered additional community matron may help to deliver this and support the broader agenda of reducing unplanned admissions. It was agreed the outcomes would need to be very clear, and if delivered well it could be an identification of an additional investment. Nonetheless, more consideration needed around this. Action: JU to work with both Dr Naidoo and Dr Smith to develop the ideas further.</p>	JU/PS/ KN
14/39	<p>Locality Development 2013/14 Connecting Communities</p>	

Southport and Formby Clinical Commissioning Group

No	Item	Action
	<p>The Connected Communities project is a scheme the locality commissioned out of last years locality monies 13/14, and will run for the next 12 months. JU expressed how she is impressed with those involved in the scheme, and they have visited all practices. So far they have taken 5 referrals in total and the next stage is to get district nurses involved in the referral process. JU circulated a case study from the Connected Communities project to highlight the benefit of the programme. See below:</p> <div style="text-align: center;">  Case Study - Mr.G.DOCX </div>	
14/40	<p>Medicines Management</p> <p>KW provided an update on medicines management as follows:</p> <p><u>Prescribing Finance Report</u> KW advised that as at Month 11, the situation remains the same with all practices in the locality overspent with the exception of Lincoln House. Work still ongoing with Finance re a number of issues around the budgets.</p> <p><u>Ivabradine</u> JMOG have approved a request from the specialist Heart Failure nurses team allowing them to initiate ivabradine, in line with NICE guidance and following discussion with the cardiologist. Ivabradine is approved by NICE as an option in appropriate patients in sinus rhythm with HR of 75 or higher, in combination with beta-blockers, ACE inhibitors and aldosterone antagonists or as an alternative to a beta-blocker where it is contraindicated or not tolerated. Full details on ivabradine for this indication are available on the Pan Mersey APC website.</p> <p><u>NHS England Safety Alert re Homecare Providers</u> If practices receive any patient queries regarding the delivery of Metoject from Healthcare at Home, please speak to practice pharmacist.</p> <p><u>Medicines Optimisation Plan for 2014-2015</u> This has now been signed off and practice pharmacists will be arranging meetings to discuss.</p> <p><u>MHRA Alert re Domperidone</u> Noted that practices have seen this.</p> <p>IK asked KW if the Sefton prescriber could go back to being emailed out. Currently everything gets set out in communication bulletin. Action: JU to feed back to CCG communications team.</p>	JU
14/41	<p>Federation Working</p> <p>This item on the agenda wasn't discussed due to it being discussed in depth at the last meeting. Moira McGuinness to confirm details of a federation working event to be held on 18th June.</p>	

**Southport and Formby
Clinical Commissioning Group**

No	Item	Action
14/43	AOB No other business was discussed.	
14/44	Date and Venue for Next Meeting: Thursday, 23 rd July, 12.30- 13.30, Ainsdale Village Surgery	

Formby Locality Meeting Minutes

Date and Time: Thursday 10th April 2014, 12:30- 14:00

Location: The Village Surgery

Attendees

Doug Callow	(Chair), GP – Chapel Lane
Moira McGuinness	Southport & Formby CCG Locality Lead
Sue Lowe	Practice Manager – The Village Surgery
Lisa Roberts	Practice Manager- Freshfield Surgery
Sarah Lindsay	GP - Freshfield Surgery
David Mortimer	GP – The Village Surgery
Tim Quinlan	GP- Chapel Lane Surgery
Susanne Lynch	Medicines Management
Collette Riley	Practice Manager – The Hollies
Stewart Eden	Practice Manager – Chapel Lane
Janice Eldridge	GP - The Hollies
Anne Lucy	Locality Development Support

In attendance

Becky Williams	Sefton CCG
James Bradley	Sefton CCG

Apologies

None

Minutes

Sadie Rose	Administrator
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Attendance Tracker

- ✓ Present
- A Apologies
- L Late or left early

Name	Practice / Organisation	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14		
Dr Doug Callow	Chapel Lane Surgery	A	✓	✓	✓	✓		✓	✓		
Dr C Bolton	The Village Surgery	A	✓					✓			
Dr J Reddington	The Village Surgery	✓	A	✓							
Dr J Eldridge	The Hollies	A	✓	✓	L	✓		✓	✓		
Dr D Sumner	The Hollies	✓	✓	✓	✓	✓		✓			
Dr T Brettel	Freshfield Surgery			A							
Dr S Johnson	The Village Surgery				✓						
Dr L Grant	The Village Surgery				L	✓					
Dr S Lindsay	Freshfield Surgery								✓		
Dr D Mortimer	The Village Surgery								✓		
Dr T Quinlan	Chapel Lane Surgery								✓		

Southport and Formby Clinical Commissioning Group

No	Item	Action
	<p>already examining the options for federation, the group also noted the following factors that need to be examined:</p> <ul style="list-style-type: none"> • The importance of getting the right balance: being able to share significant skills while still maintaining identity. • Size of federation vs spending power: too big risks losing out in the locality. However, the bigger the federation, the bigger the purchasing power. • Focus needs to be on delivery • Action needed to secure funding • Appropriate start time for federation <p>It was agreed to think about federation later, as it will happen in time. The current focus needs to be on delivering care properly. Federation requires starting small to reach bigger targets.</p> <p>Action – DC to consider specifications to be developed that would be beneficial.</p> <p>Action – MM to organise an event to discuss federation (including Ainsdale, Birkdale and other interested localities).</p> <p>Action – Group to list activities that federation could provide services for (e.g. Saturday morning health checks).</p>	ALL
14/22	<p>Care Home Project</p> <p>DM provided the group with an update on the care home project. The following points were discussed:</p> <ul style="list-style-type: none"> • The workload and objectives expected of the project exceed current allocated timeframe. For a 12 month pilot, it has ended up being bigger than originally anticipated. • In order to be able to prioritise the workload, DM devised a new approach whereby 2 homes were focussed on at one time with fewer patients. Although this is only a short term measure to deal with the workload, resource for the pilot requires a comprehensive review. • DM uses sessions to gather data opportunistically and sees several patients/relatives as and when they are available. Although fragmented, this approach is more efficient. • Crib sheet prompts next tasks/data to collect. • Requires a standard recognizable format which would create continuity. • Benefits will be difficult to realise within short timescale. There are long term benefits but it requires more time. • Assessment- group effort required to meet pilot objectives by developing business case. • Administrative support needs providing to free up GP time for patients. • Group discussed the productively of the pilot as GPs were still getting calls from nursing home. 	

Southport and Formby Clinical Commissioning Group

No	Item	Action
	<ul style="list-style-type: none"> • DC praised DM for the work he has done, but proposed that this is a team effort and requires a much bigger team. • TQ discussed a concern with Halcyon House. The home rang for an ambulance after being advised by Go to Doc. On checking this Go To Doc advised to still ring ambulance. MM to chase this up. <p>Action – DC to scale up pilot by developing business case and focusing on house bound visiting service and acute visiting scheme.</p> <p>Action – DC to link with PMO (Becky Williams) to look at how better to process information.</p>	<p>MM, DM, BW, DC, TQ</p>
14/23	<p>Medicines Management</p> <p>SL discussed the prescribing budget with particular attention to the forecast overspend. Reassurance was given that medicines management are working closely with the finance team to make budget adjustments based on anti-dementia prescribing, personally administered drugs and looking at significant changes in practice list sizes within the year.</p> <p>The prescribing quality scheme co amoxiclav peer review area of work was discussed. Practice pharmacists from each GP practice had provided the final audit results to compare against the target of 70% of co amoxiclav prescribing being in line with guidance set by the locality at the beginning of the year.</p> <ul style="list-style-type: none"> • Chapel Lane- co amoxiclav prescribing was 84% in line with guidance • The Hollies- co amoxiclav prescribing was 75% in line with guidance • Freshfield- co amoxiclav prescribing 5.5% in line with guidance (with no reduction in overall items) • Formby Village- co amoxiclav prescribing 32% in line with guidance (however due to a clinician from Formby Village Surgery not being present when the figures were discussed during the locality meeting, it has been arranged for the practice pharmacist to discuss Formby Village's results with their clinicians before final submission to medicines management regarding payment for PQS) <p>Action – SL to update locality next month about Formby Village Surgery results.</p>	<p>SL</p>
14/24	<p>Locality Chair- agreement</p> <p>Doug - Board</p> <p>Collette- PM Board Rep</p> <p>New chair of locality group required. Let MM know nominations (needs to be a GP).</p>	<p>ALL</p>

Southport and Formby Clinical Commissioning Group

No	Item	Action
14/25	<p>AOB</p> <ul style="list-style-type: none"> • Feedback for £50K spend – MM advised that the locality needs to work together to come up with an idea about how to the £50K should be spent, instead of waiting until December. The £50K is not recurrent and is in the form of a one-off payment. Action: MM to email group with ideas for consideration. • Locum Attendance Payment- Query from GP at Freshfields surgery regarding payment of attendance for locum doctors at meetings. Action: MM to clarify locum attendance payment at locality meetings. 	ALL
14/26	<p>Date of next meeting 15th May 2014 12.30- 14.00 Formby Village Surgery</p>	

Formby Locality Meeting Minutes

Date and Time: Thursday 15 May April 2014, 12:30- 14:00

Location: The Village Surgery

Attendees

Yvonne Sturdy	Nurse Practitioner (The Village Surgery)
Maria Coyne	Medicines Management
Moira McGuinness	Southport & Formby CCG Locality Development Manager
Susanne Lynch	Medicines Management
Colette Page	Practice Nurse Lead
Doug Callow	GP, Chapel Lane
Colette Riley	Practice Manager, The Hollies
Sarah Lindsay	GP, Freshfield
Lisa Roberts	Practice manager, Freshfield
Deborah Sumner	GP, The Hollies
Stewart Eden	Practice Manager, Chapel Lane
Chris Bolton (Chair)	GP, The Village Surgery
Sue Lowe	Practice Manager, The Village Surgery
Tim Quinlan	GP, Chapel Lane
Anne Lucy	Locality Development Support
Angel Parkinson	South Sefton CCG Locality Development Manager

In attendance

Rich Harkness	IM&T
Martin Smith	IM&T
J Birchall	Medical student

Apologies

None

Minutes

Anne Lucy

Southport and Formby Clinical Commissioning Group

Attendance Tracker

- ✓ Present
- A Apologies
- L Late or left early

Name	Practice / Organisation	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 2014
Dr Doug Callow	Chapel Lane Surgery	A	✓	✓	✓	✓		✓	✓	✓
Dr C Bolton	The Village Surgery	A	✓					✓		✓
Dr J Reddington	The Village Surgery	✓	A	✓						
Dr J Eldridge	The Hollies	A	✓	✓	L	✓		✓	✓	
Dr D Sumner	The Hollies	✓	✓	✓	✓	✓		✓		L
Dr T Brettel	Freshfield Surgery			A						
Dr S Johnson	The Village Surgery				✓					
Dr L Grant	The Village Surgery				L	✓				
Dr S Lindsay	Freshfield Surgery								✓	✓
Dr D Mortimer	The Village Surgery								✓	
Dr T Quinlan	Chapel Lane Surgery								✓	L

Southport and Formby Clinical Commissioning Group

No	Item	Action
14/27	<p>Welcome and Apologies None were received</p>	
14/28	<p>Notes of the last meeting /and December (2013) The minutes from the previous meeting were agreed as an accurate record. See May attendance sheet below:</p> <div style="text-align: center;">  2014 May attendees.pdf </div>	
14/29	<p>iPad solution for remotely/ EMIS Web Richard Harkness gave an update on "Access to Go" which allows GPs offsite full screen access to EMIS web via a VPN connection. The initial rollout is being coordinated by practice managers for one to two nominated GPs pre practice (iPads are configured to a named individual for security). Costs are currently being met by the Primary Quality Strategy team (Bal Duper). Equipment supplied consists of iPad, keyboard (for maximum screen visibility) and stylus. It was noted that performance / connectivity may be impaired in poor reception areas (for 3G connectivity) <u>Action: MM to enquire if community matrons would be eligible for Access to Go</u></p>	MM
14/30	<p>Primary Care Funding Angela Parkinson outlined some of the proposed changes to funding and asked attendees to note that this would be discussed at the Primary Care event to be held on 21 May (practices are to be notified by email with hard copy of the draft Local Quality Contract sent by post to practices)</p>	 Draft Local Quality Contract.msg
14/31	<p>Locality Money MM asked if the group wanted to consider a proposal to run an acute visiting service (each locality would contribute £25K). It would answer 999 calls but the scope of visiting would be extended if there were insufficient 999 calls to meet the levels of service provided. The group felt that the locality might achieve better results by itself (noting that many 999 calls would be referred back to the GP for a follow up visit anyway), and questioning speed of response (how would Formby be geographically prioritised within the CCG) The group discussed a number of potential areas noting that further work would be required to scope what might be addressed by a locality visiting service:</p> <ul style="list-style-type: none"> • Reducing activity in care / nursing homes • Acute visiting 	

Southport and Formby Clinical Commissioning Group

No	Item	Action
	<ul style="list-style-type: none"> • Ambulance pressures • GP admissions • Over 75s • Extra care home sessions • Saturday visits (heart sync patients) <p>CR noted that a conflict of interest would be caused by electing to use locality funding for work that is already being paid for through the GP contract.</p> <p>Formby Pilot</p> <p>The group discussed the current pilot and the now increased need to obtain appropriate data to measure whether the pilot was yielding the anticipated benefits and savings it is supposed to.</p>	
14/32	<p>Collaborative working – next stage</p> <p>MM has arranged a Southport and Formby wide meeting for 18 June with Mike Simpson and a guest speaker share their experiences of implementing collaborative working.</p> <p>Further inter-practice discussions re collaborative working are ongoing</p>	
14/33	<p>Intermediate beds</p> <p>MM asked the group to consider the provision of cover for 18 intermediate care beds in Central Southport. The group discussed requirements for similar intermediate care beds in Formby. The group agreed that this would be a good candidate for collaborative working although the location (some distance from Formby) was not ideal.</p>	
14/34	<p>Care records</p> <p>CR gave an update and noted that localities should reconsider summary care records. CR to meet with Sue Pearce (PM contact for care records) to discuss issues (the differences between care/.dot and care summary records) on behalf of the CCG</p> <p>CR /AL gave a brief update on the ongoing development of care plans</p>	<div style="text-align: right;">  Fact Sheet for NHS Staff.pdf </div> <div style="text-align: right; margin-top: 10px;">  5.SCR Benefits Overview.docx </div>
14/35	<p>Medicines Management update</p> <p>SL provided an update, noting the £200K forecast overspend. Although the CCG as a whole was forecast to be underspent this was not reflected at practice level and work is underway to identify how spend can be balanced. It was felt that the figures were influenced by price changes and other factors rather than being attributable to good or bad prescribing behaviours.</p> <p>It was noted that practices do not yet have sufficiently detailed data at practice level. This was echoed in figures available on dashboards as a whole – information needs to be at locality level to enable investigation of and action to</p>	<div style="text-align: right;">  Apr 14 Medicines Management Update </div>

Southport and Formby Clinical Commissioning Group

No	Item	Action
	mitigate discrepancies / variations.	
14/36	<p>Key issues</p> <p>DC noted that quality needs to be continually reviewed. CB noted an issue with the eating disorder service for one of his patients. CB to discuss with Jan Leonard</p> <p>MM requested issues to be sent to her by Monday 19 May</p>	
14/37	<p>AOB</p> <p>CP asked practices interested in the Healthcare apprenticeship scheme to provide details to her</p>	ALL
14/38	<p>Date of next meeting</p> <p>12 June 2014 12.30- 14.00 Formby Village Surgery</p>	

Central Locality Meeting Minutes

Date and Time: Tuesday 20th May 13:00 – 14:00

Location: Kew Surgery

Attendees

Dr Louise Campbell (LC)	(Chair) GP, Trinity Practice
Dr Ian Hughes (IH)	GP, Cumberland House
Sharon Forrester (SF)	Locality Development Manager, S&F CCG
Dawn Bradley-Jones (DBJ)	Practice Manager, Trinity Practice
Rachel Cummings (RC)	Practice Manager, Cumberland House
Dr Adele Farrell	GP, Curzon Road
Kate Wood (KW)	Practice Manager, Kew Surgery
Dr Halina Obuchowicz (HO)	GP, Kew Surgery
Roy Boardman (RB)	Business Manager, St Marks Medical Centre
Dr Graeme Allan (GA)	GP, St Marks Medical Centre

In attendance

Richard Harkness (RH)	Informatics Merseyside
Martin Smith (MS)	Informatics Merseyside
Paul Albert	Respiratory Consultant, Aintree NHS Trust
Jane O'Connor	Team Lead, Community Respiratory Team

Apologies

None

Minutes

Sadie Rose	Administrator
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Southport and Formby Clinical Commissioning Group

Attendance Tracker

- ✓ Present
- A Apologies
- L Late or left early

Name	Practice / Organisation	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	April 14	May 14	June 14	July 14	Aug 14
Dr Mark Bond	Curzon Road Medical Practice	✓	✓	✓	A	✓	✓	✓	✓				
Dr Hedley	St Marks Medical Centre												
Dr H Obuchowicz	Kew Surgery	A	A	✓	✓	✓		✓	A	✓			
Dr Ian Hughes	Cumberland House	✓	A	✓	✓	✓	✓	✓	✓	✓			
Dr Campbell	Trinity Practice	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Dr Stubbens	St Marks Medical Centre	✓	✓	✓	A	✓							
Dr Farrell	Curzon Road Medical Practice				✓					✓			
Dr Allen	St Marks					✓	✓		✓	✓			
Dr W Coulter	Kew Surgery						✓		✓				

Southport and Formby Clinical Commissioning Group

No	Item	Action
14/32	<p>ERICOM (EMIS Mobile) project</p> <p>Richard Harkness and Martin Smith attended the meeting to introduce the EIRCOM project to the group. ERICOM enables remote access of EMIS web on home visits using an IPAD devise. RH explained how at the moment they are in the process of contacting all Practice Managers across the CCG, and this contact will be made by Barrie Winstanley. The project has been approved and funded by the Primary Care Quality Team, and the rollout strategy has been agreed. Each practice will receive 1 IPAD, and larger sites of over 3000 p/pop will be allocated an extra devise. A survey will need to be completed by the allocated GP to obtain user details and also identify if IPAD training is required. Once the initial rollout had ended, the project will be reviewed and there could be potential for more IPADs and also a “bring your own devise” scheme. In terms of costs, the initial cost of the scheme has been met for the first year by the Primary Care Quality Team. RH explained how once the year is over, there is a possibility of recurrent costs. These may include 3G data contract costs (£154 for 1 IPAD per annum) and support licence costs (£43.45 for 1 IPAD per annum). Overall the group were pleased by what the ERICOM project has to offer, however there were a few queries discussed:</p> <ul style="list-style-type: none"> • GA questioned if referral forms and prescriptions could be generated. His concern was that although the IPAD could be used to input notes onto EMIS web, if the GPs still had to go back to the surgery to generate a prescription and complete the actions then this wouldn't be efficient. Action: RH to check this and report back to GA. • Some practices have already funded IPADS themselves, and would like to receive some sort of financial reimbursement in light of the ERICOM project. Action: SF to look into this and report back to group. • SF raised a few issues practices are having with EMIS systems, including crashing and internet connection errors. SF asked GA if his team provide ongoing support to practices with EMIS software. GA informed the group that the person to contact is Matthew Leigh who is the Technical Support Team Leader. • LC enquired why practices on Vision should lose out when the underlying principle is exactly the same. GA advised speaking to Paul Shillcock about this. 	<p>RH</p> <p>SF</p>
14/33	<p>Apologies/Minutes of previous meeting/Matters Arising</p> <p>The minutes from the previous meeting were agreed as an accurate record. No apologies were noted. See attendance sheet below:</p> <div style="text-align: center;">  <p>Attendance Sheet.pdf</p> </div> <p><u>Matters Arising</u></p> <p>Refer to 14/24- GA wrote to Fiona Clark re clarity on locality chair job role. Her response was for him to wait until the locality leads meeting on Wednesday 21st where there will be further clarity about the job description of the chair.</p>	

Southport and Formby Clinical Commissioning Group

No	Item	Action												
	<p>Refer to 14/16- SF had a meeting with Jan Leonard re orthopaedic referrals. Jan's response was that if they are asking for a re referral for a different complaint, then this could be feasible. If a re referral is being requested following the same referral- then this is not appropriate. Action: Group to provide SF with an example to be fed back to Jan to flag up at contract meeting.</p> <p>Refer to 14/28- LC has produced a draft letter to be sent on behalf of the locality. LC circulated the letter amongst the group for comment. Minor amendments to be made and then it will be ready to be sent out. Action: LC to email to SR to be put onto letterhead.</p>	<p>ALL SF</p> <p>LC</p>												
14/34	<p>Chair's Update</p> <p>No updates. LC advised the group to provide her with feedback to take to the upcoming chair's meeting.</p>													
14/35	<p>Locality Allocation 50K</p> <p>SF spoke to the group about the impending £50K locality money. There are discussions among the localities about using this money collectively (£25K each) for a home visiting service, with a view to link in with NWAS and ultimately reduce hospital admissions. This would be an in-hours service as opposed to out-of-hours. The group queried if this would be a good service and if it would work for practices on an individual level. KW explained to the group how it works at Kew Surgery, and said in her experience it works very well. LC spoke about her concerns with the quality of visits, and also affirmed how it wouldn't work well for Trinity practice. GA spoke about urgent call requests being a problem in St Marks, and perhaps there is something that could be done to make things run more smoothly (e.g. diverting urgent calls after 2pm). The group also touched upon how although the purpose of the scheme would be to avoid unplanned admissions, it might in fact end up increasing the number of unplanned admissions due to the GP not knowing the patient. Evidently each practice is different so will each have different views on the benefit of a home visiting service. A suggestion was made about doing a pilot for a year and monitoring admissions closely. Action: Group to consider home visiting service as a locality investment option.</p>	<p>ALL</p>												
14/36	<p>Lymphedema</p> <p>SF provided the group with an update on Lymphedema. She previously asked the practices to search their databases to see how many patients they have with Lymphedema. The results were as follows:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Practice</th> <th style="text-align: left;">Number of patients</th> </tr> </thead> <tbody> <tr> <td>Trinity Practice</td> <td>12 patients</td> </tr> <tr> <td>St Marks</td> <td>29 patients</td> </tr> <tr> <td>Cumberland House</td> <td>8 patients</td> </tr> <tr> <td>Curzon Road</td> <td>11 patients</td> </tr> <tr> <td>Kew Surgery</td> <td>5 patients</td> </tr> </tbody> </table> <p>SF explained how she has spoken to district nurses, and 3 in particular identified they are</p>	Practice	Number of patients	Trinity Practice	12 patients	St Marks	29 patients	Cumberland House	8 patients	Curzon Road	11 patients	Kew Surgery	5 patients	
Practice	Number of patients													
Trinity Practice	12 patients													
St Marks	29 patients													
Cumberland House	8 patients													
Curzon Road	11 patients													
Kew Surgery	5 patients													

Southport and Formby Clinical Commissioning Group

No	Item	Action
	<p>really struggling with this on a daily basis. SF shared costs for this (see breakdown of cost below). Jan Leonard has agreed to fund a 3 day pilot for Lymphedema where a specialist nurse shadows a nursing team to identify patients, see if dressings are done appropriately, etc. In light of this, a tailored education pack for nurses will be drawn up. SF circulated a case study that was previously done by Jan which was particularly successful (see below).</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  HSJ Awards.doc </div> <div style="text-align: center;">  Cost analysis of nursing time and cons </div> </div>	
14/37	<p>Connected Communities Project</p> <p>SF provided the group with an update on the Connected Communities Project. So far it is going well and they have had 4 referrals; 1 from each practice in the locality. SF shared a case study with the group to highlight the benefit of the programme. Mr.G was referred by his GP to the Connected Communities Project in April 2014. He had mobility problems, impaired eyesight and was socially isolated. Contact was made through Mr.G's daughter, and he was referred to the Salvation Army 'Young at Heart' group which he thoroughly enjoyed. SF advised the group to start considering patients that could potentially benefit from this project. LC mentioned how thinking of the patients is one thing, but referring them is the issue as they have to sign the consent form. SF suggested practices devising a letter detailing the project accompanied by a leaflet, posing the question to patients if this is something they would be interested in. Patients can then refer themselves through the contact details provided on the leaflet.</p>	
14/38	<p>Community Respiratory Team</p> <p>Paul Albert and Jane O'Connor attended the meeting to discuss the Community Respiratory Team with the group. There seems to have been some inconsistencies with referrals and misunderstands about what is provided by the community respiratory team. PA and JO wanted to clarify this with the group. JO explained how there are 2 arms of the service:</p> <ol style="list-style-type: none"> 1) <u>Early Supportive Discharge (ESD)</u>- Patients who have been admitted to hospital or who have attended A&E with an exacerbation of COPD can be assessed by a Nurse Practitioner to determine whether with suitable medication, nursing and support they can be safely cared for at home and be discharged. Patients will ideally be discharged as quickly as possible, and the service is provided every day between 8am and 8pm. 2) <u>Hospital at Home (HAH)</u> - This service is for patients with a confirmed diagnosis of COPD whom emergency admission to hospital could potentially be avoided and alternatively managed at home. Patients can be referred by GPs, practice nurses and community matrons. Referral hours are between 8am and 6pm. On receipt of the referral, the team will go out and respond with a home visit within 2 hours. <p>JO explained what would typically happen once a referral is made. Upon receipt of the referral, someone will be sent out to the patient's home within 2 hours. The necessary assessments will then be conducted to ensure they are having an exacerbation of COPD. They will often need a nebuliser and will be prescribed additional medication if required.</p>	

Southport and Formby Clinical Commissioning Group

No	Item	Action
	<p>Following the initial visit, the patient will be visited daily after the exacerbation until satisfied the patient is fully optimised.</p> <p>GA expressed how he has noted incidents of patients having problems getting back in touch with a respiratory nurse. GA asked if they monitored any abandoned calls. JO explained how they have an answerphone service, and she can also access the phone through her mobile (which she does on an hourly basis) and then chase up any messages.</p> <p>Action: JO to ensure practices have referral forms. Send referral forms out as required. Also chase up the poster with Jenny Kristiansen and circulate.</p>	JO
14/39	<p>AOB</p> <ul style="list-style-type: none"> • SF has been approached by a pharmaceutical company wanting to do pilot. SF asked the group for their thoughts on this, and the general consensus was that they were not interested. It was agreed that this is an individual practice decision so practices to contact SF if they are interested. • The group discussed that more communication needs to be had with district nurses at locality meetings. Cathy Rimmer to be invited to attend the next meeting to build this communication. • Following the visit from the community respiratory team, SF discussed the benefit of having other services attending the locality meetings to explain their services in detail. Group to email SF if they have any ideas for services 	
	<p>Date and Venue for Next meeting: Tuesday 24th June 13:00- 14:00, Kew Surgery</p>	

Central Locality Meeting Minutes

Date and Time- Tuesday 29th April 13:00 – 15:00

Location- Kew Surgery

Attendees

Dr Louise Campbell (LC)	(Chair) GP, Trinity Practice
Roy Boardman (RB)	Business Manager, St Marks Medical Centre
Graeme Allan (GA)	GP, St Marks Medical Centre
Dawn Bradley-Jones (DBJ)	Practice Manager, Trinity Practice
Dr Ian Hughes (IH)	GP, Cumberland House
Kate Wood (KW)	Practice Manager, Kew Surgery
Dr Mark Bond (MB)	GP, Curzon Road Medical Practice
Sharon Forrester (SF)	Central Locality Development Manager S&F CCG
Rachel Cummings (RC)	Practice Manager, Cumberland House
Anne Lucy (AL)	Locality Development Support S&F CCG
Jenny White (JW)	Finance, S&F CCG
Kay Walsh (KW)	Medicines Management, S&F CCG
Dr Wendy Coulter	GP, Kew Surgery

Apologies

Sandra Craggs (SC)	Medicines Management, S&F CCG
Dr Helen Obuchowicz (HO)	GP, Kew Surgery

Minutes

Sadie Rose (SR)	Administrator
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Attendance Tracker

- ✓ Present
- A Apologies
- L Late or left early

Name	Practice / Organisation	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	April 14	May 14	June 14	July 14
Dr Mark Bond	Curzon Road Medical Practice	✓	✓	✓	A	✓	✓	✓	✓			
Dr Hedley	St Marks Medical Centre											
Dr H Obuchowicz	Kew Surgery	A	A	✓	✓	✓		✓	A			
Dr Ian Hughes	Cumberland House	✓	A	✓	✓	✓	✓	✓	✓			
Dr Campbell	Trinity Practice	✓	✓	✓	✓	✓	✓	✓	✓			
Dr Stubbens	St Marks Medical Centre	✓	✓	✓	A	✓						
Dr Farrell	Curzon Road Medical Practice				✓							
Dr Allen	St Marks					✓	✓		✓			
Dr W Coulter	Kew Surgery						✓		✓			

Southport and Formby Clinical Commissioning Group

No	Item	Action	Supporting Documents
14/26	<p>Finance and Performance</p> <p>JW circulated the locality finance report to the group. The report covers overall CCG performance and locality financial performance at practice level. The budget is showing a year to date position of £1.476m overspend (Month 11 £1.172m overspend). The Independent sector is overspent by £0.331m, year to date. This has increased since month 11 (£0.199m overspent). Commissioning from Non NHS organisations is overspent by £1.999m, year to date (month 11 £1.581m). See full report in supporting documents for details and key factors contributing to the financial position.</p> <p>A few of the GPs raised an issue they had encountered with orthopaedic referrals and patients being referred more than once. They questioned if this would account to some of the overspend. GA discussed an incident where a patient with a shoulder problem was sent to physio to deal with a neck problem (which was then dealt with). The patient still had an existing shoulder problem, so another referral was made. The group discussed the ethical issues surrounding this. GA expressed how he would like to see some sort of route for GPs to be able to flag up any inappropriate issues re expenditure. KW highlighted the GP response line where a GP operational forum has just been reinstated. Action- SF to feed this information back to Jan Leonard.</p> <p>JW went on to discuss the new portal (CMIP) that will generate locality performance. The new portal will enable practices to go into specific services (e.g. orthopedic) and drill down on what other reports need to be in there. This then means a report can be built up tailored to each locality. Action- Group to have a think and feedback on what localities and practices would like and contact JW.</p> <p>JW discussed the table at the back of the locality finance report which provides a breakdown of individual practices. JW spoke about it not being possible to sit with every practice manager to discuss the findings of the report, therefore conversing via email or phone is more practical in certain cases. GA suggested prioritising financial situations depending on practice performance. It was also discussed that group targeting could also be helpful and efficient; something JW mentioned as having worked well before.</p> <p>JW also discussed the locality budgets for 2014/2015 and circulated the email around the group. Each locality has £50K non-recurrent money which is included in the CCG's financial plan for each of the next 5 years. In addition to this, the CCG has winter pressure monies of £320K. The email also detailed other planned investment budgets; Primary Care Quality Strategy and Quality Premium. Action- Group to have a think of ideas on how to invest the money to best effect.</p>	<p>SF</p> <p>ALL</p> <p>ALL</p>	 <p>Locality Finance Report.pdf</p>

**Southport and Formby
Clinical Commissioning Group**

No	Item	Action	Supporting Documents
	condensing the meetings to one hour. He spoke about this being achievable if the meeting remained focused and each agenda item was discussed as quickly as possible. The danger with this is that it could result in important discussions being overlooked.		
14/31	Date and Venue for Next meeting: The original date of the meeting was changed and brought forward a week (due to bank holiday). The confirmed new date is Tuesday 20th May 2014- 13.00- 15.00, Kew Surgery.		

North Locality Meeting Minutes

Date and Time: Thursday 17th April 2014, 13:00- 14:30

Location: Marshside / Corner Surgery

Attendees

Dr Kati Scholtz (KS)	(Chair) GP, Norwood Surgery
Dr Les Szczesniak (LS)	GP, Sussex Road Surgery
Ann Marie Woolley (AMW)	Practice Manager, Sussex Road Surgery
Dr Hilal Mulla (HM)	GP, The Corner Surgery
Sarah McGrath (SMc)	Locality Development Manager, S&F CCG
Anne Lucy (AL)	Locality Development Support, S&F CCG
Dr Ian Scott (IS)	GP, Churchtown Medical Centre
Dr Rob Caudwell (RC)	GP, Marshside Surgery
Dr Edward Todd (ET)	Registrar, Norwood Practice
Dr Ahmed Al-Dahiri (AAD)	GP, Norwood Surgery
Jane Ayres (JA)	Medicines Management
Dr Alison Trevor (AT)	GP, Roe Lane Surgery
James Bradley (JB)	Southport & Formby CCG

In attendance

Alan McGee (AM)	Senior Public Health Practitioner, Sefton Council
Olivia. Wooding (OW)	Contract Support Manager, STARS Project
Val Sheard (VS)	Health Promotion Specialist, Sefton Council
Hayley Teshome-Tesfaye (HT)	Sefton Council

Apologies

Sam Muir (SM)	Practice Manager, Norwood Surgery
Jude Storer (JS)	Business Manager, Corner Surgery
Gill Blame (GB)	Sefton CVS

Minutes

Sadie Rose	Administrator
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Southport and Formby Clinical Commissioning Group

Attendance Tracker

- ✓ Present
- A Apologies
- L Late or left early

Name	Practice / Organisation	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14
Dr Kati Scholtz	Norwood Surgery	✓	✓	✓	✓	✓	✓	✓	✓
Dr Niall Leonard	Roe Lane	✓	✓	A	✓	✓	✓	✓	
Dr Hilal Mulla	The Corner Surgery	✓	✓	✓	✓	✓	✓	✓	✓
Dr Les Szczesniak	Sussex Road	✓	A	✓	✓	✓	✓	✓	✓
Dr Rob Caudwell	Marshside Practice	✓	✓	✓	✓	✓	✓	✓	✓
Dr Stephanie Woodcock	The Corner Surgery	✓	A	✓				✓	
Dr Mary McCormack	Churchtown Medical Centre	✓	A	✓	✓	✓			
Dr Ahmed Al-Dahiri	Norwood Surgery			✓			✓	✓	✓
Dr Simon Tobin	Norwood Surgery			✓					
Dr Myles Moriarty	The Corner Surgery					✓			
Dr David Unwin	Norwood Surgery					✓			
Dr Abdul Zubairu	Norwood Surgery					✓			
Dr Rory Kidd	Churchtown Medical Centre						✓	✓	
Dr Ian Scott	Churchtown Medical Centre								✓
Dr Alison Trevor	Roe Lane								✓

No	Item	Action
14/24	<p>Welcome and Apologies</p> <p>The minutes from the previous meeting were agreed as an accurate record. Apologies were noted for Sam Muir, Jude Storer and guest speaker Gill Blane.</p> <p>See attendance sheet below:</p> <div style="text-align: center;">  <p>Attendance Sheet.pdf</p> </div>	
14/25	<p>Updates from last meeting</p> <p><u>Collaborative Working lead areas</u></p> <p>Dr Al-Dahiri took this opportunity to provide the group with an update on Musculoskeletal Services. AAD was previously asked by the CCG to review MSK services and how they can be improved. AAD asked the group if they had any suggestions and feedback on the service. The overall consensus from the group was that they were happy with the service, apart from the length of patient waiting times. The group discussed the opportunities around Primary Care, particularly around joint injections being administered outside hospital settings. ADD discussed an idea of having a group of GPs taking on orthopaedic referrals and having satellite clinics where patients will be seen. This way, it would provide a service closer to patients and there would be no need for a referral to the MCAS clinic.</p> <p>KS suggested how this could be taken on as a north locality project and used as a pilot. KS also proposed perhaps using the £50K locality money to start up a clinic; Overall, it is preferable not to send patients to MCAS where they can be seen by their local GP. This is an area for discussion starting in the CCG with the chance of developing further. SM has chased up data on volumes and waiting times in MCAS, The group discussed it would also be useful to collect data on joint injections.</p> <p>Action- Any ideas to get in touch with Dr Al-Dahiri or Sarah McGrath</p> <p>Other expressions of interest in collaborative lead roles have been received from Dr Woodcock around Advance Care Planning and Jude Storer on the business cases aspects of schemes.</p>	
14/26	<p>Sefton Treatment and Recovery Service</p> <p>AM and OW attended the meeting to discuss the STARS project (Sefton Treatment and Recovery Services). As of the 1st April 2014, STARS became the direct point of contact for dealing with any referrals for substance or alcohol misuse. Formerly known as the Integrated Recovery Provision, STARS works with individuals over the age of 18 delivering a wide range of interventions to those affected by drug and alcohol misuse. The service consists of the following:</p>	

- Assessment Hub
- 1-2-1 Support
- Outreach and Engagement
- Education, Training and Employment
- Mutual Aid and Peer Support Groups
- Access to Inpatient Detox and Rehab
- Health and Wellbeing
- Drug and Alcohol Community Detox
- Substitute Prescribing
- Complimentary Therapies
- Specialist Onward Referral
- Concerned Others Support
- GP Shared Care
- BBV Screening and Vaccinations
- Needle and Syringe Programme
- Diversionary Activities
- Volunteering and Peer Mentoring

What formerly used to be provided by a number of different services is now all under one roof and is dealt with exclusively by STARS. OW provided a summary on the referral process and answered questions from the group. OW explained that referrals are made directly to STARS through the contact details provided (see poster attachment and referral form below). Posters have also been put up around practices displaying this information.



Stars Referral
Form.pdf



Stars Poster.pdf

Anyone requiring support/treatment within the community can be referred to STARS (This includes people who have previously detoxed). Once a referral is made, the patient will be contacted and booked in for an assessment. The initial assessment will cover the needs, goals and wishes of the patient, the services STARS provides, an assessment into the health and wellbeing of the patient, an assessment into onward referrals, respiratory issues, and so on. Depending on the treatment goals, the service will then devise a suitable treatment plan. At this point a risk assessment will also be conducted and the individual's involvement with other agencies considered (e.g. involvement with social services).

Referrals can be made from self, partner agencies, family, etc. There are no restrictions on who referrals can be received from. A patient may phone up the service themselves and book an appointment there and then as opposed to being referred. OW explained how upon receipt of referral, the individual should get assessed within 5 working days. This is something that is currently being worked on, but is ultimately the goal of the service.

In terms of prescribing, the service will only prescribe detox prescriptions, not prescriptions for health and wellbeing. However, the service can link in with GP's and make recommendations for patient's requirements.

	AM concluded by reiterating that this is a new service which is subject to ongoing development and small changes of which practices will be notified.	ALL
14/27	<p>Think Differently Cope Differently Self-Management Programme</p> <p>Due to Gill Blane not being in attendance, this topic was cancelled to be rearranged for a later date.</p>	
14/28	<p>Nominations for North Locality Chair</p> <p>KS is stepping down from her position as Chair due to her new position on the CCG Governing Body; A nomination was received for Dr Ian Scott which was agreed by the Group which had representation from all practices. Therefore Dr Scott will be Chairman with effect from next month. Thanks to Kati and congratulations to Ian.</p>	
14/29	<p>Discussion topic: Avoiding Unplanned Care</p> <p>The enhanced service (ES) is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission. The ES should be complemented by whole system commissioning approaches to enable outcomes of reducing avoidable unplanned admissions. The ES requires practices to identify patients who are at high risk of unplanned admission and manage them appropriately with the aid of risk stratification tools, a case management register, personalised care plans and improved same day telephone access. See full document below:</p> <div style="text-align: center;">  <p>Avoiding unplanned admissions guidance :</p> </div> <p>KS outlined that a discussion needs to be had on what sort of help we need from the CCG to obtain this data on patients. She raised the following points:</p> <ul style="list-style-type: none"> • <u>Obtaining the Data</u>- Need factual data about emergency admissions, casualty admissions and discharges from hospital. Need to look at how this data will be obtained. SM mentioned the upcoming implementation of the new portal CMIP. A training session is scheduled for next week which will shed some light on issues that need clarifying (e.g. whether the data is going to be flown through portal or if something needs doing). Also, in an ideal process, the portal would know the risk stratification and be able to generate a report on patients recently been in A&E and inpatients. 	

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	<ul style="list-style-type: none"> • <u>What are practices intending to do?</u> - Someone needs to coordinate it and there must be a clear consensus. KS asked are there any compulsory dealings with this risk? Useful to have data of patients recently admitted into hospitals. Higher risk= more likely to come across hardcore patients than lower risk ones. Need to be practical and pragmatic how to manage this. Decision to be made on vulnerable groups. • <u>Who are these patients to have unplanned care?</u> - Requirement to review all care home patients. The CCG needs to agree on the requirements. • <u>Care Coordinator</u>- GP doesn't necessarily have to be the care coordinator. KS asked the group if they can think of a situation where this is the case, and if it was feasible. It was concluded that the responsibility ultimately always lies with the GP. The document isn't clear on identifying who the care coordinator actually is. • <u>Notifying patients</u>- Notifying patients within 21 days who appear on the register is a big responsibility. This needs to be ironed out. <p>An email has been circulated extending the time plan to 30th September. The notification period for over 70 year olds has changed from the end of June to the end of July.</p> <p>Action- SM to take forward data provision aspects of the Scheme Topic to be revisited at future meetings</p>	<p>SM ALL</p>
14/30	<p>Practice Payments for Meeting Attendance</p> <p>JB discussed the practice payments for meeting attendance JB explained that each practice should now have received a statement for validating. If happy with the amounts, an invoice then needs to be sent out in order to be paid. Payment can only be registered through a hard copy invoice processed through SBS.</p> <p>JB explained that the turnaround for payment can take longer for the first initial payment. After this, it should be pretty straightforward. However, JB advised the group to chase up payments if they still have any issues. He also advised the group not to use the contact details on the website, but to chase it up through the finance department directly.</p> <p>JB informed the group that a letter has been circulated outlining that it is £320 per locality meeting/wider constituency meeting. This is in the form of a sessional payment per practice. KS raised a point that so many GPs are encouraged to attend meetings that aren't regular (for example on Mental Health). She posed the question to JB as to whether or not they can claim for attending these additional meetings. JB explained how he is unaware of how it works for other ad-hoc meetings but agreed he will look into this further.</p> <p>Action- Email correspondence between JB and SM. SM to provide examples of this.</p>	<p>SM, JB</p>
14/31	<p>Practice Manager Update</p> <p>AMW gave the group an update on the following:</p> <ul style="list-style-type: none"> • Macmillan cancer information- HOPE (Help to Overcome Problems Effectively) is a course designed to help people who have had cancer to get on with life after treatment has finished. 	

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	<ul style="list-style-type: none"> • There's a new mentor scheme whereby a student nurse would shadow a practice nurse. This is done as an incentive to get nurses to go into practice. (To be launched 21st May) • Avoiding unplanned admissions- guidelines talked about federation needing to happen to protect NHS. Another meeting in May to follow. • Prescribing budgets- prevalence rather than numbers. • CQC- Inspection not going to be 48hours notice anymore but 2weeks notice instead. 5 practices per CCG seen in the period of 12 weeks. 	
14/32	<p>Medicines Management Update</p> <p>JA gave a brief update on Medicines Management. She explained how the CCG are in a similar financial situation as before and is still overspent. She reminded the group that the budget is not set for the next financial year.</p> <p>See full prescribing finance report below:</p> <div style="text-align: center;">  <p>Copy of 01V_SouthportFormb</p> </div>	
14/33	<p>Any other business:</p> <ul style="list-style-type: none"> • AMW informed the group that following a recent audit, her practice at Sussex Road Surgery discovered toner cartridges for half the price. She will find out the name of the cartridges and send the details around all the other surgeries. • SM reminded the group of the £50K to be spent as a locality, Ideas are needed for locality based schemes for next meeting <p>Action- AMW to email surgeries with details of cartridges.</p> <p>Action- Group to have a think and email SM with ideas for £50K locality money.</p>	AMW ALL
	<p>Date of next meeting:</p> <p>Thursday 15th May, 13:00- 14:30, Marshside/Corner Surgery</p>	

North Locality Meeting Minutes

Date and Time: Thursday 15th May 2014, 13:00- 14:30

Location: Marshside / Corner Surgery

Attendees

Dr Ian Scott (IS)	(Chair) GP, Churchtown Medical Centre
Sarah McGrath (SMc)	Locality Development Manager, S&F CCG
Sharon Johnson (SJ)	Informatics Merseyside
Sam Muir (SM)	Practice Manager, Norwood Surgery
Jude Storer (JS)	Business Manager, Corner Surgery
Nicole Marshall (NM)	Practice Manager, Marshside Surgery
Dr Myles Moriarty	GP, Corner Surgery
Jane Ayres (JA)	Medicines Management S&F CCG
Lydia Hale (LH)	Practice Manager, Roe Lane Surgery
Dr Niall Leonard (NL)	GP, Roe Lane Surgery
Dr Les Szczesniak (LS)	GP, Sussex Road Surgery
Dr Rob Caudwell (RC)	GP, Marshside Surgery
Dr Kati Scholtz (KS)	GP, Norwood Surgery

In attendance

Richard Harkness (RH)	Informatics Merseyside
Martin Smith (MS)	Informatics Merseyside
Gill Blane (GB)	Sefton CVS

Apologies

Ann Marie Woolley (AMW)	Practice Manager, Sussex Road Surgery
Lyn Roberts (LR)	Practice Manager, Churchtown Medical Centre

Minutes

Sadie Rose (SR)	Administrator
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Attendance Tracker

- ✓ Present
- A Apologies
- L Late or left early

Name	Practice / Organisation	Sept 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14
Dr Kati Scholtz	Norwood Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Dr Niall Leonard	Roe Lane Surgery	✓	✓	A	✓	✓	✓	✓		✓			
Dr Hilal Mulla	The Corner Surgery	✓	✓	✓	✓	✓	✓	✓	✓				
Dr Les Szczesniak	Sussex Road	✓	A	✓	✓	✓	✓	✓	✓	✓			
Dr Rob Caudwell	Marshside Practice	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Dr Stephanie Woodcock	The Corner Surgery	✓	A	✓				✓					
Dr Mary McCormack	Churchtown Medical Centre	✓	A	✓	✓	✓							
Dr Ahmed Al-Dahiri	Norwood Surgery			✓			✓	✓	✓				
Dr Simon Tobin	Norwood Surgery			✓									
Dr Myles Moriarty	The Corner Surgery					✓				✓			
Dr David Unwin	Norwood Surgery					✓							
Dr Abdul Zubairu	Norwood Surgery					✓							
Dr Rory Kidd	Churchtown Medical Centre						✓	✓					
Dr Ian Scott	Churchtown Medical Centre								✓				
Dr Alison Trevor	Roe Lane Surgery								✓				

No	Item	Action
14/34	<p>Welcome and Apologies</p> <p>The minutes from the previous meeting were agreed as an accurate record. LH noted that Dr Alison Trevor from Roe Lane Surgery wasn't added to the attendance tracker in the last month's minutes. Action: SR to amend accordingly.</p> <p>Apologies were noted for Lyn Roberts and Ann-Marie Woolley. See attendance sheet below:</p> <div style="text-align: center;">  Attendance Sheet.pdf </div>	SR
14/35	<p>Updates from last meeting</p> <ul style="list-style-type: none"> • SM explained to the group that instead of putting the minutes into board papers, log sheets will be devised outlining particular areas of attention. • JS looking at a proposal with SW and MM to provide advanced care planning. Outcomes of 2 pieces of work will be business cases and a potential usage for the 50K locality monies. 	
14/36	<p>Think Different Cope Differently Self-Management Programme</p> <p>Gill Blane attended the meeting to introduce the 'Think Differently Cope Differently Self-Management Programme' which is being commissioned by Southport and Formby CCG in partnership with Sefton CVS. Underpinned by 'Five Ways to Wellbeing' and cognitive behavioural therapy, the aim of the programme is to help people who have long-term health conditions manage their illness. The course comprises of 2 hour group sessions covering the following:</p> <ul style="list-style-type: none"> • Where you are: looking at the underlying problem of the illness, what's making a person feel depressed, ways to cope with depression including relaxation techniques, and so on. • Pain and fatigue: Top tips to help manage pain and fatigue. • Healthy eating and drinking: looking at the ways eating and drinking can affect you; get tips for cooking on a budget, health eating, etc. • Listen to me: help and advice with communicational skills and how to get thoughts/feelings across to family, friends and health care professional. • Moving forward: action planning and problem solving techniques (e.g. encouraging new hobbies and independence). <p>In terms of the referral process, GB explained to the group that a referral can be made through the healthcare practitioner via the telephone (only telephone referrals can be accepted at the moment). Once the initial referral is made, the service will try to accommodate the patient as best as they can and enrol them onto the nearest course to them. GB explained how if there is a high demand of patients from a particular area, they will then look at facilitating the programme in that area. In terms of capacity, each course</p>	

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	<p>can accommodate 15 patients at a time, and a minimum of 6 patients is required.</p> <p>GB explained how the programme has worked very well so far with mental health patients, and it is good to implement underpinning patients with long-term health conditions. The programme is ideal for individuals struggling to cope, and GB encouraged the practices to start considering patients that may benefit from this programme.</p> <p>Action: GB to email SMc with her contact details and then SMc to circulate these details with the rest of the group.</p>	<p>GB SMc</p>
<p>14/37</p>	<p>Quality Premium</p> <p>Becky Williams attended the meeting to discuss the May Quality Premium report with the group. Copies of the report were circulated amongst the group. See full report below:</p> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Southport Formby May 2014 Quality Pre</p> </div> <div style="text-align: center;">  <p>Copy of North Southport Locality de</p> </div> </div> <p>BW spoke about how there has been an improvement in Southport and Formby. Based on the year to date performance for the confirmed indicators (April 2013 – March 2014), Southport & Formby CCG should receive a payment in 2014/15 of £111,638 against a total possible payment (if all indicators were within tolerance) of £595,400. This is due to underperformance in a number of areas which are described in the main body of the report. However, data is still awaited for two further indicators, which may increase this amount to £279,094 should they be at or below target. BW explained how she is waiting for more data to come through and by the next meeting she will have a better idea about the potential £75,000 to be added on to the total. In terms of next year, BW is having a meeting that week to discuss 14/15 guidance. She explained how next year there won't be as many local measures, but she will have more clarity on this following the meeting.</p> <p>Governing Body discussions need to be had regarding appropriate spend for income received from Quality Premium</p> <p>BW also circulated a separate under 19s Asthma admissions report (see above) which has dropped in the last month. The group queried if the report could be broken down further by locality, and BW agreed she would request this information for next year. She explained however that there are certain areas that can't be broken down (e.g. friends and family test scores). Other measures such as potential years of life lost could be broken down further as requested. Action- BW to request a breakdown of this information.</p>	<p>BW</p>
<p>14/38</p>	<p>Assisted Living Housing Development North Locality</p> <p>SMc has been recently approached by Brunless Court and circulated the booklet amongst the group. Brunless Court is an assisted living complex for the over 75s which could bring up to a hundred new older people into the Locality. SMc asked the group to consider.</p> <ul style="list-style-type: none"> • Approach to registration across practices for likely high users of health services • Approach to providing home visits to this cohort • Could either of the above be considered on a locality footprint? 	<p>ALL</p>

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	<ul style="list-style-type: none"> • Education for the estate managers on appropriate health services for residents becoming unwell <p>The Group considered that more and more such developments were coming to the area and would have implications for general practice. NL spoke about the funding formula and that the age demographic tends to be eclipsed by deprivation. He felt this change in Southport population wouldn't be fully reflected in practice funding.</p> <p>The Group felt they would wait and see how the member practices are affected by the new development</p>	
14/39	<p>Locality Development Funds</p> <p>SMc reminded the group of the impending £50K locality money and asked if any of the group had any ideas since the last meeting. The group agreed that decisions need making sooner rather than later to avoid a situation where times runs out and hasty decisions are made. The following ideas were discussed:</p> <ul style="list-style-type: none"> • Acute Visiting Service- There has been talk about all localities pooling half their money (25K) together for an Acute Visiting Service. The group discussed the benefits and limitations of the service. The group spoke about how an Acute Visiting Service has worked particularly well in West Lancs (OWLS) and the data from this has been impressive. OWLS are happy to share this data which could perhaps be used as guidance. • Admin Support- JA suggested spending the money on employing an admin role to support the Enhanced Service around avoiding unplanned care which is something that would make a considerable difference and is also being considered by the Formby locality. Action: work on costings and logistics of such a role 	SMc
14/40	<p>Medicines Management Update</p>  <p>Apr 14 Medicines Management Update</p>	
14/41	<p>ERICOM (EMIS Mobile Project)</p> <p>Richard Harkness and Martin Smith attended the meeting to introduce the EIRCOM project to the group. ERICOM enables remote access of EMIS web on home visits using an IPAD devise. RH explained how at the moment they are in the process of contacting all Practice Managers across the CCGs, and this contact will be made by a Barry Winstanley. The project has been approved and funded by the Primary Care Quality Team, and the rollout strategy has been agreed. Each practice will receive 1 IPAD to be allocated to the nominated GP. Larger sites for over 3000 p/pop will be allocated an extra devise. Once the initial rollout is over, the project will be reviewed and there could be potential for more IPADs and also a "bring your own device" scheme. Group to email Richard with any queries.</p>	

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14/42	<p>Any other business</p> <ul style="list-style-type: none"> • There is a Primary Care Commissioning event to be held (probably) on June 18th to look at collaborative working. Group will all receive invites for this in due course. • Issues with referral forms on EMIS web- practices having difficulty locating them and noticed a lot are out-of-date and need updating and naming meaningfully. Requires somebody to sort this out as it would make a big impact on primary care. The group agreed it would be best to start with Norwood Surgery via Dr Tobin and Sam Muir who have already started work on this. 	
	<p>Date of next meeting: Thursday 19th June, 13:00- 14:30, Marshside/Corner Surgery</p>	