NHS
South Sefton
Clinical Commissioning Group

South Sefton Clinical Commissioning Group

Integrated Performance Report
April 2019

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Summary Performance Dashboard

Metric	Reporting Level		2019-20												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
E-Referrals															
NHS e-Referral Service (e-RS) Utilisation Coverage Utilisation of the NHS e-referral service to enable choice at first routine elective referral. Highlights the percentage via the e-Referral Service.	South Sefton CCG	RAG	R												R
		Actual	66%												66%
		Target	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Diagnostics & Referral to Treatment (RTT)															
% of patients waiting 6 weeks or more for a diagnostic test The % of patients waiting 6 weeks or more for a diagnostic test	South Sefton CCG	RAG	G												G
		Actual	0.765%												0.765%
		Target	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
% of all Incomplete RTT pathways within 18 weeks Percentage of Incomplete RTT pathways within 18 weeks of referral	South Sefton CCG	RAG	R												R
		Actual	89.486%												89.486%
		Target	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%
Referral to Treatment RTT - No of Incomplete Pathways Waiting >52 weeks The number of patients waiting at period end for incomplete pathways >52 weeks	South Sefton CCG	RAG	R												R
		Actual	1												1
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Cancelled Operations															
% of Cancellations for non clinical reasons who are treated within 28 days Patients who have ops cancelled, on or after the day of admission (Inc. day of surgery), for non-clinical reasons to be offered a binding date within 28 days, or treatment to be funded at the time and hospital of patient's choice.	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RAG	G												G
		Actual	0												
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Operations cancelled for a 2nd time Number of urgent operations that are cancelled by the trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons.	AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	RAG	G												G
		Actual	0												
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0

Cancer Waiting Times															
% Patients seen within two weeks for an urgent GP referral for suspected cancer (MONTHLY) The percentage of patients first seen by a specialist within two weeks when urgently referred by their GP or dentist with suspected cancer	South Sefton CCG	RAG	R												R
		Actual	86.142%												86.142%
		Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
% of patients seen within 2 weeks for an urgent referral for breast symptoms (MONTHLY) Two week wait standard for patients referred with 'breast symptoms' not currently covered by two week waits for suspected breast cancer	South Sefton CCG	RAG	R												R
		Actual	50.00%												50.00%
		Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
% of patients receiving definitive treatment within 1 month of a cancer diagnosis (MONTHLY) The percentage of patients receiving their first definitive treatment within one month (31 days) of a decision to treat (as a proxy for diagnosis) for cancer	South Sefton CCG	RAG	G												G
		Actual	96.296%												96.296%
		Target	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
% of patients receiving subsequent treatment for cancer within 31 days (Surgery) (MONTHLY) 31-Day Standard for Subsequent Cancer Treatments where the treatment function is (Surgery)	South Sefton CCG	RAG	G												G
		Actual	100.00%												100.00%
		Target	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
% of patients receiving subsequent treatment for cancer within 31 days (Drug Treatments) (MONTHLY) 31-Day Standard for Subsequent Cancer Treatments (Drug Treatments)	South Sefton CCG	RAG	G												G
		Actual	100.00%												100.00%
		Target	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
% of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy Treatments) (MONTHLY) 31-Day Standard for Subsequent Cancer Treatments where the treatment function is (Radiotherapy)	South Sefton CCG	RAG	G												G
		Actual	96.667%												96.667%
		Target	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
% of patients receiving 1st definitive treatment for cancer within 2 months (62 days) (MONTHLY) The % of patients receiving their first definitive treatment for cancer within two months (62 days) of GP or dentist urgent referral for suspected cancer	South Sefton CCG	RAG	R												R
		Actual	75.00%												75.00%
		Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
% of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service (MONTHLY) Percentage of patients receiving first definitive treatment following referral from an NHS Cancer Screening Service within 62 days.	South Sefton CCG	RAG	n/a												
		Actual	-												
		Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
% of patients receiving treatment for cancer within 62 days upgrade their priority (MONTHLY) % of patients treated for cancer who were not originally referred via an urgent GP/GDP referral for suspected cancer, but have been seen by a clinician who suspects cancer, who has upgraded their priority.	South Sefton CCG	RAG	R												
		Actual	60.00%												60.00%
		Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%

Metric	Reporting Level		2019-20												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Accident & Emergency															
4-Hour A&E Waiting Time Target (Monthly Aggregate based on HES 17/18 ratio) % of patients who spent less than four hours in A&E (HES 17/18 ratio Acute position via NHSE HES DataFile)	South Sefton CCG	RAG	R												R
		Actual	78.178%												78.178%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
EMSA															
Mixed sex accommodation breaches - All Providers No. of MSA breaches for the reporting month in question for all providers	South Sefton CCG	RAG	G												G
		Actual	0												0
		Target	0	0	0	0	0	0	0	0	0	0	0	0	0
Mixed Sex Accommodation - MSA Breach Rate MSA Breach Rate (MSA Breaches per 1,000 FCE's)	South Sefton CCG	RAG	G												
		Actual	0												
		Target	0												
HCAI															
Number of MRSA Bacteraemias Incidence of MRSA bacteraemia (Commissioner)	South Sefton CCG	RAG	G												G
		YTD	0												-
		Target	-	-	-	-	-	-	-	-	-	-	-	-	0
Number of C.Difficile infections Incidence of Clostridium Difficile (Commissioner)	South Sefton CCG	RAG	R												G
		YTD	7												7
		Target	6	11	15	20	24	28	34	40	46	51	55	60	60
Number of E.Coli infections Incidence of E.Coli (Commissioner)	South Sefton CCG	RAG	R												G
		YTD	15												
		Target	11	21	32	42	53	63	75	85	96	108	125	128	128

Metric	Reporting Level		2019-20												YTD
			Q1			Q2			Q3			Q4			
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Mental Health															
Proportion of patients on (CPA) discharged from inpatient care who are followed up within 7 days The proportion of those patients on Care Programme Approach discharged from inpatient care who are followed up within 7 days	South Sefton CCG	RAG													
		Status													-
		Actual													
		Target	95.00%			95.00%			95.00%			95.00%			
Episode of Psychosis															
First episode of psychosis within two weeks of referral The percentage of people experiencing a first episode of psychosis with a NICE approved care package within two weeks of referral. The access and waiting time standard requires that more than 50% of people do so within two weeks of referral.	South Sefton CCG	RAG	R												R
		Actual	50.00%												50.00%
		Target	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	56.00%	
IAPT (Improving Access to Psychological Therapies)															
IAPT Recovery Rate (Improving Access to Psychological Therapies) The percentage of people who finished treatment within the reporting period who were initially assessed as 'at caseness', have attended at least two treatment contacts and are coded as discharged, who are assessed as moving to recovery.	South Sefton CCG	RAG	R												R
		Actual	38.00%												38.00%
		Target	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	
IAPT Access The proportion of people that enter treatment against the level of need in the general population i.e. the proportion of people who have depression and/or anxiety disorders who receive psychological therapies	South Sefton CCG	RAG	R												R
		Actual	1.23%												1.23%
		Target	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.59%	1.83%	1.83%	1.83%	
IAPT Waiting Times - 6 Week Waiters The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number who finish a course of treatment.	South Sefton CCG	RAG	G												G
		Actual	99.30%												99.30%
		Target	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	75.00%	
IAPT Waiting Times - 18 Week Waiters The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment, against the number of people who finish a course of treatment in the reporting period.	South Sefton CCG	RAG	G												G
		Actual	100.00%												99.30%
		Target	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	
Dementia															
Estimated diagnosis rate for people with dementia Estimated diagnosis rate for people with dementia	South Sefton CCG	RAG	R												R
		Actual	64.169%												64.169%
		Target	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%	66.70%

Metric	Reporting Level		2019-20												
			Q1			Q2			Q3			Q4			YTD
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Children and Young People with Eating Disorders															
The number of completed CYP ED routine referrals within four weeks The number of routine referrals for CYP ED care pathways (routine cases) within four weeks (QUARTERLY)	South Sefton CCG	RAG													
		Actual													
		Target	95.00%			95.00%			95.00%			95.00%			95.00%
The number of completed CYP ED urgent referrals within one week The number of completed CYP ED care pathways (urgent cases) within one week (QUARTERLY)	South Sefton CCG	RAG													
		Actual													
Wheelchairs															
Percentage of children waiting less than 18 weeks for a wheelchair The number of children whose episode of care was closed within the reporting period, where equipment was delivered in 18 weeks or less of being referred to the service.	South Sefton CCG	RAG													
		Actual													
		Target													

1. Executive Summary

This report provides summary information on the activity and quality performance of South Sefton Clinical Commissioning Group at Month 1 (note: time periods of data are different for each source).

Planned Care
Month one referrals are -9.9% down on 2018/19 due to a -17% reduction in GP referrals. In contrast, consultant-to-consultant referrals during month one were 2.6% higher than in April 2018. However, consultant-to-consultant referrals have been below the current baseline median for three consecutive months.

At provider level, Aintree saw a 15% decrease in total referrals in month one. Royal Liverpool and Liverpool Women's have also reported reductions in April 2019 when comparing to April 2018.

In April, there was 1 South Sefton patient waiting on the incomplete pathway for 52+ weeks against the national zero tolerance threshold. This is the same patient who breached in previous few months at Liverpool Womens, the treatment issue for the patient has been resolved and they have a confirmed booked appointment.

For patients on an incomplete non-emergency pathway waiting no more than 18 weeks the CCG has remained just over 89% for the past several months and have achieved the improvement plan of 88.7% in April reporting 89.5%. In April the incomplete waiting list for the CCG was 11309 against a plan of 10833 a difference of 476 patients. A 446/4% increase in April-19 Incomplete Pathways compared to March-19. Aintree make up 62% of the CCG increase with a Provider variance of 276/4%.

The CCG are failing 5 of the 9 cancer measures year to date. Aintree are also failing 5 of the 9 cancer measures.

Aintree Friends and Family Inpatient test response rates have fallen further below the England average of 24.9% in April at 16%; over 4% worse than last month when 20.8% was recorded. The percentage of patients who would recommend the Trust remains the same at 94% but is still below the England average of 96%.The proportion who would not recommend is the same as last month at 4% and above the England average.

Unplanned Care
In relation to A&E 4-Hour waits, Aintree revised their trajectory for 2019/20. The Trust has failed their improvement plan target of 88% in April reaching 82.67%.

The 2019/20 contract has been negotiated and agreed with recurrent investment to deliver additional capacity and transformation of the service delivery model. Additional non recurrent capacity investment of £1m is conditional upon NWAS delivering the ARP standards in full (with the exception of the C1 mean) from quarter 4 2019/20. The C1 mean target is to be delivered from quarter 2 2020/21. A trajectory has been agreed with the Trust for progress towards delivery of the standards and if these are not met as per the trajectory, the payment will not be made.

Performance against the National Quality Stroke metric 90% stay standard was 60% for April 2019 so below the 80% plan for Aintree.

The CCG had 7 new cases of C.Difficile in April, against a year to date plan of 5 so are over plan currently (2 apportioned to acute trust and 5 apportioned to community).

NHS Improvement and NHS England have set CCG targets for reductions in E.coli for 2019/20 NHS South Sefton CCG's year-end target is 128). In April there were 15 cases (against a year to date plan of 128. Aintree reported 32 cases in March (358 YTD). There are no targets set for Trusts at present.

Mental Health
For Improving Access to Psychological Therapies (IAPT), Cheshire and Wirral Partnership reported the monthly target for M1 19/20 is approximately 1.83%. Month 1 performance was 1.23% so failed to achieve the target standard. The percentage of people moved to recovery was 38% in month 1 of 2019/20 (target 50%).

The latest data shows South Sefton CCG are recording a dementia diagnosis rate in April of 64.17%, which is under the national dementia diagnosis ambition of 66.7% and a slight decline on last month when 65% was reported.

Community Health Services
CCG and Mersey Care leads are working to progress the outcomes and recommendations from the service reviews undertaken of all South Sefton community services. A transformation plan has now been developed and will provide the focus for service improvements over the coming year. It has been agreed that reporting requirements and activity baselines will be reviewed alongside service specifications and transformation work.

Children's Services
Children's services have experienced a reduction in performance across a number of metrics linked to mental health and community services. Long waits in Paediatric speech and language remains an issue however discussions are progressing with Alder Hey regarding improvements in provision across SALT and other services.

Better Care Fund
A quarter 4 2018/19 BCF performance monitoring return was submitted on behalf of the Sefton Health and Wellbeing Board in May 2019. This reported that all national BCF conditions were met in regard to assessment against the High Impact Change Model; but with on-going work required against national metric targets for non-elective hospital admissions, admissions to residential care, reablement and Delayed Transfers of Care. Narrative is provided of progress to date. Work is now ongoing in regard to collaborative work between health and social care which will evidence the 2019/20 BCF returns.

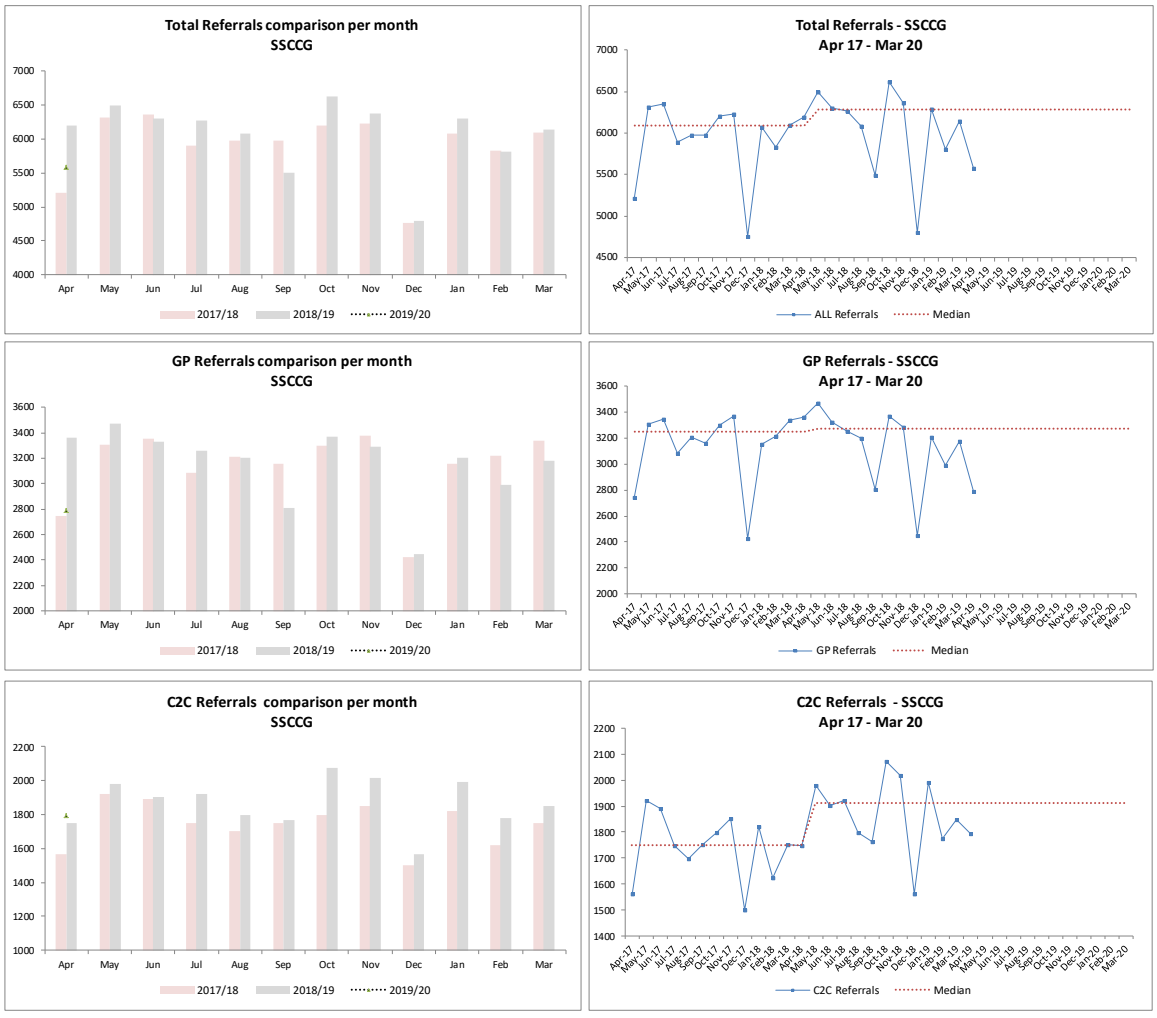
CCG Improvement & Assessment Framework
A full exception report for each of the indicators citing performance in the worst quartile of CCG performance nationally or a trend of three deteriorating time periods is presented to Governing Body as a standalone report. This outlines reasons for underperformance, actions being taken to address the underperformance, more recent data where held locally, the clinical, managerial and SLT leads responsible and expected date of improvement for the indicators.

2. Planned Care

2.1 Referrals by source

Indicator												
Month	GP Referrals				Consultant to Consultant				All Outpatient Referrals			
	Previous Financial Yr Comparison				Previous Financial Yr Comparison				Previous Financial Yr Comparison			
	2018/19 Previous Financial Year	2019/20 Actuals	+/-	%	2018/19 Previous Financial Year	2019/20 Actuals	+/-	%	2018/19 Previous Financial Year	2019/20 Actuals	+/-	%
April	3361	2787	-574	-17.1%	1748	1794	46	2.6%	6193	5581	-612	-9.9%
May	3469				1981				6498			
June	3327				1902				6305			
July	3256				1920				6273			
August	3202				1798				6081			
September	2806				1765				5497			
October	3370				2074				6623			
November	3289				2018				6369			
December	2449				1563				4801			
January	3207				1990				6296			
February	2992				1776				5814			
March	3177				1849				6145			
Monthly Average	**3159**	**2787**	**-372**	**-11.8%**	**1865**	**1794**	**-71**	**-3.8%**	**6075**	**5581**	**-494**	**-8.1%**
YTD Total Month 1	**3361**	**2787**	**-574**	**-17.1%**	**1748**	**1794**	**46**	**2.6%**	**6193**	**5581**	**-612**	**-9.9%**
Annual/FOT	**37905**	**33444**	**-4461**	**-11.8%**	**22384**	**21528**	**-856**	**-3.8%**	**72895**	**66972**	**-5923**	**-8.1%**

Figure 1 - Referrals by Source across all providers for 2017/18, 2018/19 & 2019/20



Data quality note:
Liverpool Heart & Chest data has been unavailable from month 9 of 2018/19 onwards. Therefore, to allow for consistency, Liverpool Heart & Chest referrals have been removed from 2017/18 data onwards.

- Trends show that the baseline median for total South Sefton CCG referrals has remained flat since May 2018. However, a recent downward trend has been evident.
- Month one referrals are -9.9% down on 2018/19 due to a -17% reduction in GP referrals.
- In contrast, consultant-to-consultant referrals during month one were 2.6% higher than in April 2018. However, consultant-to-consultant referrals have been below the current baseline median for three consecutive months.
- Aintree saw a 15% decrease in total referrals in month one. Royal Liverpool and Liverpool Women's have also reported reductions in April 2019 when comparing to April 2018.
- Renacres, Southport & Ormskirk and St Helens & Knowsley are seeing a notable increase in referrals at month one when comparing to the previous year. Southport & Ormskirk has seen an increase in consultant-to-consultant referrals to Paediatrics, General Medicine and Clinical Physiology.
- GP referrals have now been below average for five consecutive months, which can largely be attributed to reduced referrals to Aintree Hospital.
- Taking into account working days, further analysis has established there were 29 fewer GP referrals per day in April 2019 when comparing to the previous year with specialities such as ENT, Gynaecology, Dermatology, Gastroenterology and Colorectal Surgery seeing notable decreases.
- Trauma & Orthopaedics was the highest referred to specialty for South Sefton CCG in 2018/19. Referrals to this speciality in month one has decreased by 9% when comparing to an average.

2.2 E-Referral Utilisation Rates

Indicator		Performance Summary				IAF	Potential organisational or patient risk factors
NHS e-Referral Service (e-RS): Utilisation Coverage		**Latest and previous 3 months**				IAF - 144a (linked)	e-RS national reporting has been escalated to NHSD via NHSE/I. Data provided potentially inaccurate therefore making it difficult for the CCG to understand practice utilisation. Potential for non e-RS referrals that are rejected to be missed by the practice.
RED	**TREND**	Jan-19	Feb-19	Mar-19	Latest		
		62%	66%	65%	66%		
		Plan: 100% by end of Q2 2018/19					

Performance Overview/Issues:

The national ambition is that E-referral utilisation coverage should be 100% by the end of Q2 2018/19. Latest published e-referral utilisation data for South Sefton CCG is for April 2019 and reports performance to be 66%. Performance has remained similar over past couple of months, however, remains significantly below the national position. The above data however is based upon NHS Digital reports that utilises MAR (Monthly Activity Reports) data and initial booking of an E-Rs referral, excluding re-bookings. MAR data is nationally recognised for not providing an accurate picture of total referrals received, and as such NHS Digital will, in the near future, use an alternative data source (SUS) for calculating the demonitator by which utilisation is ascertained.

In light of the issues in the national reporting of E-Rs utilisation, a local data set derived from SUS has been used. The referrals information above is sourced from a local referrals flow submitted by the CCGs main hospital providers. This has been used locally to enable a GP practice breakdown. March data shows an overall performance of 75% for South Sefton CCG, a decline on last month (75.7%).

Actions to Address/Assurances:

A review of referral data was undertaken to get a greater understanding of the underlying issues relating to the underperformance. The data indicates that there is no uniform way that trusts code receipt of electronic referral and the e-RS data at trust level is of poor quality. This has therefore provided difficulties in identifying the root causes of the underperformance.

A meeting with relevant Trust and CCG staff was organised for the 17th June to discuss issues relating to Advice & Guidance and performance reporting for eRs. This unfortunately was cancelled due to forces outside our control. A new meeting will be reconvened as soon as conveniently possible. A series of actions will been formulated,with agreed actions and timescales for implementation. This will form the basis for a more robust contract management of e-RS with acutes, and the non-payment of activity not referred through e-RS.

When is performance expected to recover:

A recovery trajectory will be formulated after discussions with providers.

Quality impact assessment:

An incident has been reviewed relating to Alder Hey with subsequent actions agreed with NHSE and Liverpool CCG relating to mitigating risks of non e-RS patients being missed, the following actions were agreed:
- A review of Trust SOPs to be fit for 'business as usual'
- NHSE to escalate to NHSE/I concerns regarding e-RS National Reporting

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Rob Caudwell	Terry Hill

2.3 Referral to Treatment Performance

Indicator		Performance Summary					IAF	Potential organisational or patient risk factors
Referral to Treatment Incomplete pathway (18 weeks)		Latest and previous 3 months					129a	The CCG is unable to meet statutory duty to provide patients with timely access to treatment. Potential quality/safety risks from delayed treatment ranging from progression of illness to increase in symptoms/medication or treatment required. Risk that patients could frequently present as emergency cases.
RED	TREND		Jan-19	Feb-19	Mar-19	Latest		
		CCG	89.02%	89.09%	89.04%	89.48%		
		Aintree	90.13%	90.45%	88.98%	89.67%		
		Plan: 92% April's improvement plan: CCG -88.7% and Aintree - 88.6% Yellow denotes achieving 19/20 improvement plan but not national standard of 92%						

Performance Overview/Issues:

The CCG's Performance has remained just over 89% for the past several months and have achieved the the improvement plan of 88.7% in April reporting 89.5%. The CCG's main provider Aintree are also under the 92% target reporting 89.7% but achieving to local trajectory of 88.6% for April. Gastroentrology is the specialty most underperforming with achievement of 73.6%. This equates to 472 patients waiting over 18 weeks and equlivalent to 2.86% of their overall demoninator. The continued non-elective pressure combined with capacity issues brought about via increased levels of short term sickness and leave in certain specialties has impacted on RTT performance although mitigations are in place and re continually reviewed. The increase in non-elective demand is being managed effectively and the Trust is monitoring the situation to ensure elective activity and patient experience is not negatively impacted.

In April the incomplete waiting list for the CCG was 11309 against a plan of 10833 a difference of 476 patients. A 446/4% increase in April-19 Incomplete Pathways compared to March-19. Aintree make up 62% of the CCG increase with a Provider variance of 276/4%. Liverpool Women's makes up the second highest proportion of the overall increase with a Provider variance of 74/9%. Notably, Liverpool Women's has seen an increase in waiting list numbers for 4 consecutive months, rising from 698 in Jan-19 to 854 in Apr-19, percentage wise this is a 22% increase in Incomplete Pathways. In terms of the NHSE submitted plans, 2019/20 Incomplete Pathways is currently 426/4% over plan.

Actions to Address/Assurances:

CCG Actions:

• The CCG has recruited 3 interim project managers whose focus is on redesigning services that will support the system in terms of of financial and acute sustainability.
• Issues relating to gastroentrology have been escalated via the Aintree Planned Care Group Meeting (APCG). A highlight report was circulated by Aintree to APCG members articulating issues and actions being undertaken.
• A further request will be made to Aintree to initate a Task & Finish Group with Clinical and Managerial leads from both CCGs and Trusts to formulate a System Recovery Plan.

Trust Actions:

• Improve theatre utilisation at speciality level.
• Regularly review all long waiting patients within the clinical business units to address capacity issues and undertake waiting list initiatives (WLI's) where available in conjunction with weekly performance meetings with Planning and performance / Business Intelligence leads.
• Continue to support the reduction in Endoscopy waits by supporting WLI scope lists using dropped sessions in the week and additional sessions at weekends along with Insourcing extra capacity.
• Continued weekly monitoring of diagnostics waiting times to ensure delivery of the 6 week standard as a milestone measure for RTT performance. This to include horizon scanning and capacity / demand planning with Head of Planning and Performance
• Continue to meet with clinical business managers (CBMs) on a weekly basis to focus on data quality, capacity & demand and pathway validation.
• Continue to support the clinical business units (CBUs) with their RTT validation processes and Standard Operating procedures with a special focus on inter Provider Transfers and data recording/entry.
• Conduct a review of current processes, operating procedures and training revalidation at business unit level to ensure compliance with best practice and national guidance.

When is performance expected to recover:

The CCG have an improvement plan trajectory which shows the performance plans to improve by by Quarter 4, 2019/20.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Terry Hill

Figure 2 – RTT Performance & Activity Trend

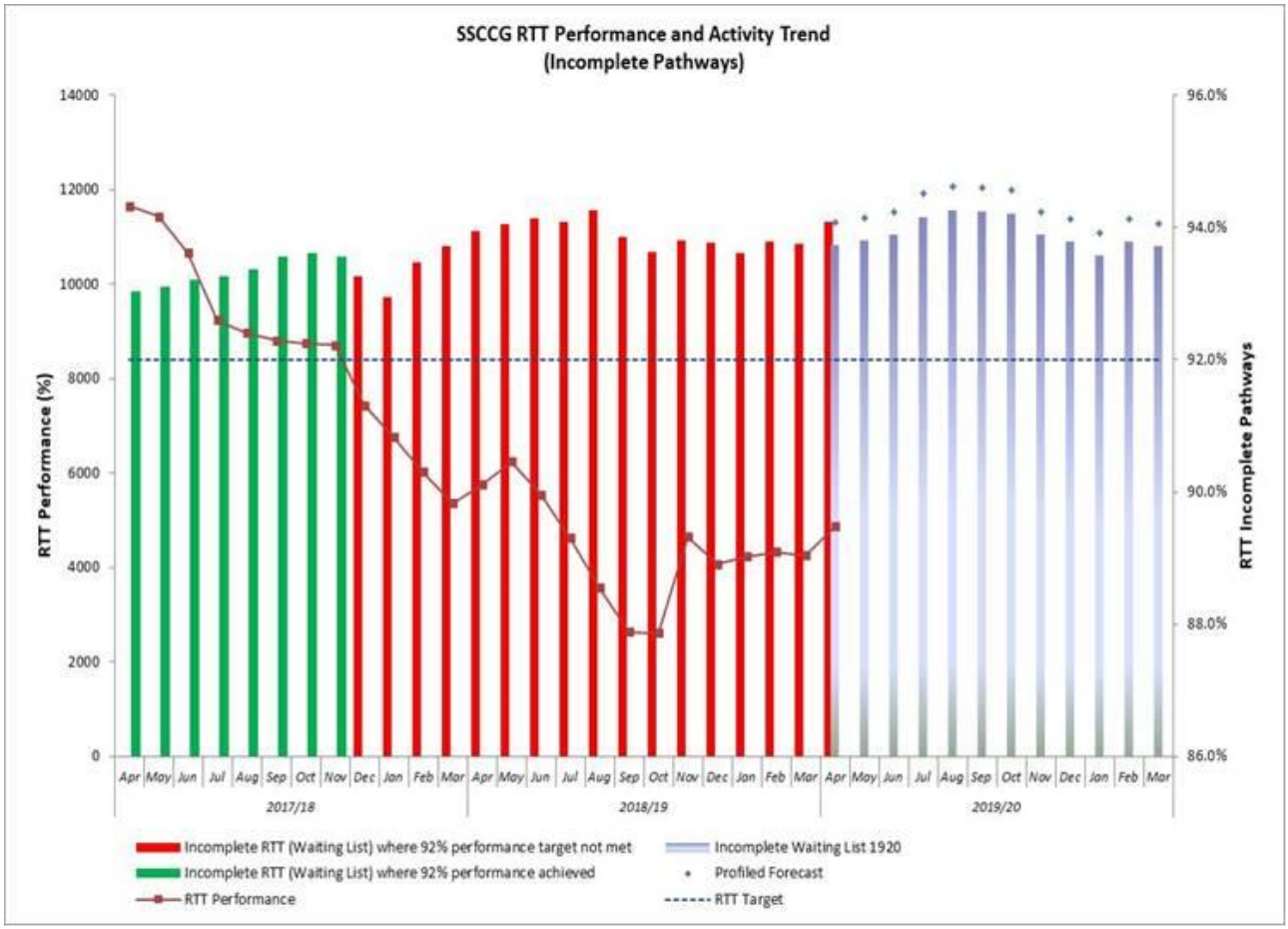


Figure 3 – South Sefton CCG Total Incomplete Pathways

Total Incomplete Pathways	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Plan v Latest
Plan	10,833	10,934	11,046	11,422	11,561	11,541	11,498	11,052	10,910	10,608	10,893	10,805	10,833
2019/20	11,309												11,309
Difference	476												476

South Sefton CCG has seen a 446/4% increase in April-19 Incomplete Pathways compared to March-19. Aintree make up 62% of the CCG increase with a Provider variance of 276/4%. Liverpool Women's makes up the second highest proportion of the overall increase with a Provider variance of 74/9%. Notably, Liverpool Women's has seen an increase in waiting list numbers for 4 consecutive months, rising from 698 in Jan-19 to 854 in Apr-19, percentage wise this is a 22% increase in Incomplete Pathways. In terms of the NHSE submitted plans, 2019/20 Incomplete Pathways is currently 426/4% over plan.

2.3.1 Referral to Treatment Incomplete pathway – 52+ week waiters

Indicator		Performance Summary					Potential organisational or patient risk factors
Referral to Treatment Incomplete pathway (52+ weeks)		Latest and previous 3 months					The CCG is unable to meet statutory duty to provide patients with timely access to treatment. Potential quality/safety risks from delayed treatment ranging from progression of illness to increase in symptoms/medication or treatment required. Risk that patients could frequently present as emergency cases.
RED	TREND		Jan-19	Feb-19	Mar-19	Latest	
		CCG	1	1	1	1	
		Aintree	0	0	0	0	
		Plan: Zero					

Performance Overview/Issues:
In April there was 1 South Sefton patient waiting on the incomplete pathway for 52+ weeks against the national zero tolerance threshold. This is the same person who breached in the previous few months at Liverpool Womens. The delay in the patient's treatment was due to the initial physio treatment offered to the patient being no longer being offered by the Trust. The Trust has now purchased PTNS equipment and training has been given, the patients appointment is booked and confirmed with for 28th May 2019.
Actions to Address/Assurances:
The Trust purchased the relevant equipment, staff training has taken place and the patients now has a booked appointment. The above 52 week breach occurred in the last financial year and as such clarification has been sought from NHSE as to whether this breach should be excluded from 2019/20 performance reporting.
When is performance expected to recover:
A decision from NHSE is expected in July 2019 regarding this breach.
Quality impact assessment:
Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Terry Hill

2.3.2 Provider assurance for long waiters

Figure 4 - South Sefton CCG Provider Assurance for Long Waiters

CCG	Trust	Specialty	Wait band (Weeks)	Details
South Sefton CCG	Liverpool Womens	Gynaecology	52+ weeks	Physio patient requiring PTNS Physio, treatment no longer offered at LWH (x5 alternative appointments requested by patient). Patient attended clinic 16/04/2019 to discuss alternative treatment options with the Consultant however patient would prefer to wait for the PTNS option and is fully aware of the lead in time. Trust has purchased equipment, delivered last week. 6 sessions of staff training for PTNS commences on 23/05/19. Training company have confirmed attendance and appointment booked and confirmed with patient for 28/05/19.
South Sefton CCG	Liverpool Womens	Gynaecology	51 Weeks	**1 patient**; Awaiting update from CSU
South Sefton CCG	Liverpool Womens	Gynaecology	36 to 45 weeks	**21 patients**; Trust only send updates on 52 week waiters
South Sefton CCG	Alder Hey	Other	37 to 44 weeks	**7 patients** sent to service for dates, Audiology and community known capacity constraints action plan in place
South Sefton CCG	Royal Liverpool	General Surgery	37 weeks	**1 patient** no date yet
South Sefton CCG	Hull & East Yorkshire	All Other	36 weeks	**1 patient** awaiting TCI date
South Sefton CCG	Morecambe Bay	All Other	36 weeks	**1 patient** no trust reason
South Sefton CCG	St Helens & Knowlsey	General Surgery	41 weeks	**1 patient** no trust reason
South Sefton CCG	Wirral	Gynaecology	36 weeks	**1 patient**; Trust no longer provide updates on 40 week waiters

The CCG had a total of 81 patients waiting 36 weeks and over 36 of which there was 1 patient over 52 weeks at Liverpool Womens this patient now has a confirmed booked appointment. Of the remaining 80, 22 patients have been treated, 11 have a TCI date, 7 patients sent to service for dates, 15 patients had pathway stopped 1 awaiting trust update, 21 where trust only provides updates on over 52 week waiters, 4 other which include no longer on pathway, clock closed, pathway stopped.

2.4 Cancer Indicators Performance

2.4.1 - Two Week Urgent GP Referral for Suspected Cancer

Indicator		Performance Summary					IAF	Potential organisational or patient risk factors
2 week urgenty GP Referral for suspected cancer		Previous 3 months, latest and YTD					122a (linked)	Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Delayed dianosis can potentially impact significantly on patient outcomes. Delays also add to patient anxiety, affecting wellbeing.
RED	TREND		Jan-19	Feb-19	Mar-19	Latest	YTD	
		CCG	78.78%	90.54%	91.06%	86.14%	86.14%	
		Aintree	75.44%	83.47%	85.92%	76.97%	76.97%	
		Plan	93%	93%	93%	93%	93%	
		Aintree April Trajectory: 84.1% (National 93%)						

Performance Overview/Issues:

The CCG failed the target for cancer 2 week waits for April with 86.14%. In April there were 88 breaches from a total of 635 patients treated. There were 81 breaches at Aintree, 5 at Royal Liverpool, 1 at Liverpool Women's Hospital and 1 at Blackpool Fylde and Wyre. 63 breaches were due to inadequate out-patient capacity, 24 were due to patient choice and 1 due to other reason. The maximum wait was 63 days and was due to patient choice.

Aintree reported under the 93% target in April too recording 76.97% and also below the planned trajectory of 84.1%, having 257 breaches out of a total of 1158, majority of those breaches were due to in-adequate out-patient capacity.

Actions to Address/Assurances:

Breast services dominate the underperformance against this standard. As a health economy we have developed some revised referral forms and educational resources for primary care aimed at better risk stratification of referrals into suspected cancer and symptomatic pathways and increased management of benign breast disease in primary care. There will be a detailed review of cancer services for the Planned Care Group with Aintree.

When is performance expected to recover:

June 2019.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Debbie Harvey	Sarah McGrath

2.4.2 Two Week Wait for Breast Symptoms

Indicator		Performance Summary					IAF	Potential organisational or patient risk factors
2 week wait for breast symptoms (where cancer was no initially suspected)		Previous 3 months, latest and YTD						Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Delayed dianosis can potentially impact significantly on patient outcomes. Delays also add to patient anxiety, affecting wellbeing.
RED	TREND		Jan-19	Feb-19	Mar-19	Latest	YTD	
		CCG	56.67%	57.58%	68.00%	50.00%	50.00%	
		Aintree	57.82%	40.97%	64.83%	39.10%	39.10%	
		Plan	93%	93%	93%	93%	93%	
		Aintree April Trajectory: 74.9% (National 93%)						

Performance Overview/Issues:

The CCG failed the 93% target for April reporting 50.00%. In April there were 25 breaches from a total of 50 patients treated. All breaches were at Aintree with 21 due to inadequate out-patient capacity and 4 breaches were due to patient choice. The maximum wait was 32 days and was due to patient choice.

Aintree reported 39.10% and are also failing the planned trajectory of 74.9% having 95 breaches out of a total of 156 patients, of which 84 were for inadequate out-patient capacity.

Actions to Address/Assurances:

As a health economy we have developed some revised referral forms and educational resources for primary care aimed at better risk stratification of referrals into suspected cancer and symptomatic pathways and increased management of benign breast disease in primary care.

When is performance expected to recover:

June 2019.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Debbie Harvey	Sarah McGrath

2.4.3 - 62 Day Cancer Urgent Referral to Treatment Wait

Indicator		Performance Summary					IAF	Potential organisational or patient risk factors
All cancer two month urgent referral to treatment wait		**Previous 3 months, latest and YTD**					122b	Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Delayed dianosis can potentially impact significantly on patient outcomes. Delays also add to patient anxiety, affecting wellbeing.
RED	**TREND**		Jan-19	Feb-19	Mar-19	Latest	YTD	
		CCG	69.23%	68.18%	78.79%	75.00%	75.00%	
		Aintree	74.81%	74.44%	81.58%	69.06%	69.06%	
		Plan	85%	85%	85%	85%	85%	
		Aintree April Trajectory: 71.9% (National 85%)						

Performance Overview/Issues:

The CCG failed the target for April reporting 75%. In April there were 8 breaches from a total of 32 patients seen, breach reasons include delays due to complex diagnostic pathways, delays for medical reasons, patient DNA and ther reasons not stated. There appears to be breast breaches for 62 days which is unusual, see 2 week breast actions.

Aintree also failed the target and planned trajectory of 71.9% in April reporting 69.06%.

Actions to Address/Assurances:

The Cancer Alliance has allocated funding in the region of £2.2M across the footprint to optimise pathways for the following cancers and create sustainable operational performance, Head and neck, Oesophago-gastric, Urology, Colorectal and Gynae-oncology.
Work with Aintree through the monthly Planned Care Group to develop a realistic cancer recovery plan.

When is performance expected to recovery:

Trajectory submitted by Aintree does not indicate recovery within this financial year.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Debbie Harvey	Sarah McGrath

2.4.4 62 Day wait for first treatment for Cancer following a Consultants Decision to Upgrade

Indicator		Performance Summary					IAF	Potential organisational or patient risk factors
62 day wait for first treatment for Cancer following a Consultants Decision to Upgrade the Patient's Priority		**Previous 3 months, latest and YTD**						Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Delayed dianosis can potentially impact significantly on patient outcomes. Delays also add to patient anxiety, affecting wellbeing.
RED	**TREND**		Jan-19	Feb-19	Mar-19	Latest	YTD	
		CCG	60.00%	85.71%	90.91%	60.00%	60.00%	
		Aintree	69.70%	79.07%	76.47%	70.00%	70.00%	
		Plan	85%	85%	85%	85%	85%	
		Aintree April Trajectory: 87.5% (National 85%)						

Performance Overview/Issues:

The CCG failed the target for April with 60.00%. In April there were 6 breaches from a total of 15 patients seen, reasons were complex diagnostic pathways (4) and other (2).

Aintree failed the monthly target for April with 70% also failing the trajectory of 87.5%. There were the equivalent of 6 breaches out of a total of 20 patients seen.

Actions to Address/Assurances:

When is performance expected to recovery:

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	Debbie Harvey	Sarah McGrath

2.4.5 104+ Day Breaches

Indicator		Performance Summary				IAF	Potential organisational or patient risk factors
Cancer waits over 104 days - Aintree		**Latest and previous 3 months**					Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Delayed dianosis can potentially impact significantly on patient outcomes. Delays also add to patient anxiety, affecting wellbeing.
RED	**TREND**	Jan-19	Feb-19	Mar-19	Latest		
		10	2	4	4		
		Plan: Zero					

Performance Overview/Issues:

In April there were 4 over 104 day breaches at Aintree the longest waiting 135 days, reason not listed this was an upper gastro patient, there was 1 other with no reason, the other 2 delays were due to complex diagnostics pathways.

Actions to Address/Assurances:

A Local Agreement process for notifying CCGs of 104 day breaches and undertaking Root Cause Analyses (RCAs) will be varied into provider contracts. Action plans driven through these RCAs will be developed through the CCGs' PQIRP Group.

When is performance expected to recovery:

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Jan Leonard	Debbie Harvey	Sarah McGrath

2.5 Patient Experience of Planned Care

Indicator		Performance Summary					Potential organisational or patient risk factors
Aintree Friends and Family Test Results: Inpatients		**Previous 3 months and latest**					
RED	**TREND**		Jan-19	Feb-19	Mar-19	Latest	
		RR	18.9%	19.5%	20.8%	16.0%	
		% Rec	94.0%	94.0%	94.0%	92.0%	
		% Not Rec	3.0%	3.0%	4.0%	4.0%	
		April 2019 England Averages Response Rates: 24.9% % Recommended: 96% % Not Recommended: 2%					

Performance Overview/Issues:

Aintree Trust has reported a response rate for inpatients of 16% in April 2019. This is significantly below the England average of 24.9%. The percentage of patients who would recommend the service decreased to 92% below the England average of 96% and the percentage who would not recommend has remained the same at 4% above the England average of 2%.

Actions to Address/Assurances:

Friends and Family is a standing agenda item at the Clinical Quality Performance Group (CQPG) meetings. The CCG Engagement and Patient Experience Group (EPEG) have sight of the Trusts friends and family data on a quarterly basis and seek assurance from the trust that areas of poor patient experience is being addressed.

When is performance expected to recover:

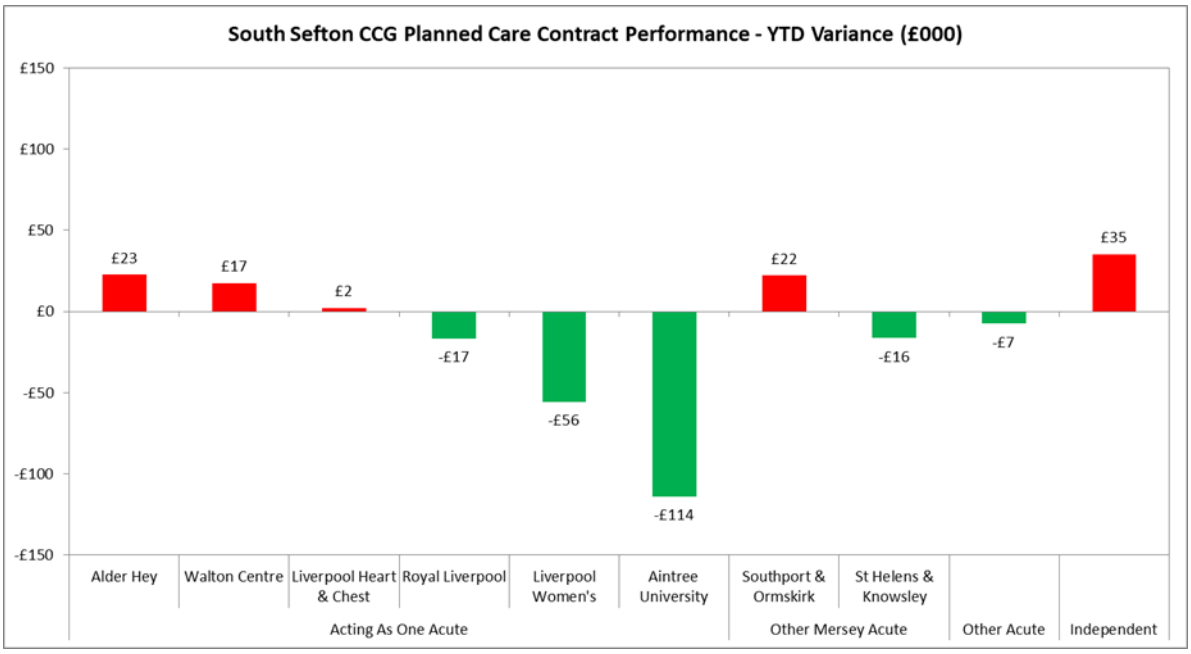
Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Brendan Prescott	N/A	Amanda Gordon

2.6 Planned Care Activity & Finance, All Providers

Figure 5 - Planned Care - All Providers



Performance at Month 1 of financial year 2019/20, against planned care elements of the contracts held by NHS South Sefton CCG shows an under performance of circa -£111k/-2.8%. However, applying a neutral cost variance for those Trusts within the Acting as One block contract arrangement results in an over spend of approximately £33k/0.8%.

At individual providers, Aintree Hospital is showing the largest under performance at month 1 with a variance of -£114k/-4.7%. Outpatients (first, follow up and procedures) account for the majority of the variance against plan in month. Outpatient activity for the aforementioned points of delivery is also -17% below activity levels in the equivalent month in 2018/19.
For other Providers, Renacres make up the majority of over performance at month 1 with elective procedures within the elective point of delivery responsible for the majority of the £50k/29% variance against plan. However, activity variances are minimal.

NB. There is no financial impact to South Sefton CCG for contract performance at any Providers within the Acting as One block contract arrangement.

It should also be noted that 2019/20 activity plans are yet to be agreed for a number of Providers. Therefore, contract performance values included in the above chart may relate to variances against 2018/19 plan values.

3. Unplanned Care

3.1 Accident & Emergency Performance

3.1.1 A&E 4 Hour Performance: South Sefton CCG

Indicator		Performance Summary						IAF	Potential organisational or patient risk factors
CCG A&E Waits - % of patients who spend 4 hours or less in A&E (cumulative) 95%		Previous 2 months, latest and YTD						127c	Risk that CCG is unable to meet statutory duty to provide patients with timely access to treatment. Quality of patient experience and poor patient journey. Risk of patients conditions worsening significantly before treatment can be given, increasing patient safety risk.
RED	TREND		Jan-19	Feb-19	Mar-19	Latest	YTD		
		All Types	82.36%	80.14%	80.64%	78.17%	78.17%		
		Type 1	79.30%	76.42%	77.15%	74.01%	74.01%		
		Plan: 95%							

Performance Overview/Issues:

The CCG is failing the national standard of 95% in April reporting 78.17%. A drop from the previous month with average reduced following lower performance in week following Easter bank holidays. A trajectory has been agreed with NHSE/I that runs to 89% in March 2020 not the national target.

Actions to Address/Assurances:

A wide range of work is ongoing to support the Aintree system involving CCG and community provider, local authority:

• Action on A&E is supported by a system wide approach with significant involvement of the CCG Urgent Care lead, our community provider and local authority. Work has been refocused following the Newton Europe review with a wide range of work which focuses on improving patient flow within A&E and main hospital in regard to discharge planning that enables movement from A&E for appropriate admissions; as well as admission/attendance avoidance schemes to reduce A&E activity. This work will remain on-going in 2019/20.

• CCG have taken a lead role in facilitating the Newton Europe DTOC project with system wide action plans now developed to support patient flow and enhance quality of care in three specific areas – decision making, placements and home care. Work is being undertaken with all health and social care providers and commissioners across North Mersey. Within Aintree Hospital there is specific focus on the decision making element of this work.

• An escalation plan has been in place over the winter within North Mersey which outlines the expected roles and responsibilities of all providers with guidance as to when issues should be escalated outside of the Trust to commissioners. This was developed to ensure that resources are used appropriately and that there is a clear understanding of the mutual aid and partnership working that is expected at provider level prior to commissioner engagement. Aintree managed AED pressures over a challenging winter often providing support through ambulance diversions for other local Trusts. This support has continued in 2019.

• The weekly Multi Agency Discharge Events (MADE) which involve representatives from health and social care have being revised to provide a greater focus on areas requiring immediate action. Instead they have been operating as MDT Flying Squads from the start of December targeting front of house areas e.g. AED, Frailty, Observation ward. Working to maintain focus on patient flow from front door units has continued in 2019/20 with system work initiated to improve ambulatory care pathways within the Frailty Assessment Unit.

• On-going implementation of Mersey Care Alternative to Transfer scheme with system introduced to provide timely response to NWAS to support patients at home who do not require conveyance to A&E. Work underway to promote service further and increase referrals and range of pathways that can be supported. Work is being rolled out within Mersey Care to Liverpool and aim to share good practice and roll out to Southport & Formby to ensure consistent offer to NWAS.

• Collaborative work is underway with Liverpool and Knowsley CCGs to review potential Urgent Treatment Centre provision within Aintree footprint again with focus of reducing A&E attendances.

• Weekly Aintree system calls are in place with NHSE and all partners to agree priority areas to progress each week reflecting local requirements. These are working well in maintaining operational and strategic communication across organisations.

In addition to above the three priority areas which the Trust have identified will make the greatest impact on A&E performance are:

- Optimising processes for See and Treat / Primary Care Streaming cohort of patients
- Ambulance turn around times and introduction of direct conveyancing to agreed front door units
- Integrated work with partners to address superstranded and support patient flow in and out of hospital.

When is performance expected to recovery:

Aintree have an agreed trajectory with NHSE/I profiled from 88% in Month 1 to 89% in Month 12 not the national target of 95%.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Janet Spallen

3.1.2 A&E 4 Hour Performance: Aintree

Indicator		Performance Summary						Potential organisational or patient risk factors
Aintree A&E Waits - % of patients who spend 4 hours or less in A&E (cumulative) 95%		**Previous 2 months, latest and YTD**						Risk that the Trust is unable to meet statutory duty to provide patients with timely access to treatment. Quality of patient experience and poor patient journey. Risk of patients conditions worsening significantly before treatment can be given, increasing patient safety risk.
RED	**TREND**		Jan-19	Feb-19	Mar-19	Latest	YTD	
		Improvement Plan	93.30%	84.20%	95%	88%		
		All Types	87.55%	84.89%	85.12%	82.67%	82.67%	
		Type 1	77.68%	73.38%	73.36%	69.69%	69.69%	
		Plan: 95% April's improvement plan: 88% Yellow denotes achieving 19/20 improvement plan but not national standard of 95%						

Performance Overview/Issues:

The performance against the 4 hour care standard saw a drop in April's performance to 82.67% for type 1 and 3, against March's performance of 85.12% (-2.45%). When comparing T1 with April 2018 it should be noted that there was a 1% decline against a 9% increase in attendance.

Actions to Address/Assurances:

Trust Actions:

• Increased nursing support in in the form of a senior nurse and HCA's based in the See and Treat area during the times when mose breaches occur will commence as soon as possible. The presence of a senior doctor to support the medical workforce in decision making and oversee the overall safety of the area will also imorove the throughput rate. **Outcome: Rapid improvement in non-admitted performance and improved flow through See and Treat.**

• The Clinical Director and CBM will reaffirm to all clinicians of FY3 and above the need to Pit Stop between the hours of 7am and midnight everyday, with the aim to formalise a Pit Stop roster encompassing the full set of staff required to successfully deliver the model during these hours including senior nurse, TY1's, staff nurse and HCA. **Outcome: Consistent coverage of the Pit Stop Model with improved WTTBS performance and improved Ambulance Turnaround Times.**

• Rapid Process Improvement Event focussing on the AEC pathway from the point of referral to the point of discharge. **Outcome: A completed RPIW**

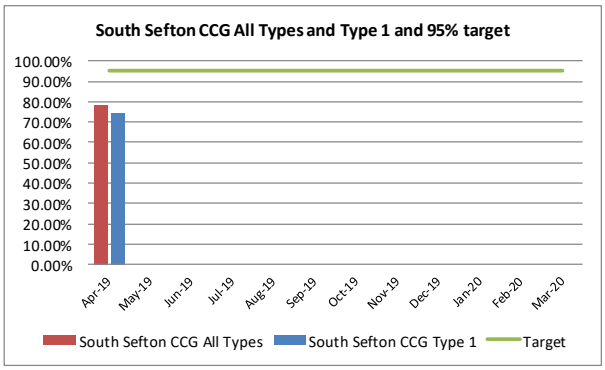
When is performance expected to recovery:

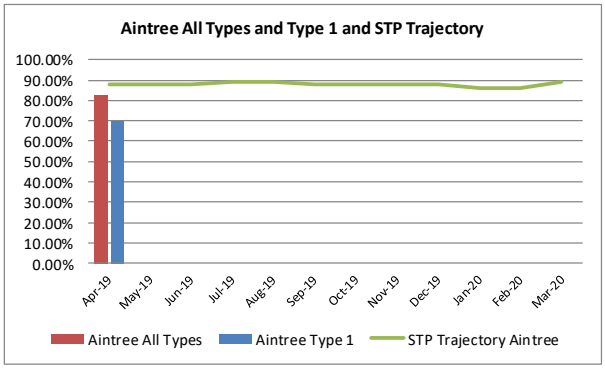
Quarter 4, 2019/20.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Jan Leonard	John Wray	Janet Spallen

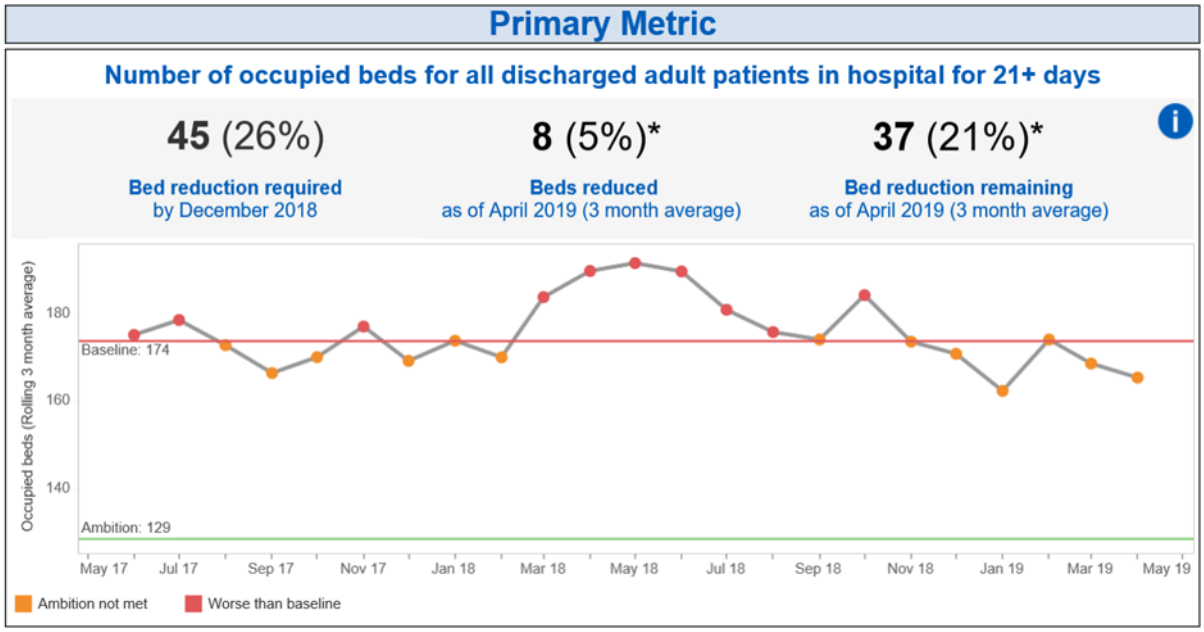




3.2 Occupied Bed Days

NHS England and NHS Improvement expect to reduce long stay patients (as defined by LOS of 21+ days) by 25% and free up at least 4,000 beds by December 2018. The reduction will be monitored on a 3 month rolling basis and success will be judged against the average for Jan-Mar 2019.

Figure 6 – Occupied Bed Days, Aintree Hospital



Data Source: NHS Improvement – Long Stays Dashboard

The Trust's target is to reduce total occupied beds by 45 (26%) by December 2018; therefore the target is 129 or less. This target is yet to be achieved as current reporting for April 2019 (rolling 3 months) shows 165 occupied beds (a decrease of 8 beds). This is a decrease of 4 occupied beds compared to last month.

Actions to support improvement are identified within Newton work with a focus on initiatives which will support complex discharges with longer lengths of stay. There are a range of developments underway in regard to placement processes; discharge to assess pathways, the patient choice policy to facilitate flow, development of care home trusted assessor roles and community pathways to facilitate earlier discharge. Patient Flow Telecoms and focussed individual patient case work continue where stranded and super stranded patients reviewed with MDT involvement. Support provided where required with opportunity to identify specific themes requiring further action. Collaborative work by all Aintree partners is detailed in NHSI action plan and trajectory to address patients with long lengths of stay.

3.3 Ambulance Performance

Indicator		Performance Summary					Definitions	Potential organisational or patient risk factors
Category 1,2,3 & 4 performance		Latest and previous 2 months					**Category 1** -Time critical and life threatening events requiring immediate intervention **Category 2** -Potentially serious conditions that may require rapid assessment, urgent on-scene clinical intervention/treatment and / or urgent transport **Category 3** - Urgent problem (not immediately life-threatening) that requires treatment to relieve suffering **Category 4 / 4H / 4HCP**- Non urgent problem (not life-threatening) that requires assessment (by face to face or telephone) and possibly transport	Longer than acceptable response times for emergency ambulances impacting on timely and effective treatment and risk of preventable harm to patient. Likelihood of undue stress, anxiety and poor care experience for patient as a result of extended waits. Impact on patient outcomes for those who require immediate lifesaving treatment.
RED	TREND	Cat	Target	Feb-19	Mar-19	Latest		
		1 mean	<=7 mins	00:08:34	00:07:22	00:07:13		
		1 90	<=15 mins	00:14:26	00:12:50	00:11:36		
		2 mean	<=18 mins	00:32:26	00:28:24	00:26:56		
		2 90	<=40 mins	01:16:55	01:05:08	01:01:45		
		3 90	<=120 mins	03:16:49	02:58:45	03:03:14		
		4 90	<=180 mins	03:11:09	02:50:09	03:00:37		

Performance Overview/Issues:

In April 2019 there was an average response time in South Sefton of 7 minutes 13 seconds against a target of 7 minutes for Category 1 incidents. For Category 2 incidents the average response time was 26 minutes against a target of 18 minutes, the slowest response time in Merseyside. The CCG also failed the category 3 and category 4 90th percentile response. Performance is being addressed through a range of actions including increasing number of response vehicles available, reviewing call handling and timely dispatch of vehicles as well as ambulance handover times from A&E to release vehicles back into system.

Actions to Address/Assurances:

Through 2018/19 NWAS has made good and sustained progress in improving delivery against the national ARP standards. Significant progress has been made in re-profiling the fleet, improving call pick up in the EOCs, use of the Manchester Triage tool to support both hear & treat and see & treat and reduce conveyance to hospital. The joint independent modelling commissioned by the Trust and CCGs set out the future resource landscape that the Trust needs if they are to fully meet the national ARP standards, critical to this is a realignment of staffing resources to demand which will only be achieved by a root and branch re-rostering exercise. This exercise has commenced however due to the scale and complexity of the task, this will not be fully implemented until the end of Quarter 1 2020/21. To support the service to both maintain and continue to improve performance, the contract settlement from commissioners for 2019/20 provided the necessary funding to support additional response staffing and resources, including where required the use of VAS and overtime to provide interim additional capacity, prior to full implementation of the roster review.

When is performance expected to recovery:

The 2019/20 contract agreement with NWAS identifies that the ARP standards must be met in full (with the exception of the C1 mean) from quarter 4 2019/20. The C1 mean target is to be delivered from quarter 2 2020/21. A trajectory has been agreed with the Trust for progress towards delivery of the standards.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Janet Spallen

3.4 Ambulance Handovers

Indicator		Performance Summary					Indicator a) and b)	Potential organisational or patient risk factors
Ambulance Handovers		Latest and previous 2 months					a) All handovers between ambulance and A&E must take place within 15 minutes with non waiting more than 30 minutes b) All handovers between ambulance and A&E must take place within 15 minutres with non waiting more than 60 minutes	Longer than acceptable response times for emergency ambulances impacting on timely and effective treatment and risk of preventable harm to patient. Likelihood of undue stress, anxiety and poor care experience for patient as a result of extended waits. Impact on patient outcomes for those who require immediate lifesaving treatment.
RED	TREND		Target	Feb-19	Mar-19	Latest		
		(a)	<=15 mins	164	159	183		
		(b)	<=15 mins	96	71	101		

Performance Overview/Issues:

Performance for the month of April saw a decline all over with 183 delays in excess of 30 minutes, which is + 24 from the March figure of 159, delays over 60 minutes increased to 101, + 30 from March. The average time from notification to handover for April was 15.47 minutes which is 1.3 minutes increase from March. The median time to see 1st clinician has seen a drop to 88 minutes to be seen against 76 minutes in March (-12 minutes). The % of patients seen from registration within 15 minutes has also seen a decline from 78.67% to 74.68% in April, a drop of 3.99%. The clinical quality indicators for the number of patients who leave the department before being seen has increased to 419 (+114) with 5.27% (+1.4%). The number of patients re-attending in April has remained static at 8.41%.

Actions to Address/Assurances:

Aintree have been part of the Super Six working with NWAS to improve processes to support achievement of the handover targets. They have identified that the priority area which will have the greatest impact will be the introduction of direct conveyancing of appropriate patients to front door units e.g. Ambulatory Medical Unit, Frailty Assessment Unit, without being first triaged through AED. The TRust have been asked to update their Ambulance Handover Improvement Plan with details of implementation plans and timescales for the introduction of direct conveyancing.

When is performance expected to recovery:

This is a priority area for immediate improvement. We are awaiting an update Improvement Plan which will detail timescales for implementation of direct conveyancing.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Karl McCluskey	John Wray	Janet Spallen

3.5 Unplanned Care Quality Indicators

3.5.1 Stroke and TIA Performance

<table>
<tr><th colspan="2">Indicator</th><th colspan="4">Performance Summary</th><th>Measures</th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">Aintree Stroke & TIA</td><td colspan="4">Latest and previous 3 months</td><td rowspan="3">a) % who had a stroke & spend at least 90% of their time on a stroke unit

b) % high risk of Stroke who experience a TIA are assessed and treated within 24 hours</td><td rowspan="3">Risk that CCG is unable to meet statutory duty to provide patients with timely access to Stroke treatment. Quality of patient experience and poor patient journey. Risk of patients conditions worsening significantly before treatment can be given, increasing patient safety risk.</td></tr>
<tr><td>RED</td><td>TREND</td><td>Jan-19</td><td>Feb-19</td><td>Mar-19</td><td>Latest</td></tr>
<tr><td>  </td><td>  </td><td>71.90%</td><td>73.00%</td><td>70.60%</td><td>60.00%</td></tr>
<tr><td colspan="6">Stroke Plan: 90%
TIA 60% (achieving in April)</td></tr>
<tr><td colspan="8">Performance Overview/Issues:</td></tr>
<tr><td colspan="8">Performance against the National Quality Stroke metric 90% stay standard was 60% for April 2019 for Aintree. There were 45 patients with a primary diagnosis of stroke discharged from the Trust during the month. Of these, 27 patients spent 90% of their stay on the Stroke Unit. The standard was not achieved for 18 patients. All breaches of the standard are reviewed and reasons for underperformance identified:

- 12 patients required admission to the Stroke Unit with no bed availability
- 3 patients presented with atypical symptoms and diagnosed after MRI scan
- 1 patient was for palliative care and was nurses on a side-room
- 2 patients were later referrals after a MRI diagnosed Stroke</td></tr>
<tr><td colspan="8">Actions to Address/Assurances:</td></tr>
<tr><td colspan="8">Trust Actions:
• Work with Lead Nurse for workforce on a recruitment strategy for Registered Nursing vacancies.
• Develop a case for 2 additional HASU beds.
• Work with AED, Stroke MDT and Radiology to Review 1 hour scanning time on arrival to Trust.
• Review process for step down from Ward 33 to Aintree2home and Ward 34.</td></tr>
<tr><td colspan="8">When is performance expected to recovery:</td></tr>
<tr><td colspan="8">Quarter 2, 2019/20.</td></tr>
<tr><td colspan="8">Quality impact assessment:</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">Indicator responsibility:</td></tr>
<tr><td colspan="2">Leadership Team Lead</td><td colspan="3">Clinical Lead</td><td colspan="3">Managerial Lead</td></tr>
<tr><td colspan="2">Karl McCluskey</td><td colspan="3">John Wray</td><td colspan="3">Janet Spallen</td></tr>
</table>

3.5.2 Healthcare associated infections (HCAI): C Difficile

Indicator		Performance Summary					Potential organisational or patient risk factors
Incidence of Healthcare Acquired Infections: C Difficile		**Latest and previous 3 months**					
RED	**TREND**	Jan-19	Feb-19	Mar-19	Latest		
		6	3	4	7	Plan: 60 YTD for the CCG Plan: 56 for Aintree	

Performance Overview/Issues:

The CCG had 7 new cases of C.Difficile in April, against a year to date plan of 5 (year end plan 60) so are over plan currently (2 apportioned to acute trust and 5 apportioned to community).

The national objective for C Difficile has changed. All acute trusts are now performance monitored on all cases of healthcare associated infections including those which are hospital onset health care associated (HOHA): cases detected in the hospital three or more days after admission and community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks. The Trusts national objective is to have no more than 56 healthcare associated cases in 2019/20. In April 2019 there have been 5 healthcare associated cases (2 x COHA and 3 X HOHA). This slightly exceeds the monthly objective of no more than 4.66 cases per month. NB the national PHE data set does not currently reflect this change attribution and shows Aintree have had 9 cases in April (3 apportioned to the trust and 6 community onset).

Actions to Address/Assurances:

Trust Actions:
- Commode cleanliness monitored weekly and performance sent to WNM
- Bristol stool chart to be used for all patients
- Review of all CDI and GDH tox B positive cases ribotyping
- Deep clean programme to be developed for 19/20
- Review of signage in patients toilets
- Standardise signage in patients toilets
- Poster to be developed for PEE in side rooms – to trial in IPC collaborative
- Revised commode cleaning guide and checklist issues to wards

When is performance expected to recovery:

Quarter 2, 2019/20

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Brendan Prescott	Gina Halstead	Amanda Gordon

3.5.3 Healthcare associated infections (HCAI): E Coli

Indicator		Performance Summary				RightCare Peer Group	Potential organisational or patient risk factors
Incidence of Healthcare Acquired Infections: E Coli		Latest and previous 3 months					
RED	TREND	Jan-19	Feb-19	Mar-19	Latest		
		15	13	12	15		
		Plan: 128 YTD for the CCG					

Performance Overview/Issues:
NHS Improvement and NHS England have set CCG targets for reductions in E.coli for 2019/20 NHS South Sefton CCG's year-end target is 128 the same as last year when the CCG failed reporting 170 cases. In April there were 15 cases against a year to date plan of 11. Aintree reported 32 cases in April there are no targets set for Trusts at present.
Actions to Address/Assurances:
The Gram Negative Bloodstream Infection Steering Group continues to meet on a bi-monthly basis with specific work stream areas on surveillance and reporting; continence and hydration to prevent symptoms of Urinary Tract Infection (UTI). The outputs of the work streams should impact on HCAI outcomes (inclusive of both C.difficile and E.Coli). Due to the failure of the C.difficile, the year-end target for 2019-20 has increased to 60 for the CCG. The target for E.coli remains the same for 2019-20 as it did in 2018/19, 128 cases.
When is performance expected to recovery:
Quarter 1, 2019/20
Quality impact assessment:
Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Brendan Prescott	Gina Halstead	Amanda Gordon

3.5.4 Hospital Mortality

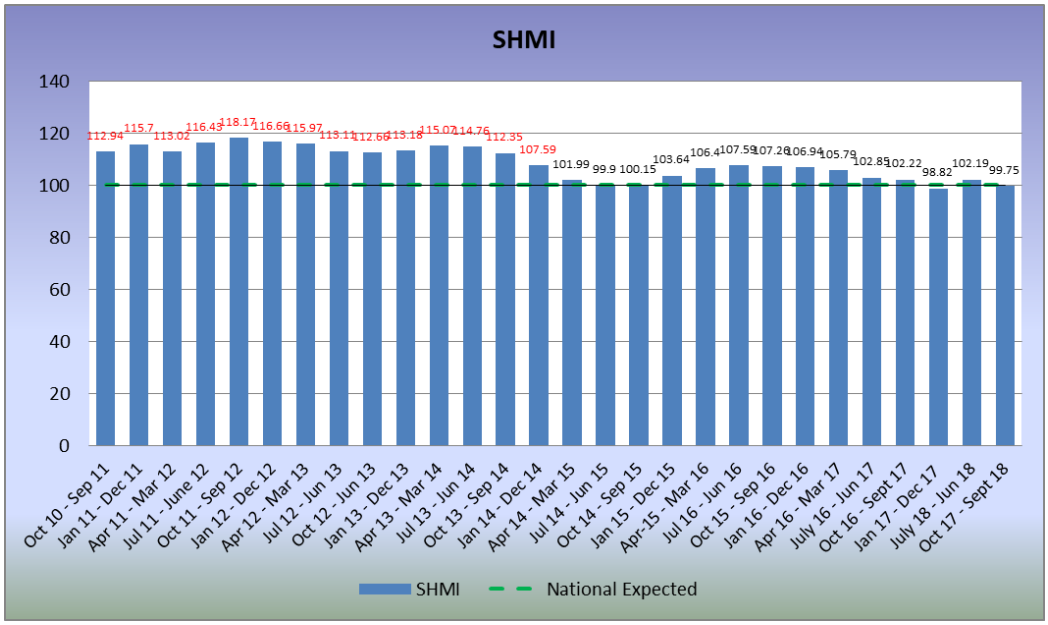
Figure 7 - Hospital Mortality

Mortality				
Hospital Standardised Mortality Ratio (HSMR)	19/20 - Apr	100	93.11	↓

HSMR is slightly lower than last month at 93.11 (Feb 18 – Jan 19) (95.84 was previously reported). Position remains better than expected. A ratio of greater than 100 means more deaths occurred than expected, while the ratio is fewer than 100 this suggest fewer deaths occurred than expected. Ratio is the number of observed deaths divided by predicted deaths. HSMR looks at diagnoses which most commonly result in death.

SHMI at 99.75 is lower than previous period and within tolerance levels. SHMI is risk adjusted mortality ratio based on number of expected deaths.

Figure 8 - Summary Hospital Mortality Indicator



3.6 CCG Serious Incident Management

In April there are a total of 43 serious incidents (SIs) open on StEIS for South Sefton as the RASCI (Responsible, Accountable, Supporting, Consulted, Informed) commissioner or that involve a South Sefton CCG patient. There is an increase of 3 compared to the previous month which is due to an increase in SIs reported for Month 1. Those where the CCG is not the RASCI responsible commissioner are highlighted in green in the table below.

Figure 9 – Serious Incident for South Sefton Commissioned Services and South Sefton CCG patients

Trust	SIs reported (M1)	SIs reported (YTD)	Closed SIs (M1)	Closed SIs (YTD)	Open Sis (M1)	SIs open >100days (M1)
Aintree University Hospital	5	5	5	5	27	18
Mersey Care NHS Foundation NHS Trust (SSCS)	4	4	1	25	7	0
South Sefton CCG	0	0	0	0	2	1
Mersey Care NHS Foundation Trust (Mental Health)	0	0	1	1	3	1
Royal Liverpool and Broadgreen	0	0	0	0	1	0
The Walton Centre	0	0	0	0	1	1
Alder Hey Children's Hospital	0	0	0	0	1	0
UC24	0	0	0	0	1	0
TOTAL	**9**	**9**	**7**	**31**	**43**	**21**

Of the 18 SIs open > 100 days for Aintree University Hospital (AUH), the following applies at the time of writing this report:

- 9 have been reviewed and are now closed

- 6 have been reviewed and closure agreed at South Sefton SIRG, however awaiting confirmation of closure from patients CCG.
- 2 have been reviewed at SIRG and further assurance has been requested from the provider.
- 1 has been re-opened from 2016 following a coroner's report highlighting potential learning. A multi-organisational investigation is being carried out with AUH leading and is not due until the beginning of July 2019.

For the remaining SIs open > 100 days the following applies:

- *South Sefton CCG* – this SI is subject to safeguarding processes therefore the normal timescales do not apply.
- *Mersey Care NHS Foundation Trust (Mental Health)* – RCA reviewed at SIRG but further assurances requested from the provider via Liverpool CCG.
- *The Walton Centre NHS Foundation Trust* - This RCA is being performance managed by NHSE Specialised Commissioning.

Figure 10 – Timescale Performance for Aintree University Hospital

PROVIDER	SIs reported within 48 hours of identification (YTD)		72 hour report received (YTD)			RCAs Received (YTD)				
	Yes	No	Yes	No	N/A	Total RCAs due	Received within 60 days	Extension Granted	SI Downgraded	RCA 60+
Aintree	5	0	3	2*	-	2	1	1	0	0

**N.B. The trust performance against this target continues to improve following an increased emphasis on submission of 72 hour reports. The CCG continue to monitor this requirement and work with the providers to ensure reports are submitted on time or rationales are provided where a 72 hour report is not submitted.*

Figure 11 – Timescale Performance for Mersey Care Foundation Trust (South Sefton Community Services (SSCS)

PROVIDER	SIs reported within 48 hours of identification (YTD)		72 hour report received (YTD)		RCAs Received (YTD)				
	Yes	No	Yes	No	Total RCAs Due	Received within 60 days	Extension Granted	SI Downgraded	RCA 60+
Mersey Care (Community)	3	1	0	4*	1	0	0	0	1

**N.B. The trust performance against this target is monitored by Liverpool CCG, the Lead Commissioner for Mersey Care Trust. However, the requirement to submit a 72 hour report following the reporting of an SI was discussed at the January 2019 Divisional Harm Free Care Group of which SSCCG is a member.*

3.7 CCG Delayed Transfers of Care

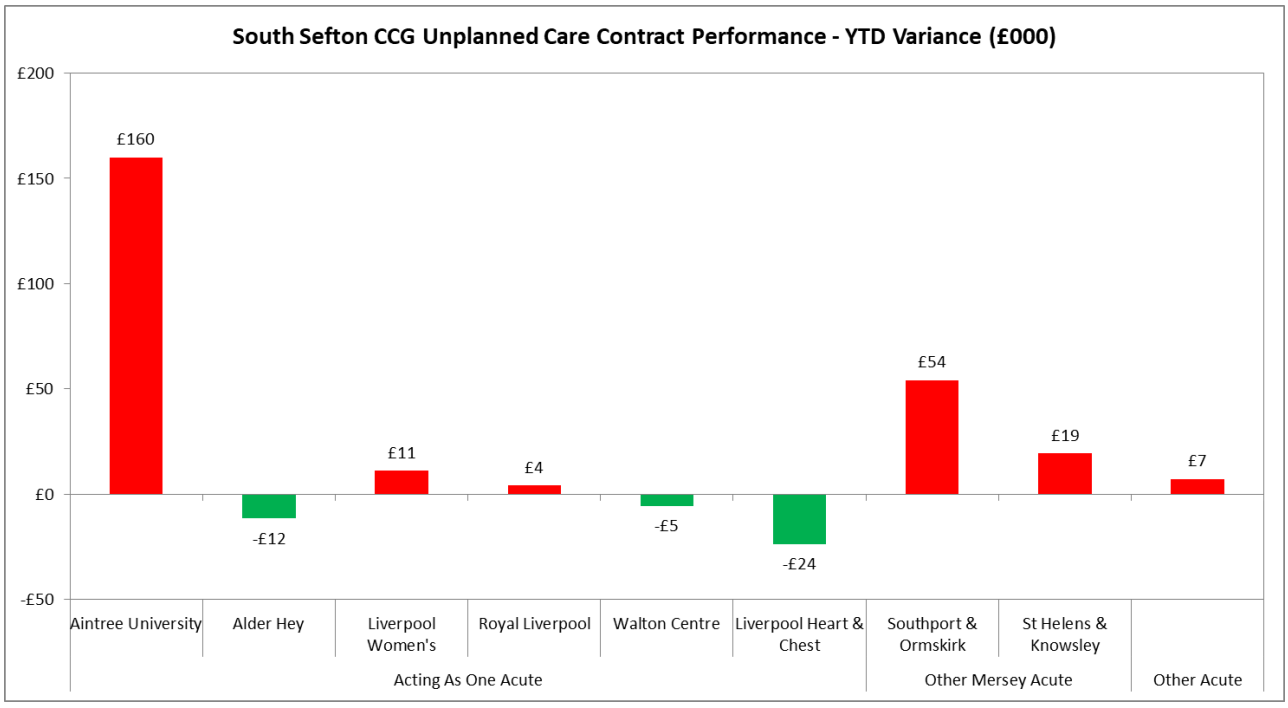
The CCG Urgent Care lead works closely with Aintree and the wider MDT involving social care colleagues to review delayed transfers of care on a weekly basis. There is weekly telecom to review patients waiting over 7 and 21 days with the aim of ensuring movement against agreed discharge plans. There is opportunity within these interventions to identify key themes which need more specific action e.g. we are presently reviewing our discharge to assess pathway where we aim to ensure DSTs are undertaken outside of a hospital setting. We are also working with Mersey Care as our community provider to ensure that ward staff are educated on community pathways which are available to facilitate early discharge with particular focus on ICRAS. Collaborative action by all Aintree partners is detailed in NHSI action plan with trajectory for reductions on long lengths of stay.

Total delayed transfers of care (DTOC) reported in April 2019 was 506, a decrease compared to April 2018 with 871. Delays due to NHS have worsened, with those due to social care improving. The majority of delay reasons in April 2019 were due to patient family choice, further non-acute NHS and care package in home. See DTOC appendix for more information.

3.8 Unplanned Care Activity & Finance, All Providers

3.8.1 All Providers

Figure 12 - Month 1 Unplanned Care – All Providers



Performance at Month 1 of financial year 2019/20, against unplanned care elements of the contracts held by NHS South Sefton CCG shows an over performance of circa £216k/5.2%. Applying a neutral cost variance for those Trusts within the Acting as One block contract arrangement results a reduced overspend of approximately £81k/1.9%.

This over performance is clearly driven by Aintree Hospital, which has a variance of £160k/4.4% against plan at month 1. A&E attendances were 6% above plan but non-elective admissions account for the majority of the over performance reported. This is despite overall activity within the non-

elective point of delivery being slightly below plan, which suggests a possible change in case mix for patients presenting.

Southport Hospital is also reporting an over performance of £54k/24%. However, as a 2019/20 contract has yet to be formally agreed with this Provider, planned values relate to 2018/19 values. As such, non-elective activity recorded as a result of pathway changes implemented by the Provider within 2018/19 will account for the significant over performance reported at month 1 of 2019/20.

NB. There is no financial impact to South Sefton CCG for contract performance at any Providers within the Acting as One block contract arrangement.

It should also be noted that 2019/20 activity plans are yet to be agreed for a number of Providers. Therefore, contract performance values included in the above chart may relate to variances against 2018/19 plan values.

4. Mental Health

4.1 Mersey Care NHS Trust Contract (Adult)

4.1.1 Mental Health KPI

Indicator		Performance Summary					Potential organisational or patient risk factors
% of people experiencing first episode psychosis (EIP) or an "at risk mental state" that wait 2 weeks or less to start a NICE recommended package of		Latest and previous 3 months					
RED	TREND	Jan-19	Feb-19	Mar-19	Latest		
		50.0%	50.0%	62.5%	50.0%		
		Plan: 56% - 2019/20 reported 50% and failed					

Performance Overview/Issues:

There were 3 breaches out of a possible 6 Service Users. The first was due to the complexity of the issues faced resulting in the Service User not being able to respond to simple questions and further information from medical records bening required thus causing a delay. The second was due to 3 appointments being offered and DNA'd, and the third was due to a DNA and cancellation of subsequent appointment.

Actions to Address/Assurances:

When is performance expected to recover:

Ongoing throughout 2019/20

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Sue Gough	Gordon Jones

4.1.2 Mental Health Contract Quality Overview

The Trust, in response to the Crisis Resolution Home Treatment Team (CRHTT) core fidelity review findings has established an urgent pathway work stream to establish a Single Point of Access to enable a more responsive access point for urgent referrals. This work also includes the identification of staff who undertake CRHTT functions with the aim of establishing a one stop integrated referral and response across the Trust's footprint.

The Trust has confirmed that through a combination of reorganisation and recruitment they are planning to have 50.3 WTE multi-disciplinary staff providing the CRHTT function from May 2020 onwards. Commissioners and the Trust will be working with the Trust to agree reportable KPIs and outcomes.

Mersey Care NHS RiO M1 update
As part of the implementation of the RiO system in June 2018 a plan was agreed between the Trust and CCGs; whereby some KPIs were suspended until RiO was able to provide KPI data. A plan of shadow reporting was set up, and then reporting of all KPIs was implemented and back dated information was supplied. There remain gaps for some measures which will be implemented going forward in 2019/20 KPI reporting however it is anticipated that KPIs will be fully reported from Q2 with backdated to Q1 where applicable.

Safeguarding
The contract performance notice remains in place in respect of training compliance. Bi-monthly meetings continue to take place between the Trust and CCG Safeguarding teams to scrutinise progress against the agreed action plan and trajectory. The performance notice will remain open for a further 6 months to ensure sustainability.

4.1.3 Mental Health Contract Quality

KPI 125: Eating Disorder Service Treatment commencing within 18 weeks of referrals – Target 95%

<table>
<tr><th colspan="2">Indicator</th><th colspan="4">Performance Summary</th><th></th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">Eating Disorder Service: Treatment commencing within 18 weeks of referrals</td><td colspan="4">Latest and previous 3 months</td><td rowspan="3">KPI 125</td><td rowspan="3"></td></tr>
<tr><td>RED</td><td>TREND</td><td>Jan-19</td><td>Feb-19</td><td>Mar-19</td><td>Latest</td></tr>
<tr><td rowspan="2"></td><td rowspan="2"></td><td>40.0%</td><td>23.5%</td><td>5.9%</td><td>0.0%</td></tr>
<tr><td colspan="4">Plan: 95% - 2019/20 reported 0.0% and failed</td></tr>
<tr><td colspan="8">Performance Overview/Issues:</td></tr>
<tr><td colspan="8">Out of a potential 12 Service Users, 0 started treatment within the 18 week target. Issues contributing to this poor performance are the high number of referrals to the service (54 in April 2019) and there is also a vacant post that the provider is planning on recruiting for; in the meantime the possibility of internal or bank staff carrying out additional duties is being explored. In addition to this, two part time staff will be returning from maternity leave which will increase the therapy capacity.</td></tr>
<tr><td colspan="8">Actions to Address/Assurances:</td></tr>
<tr><td colspan="8">Demand for the service continues to increase and to exceed capacity. The Trust will undertake a detailed review of capacity and demand with the aim of stabilising the service pending confirmation of whether the proposed Business Case has been approved. The Business Case recognises that since the initial service was commissioned that prevalence and identification of eating disorders in the population has increased.

The provider has also developed a psychological skill/psycho- education group consisting of 4 two hour sessions a week. The first cohort of clients have completed this programme and the intervention is being evaluated; the intention being to deliver 4 to 5 groups in the coming months to assess how effective it is.</td></tr>
<tr><td colspan="8">When is performance expected to recover:</td></tr>
<tr><td colspan="8">Performance is linked to current service capacity which mitigates against significant recovery.</td></tr>
<tr><td colspan="8">Quality impact assessment:</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">Indicator responsibility:</td></tr>
<tr><td colspan="3">Leadership Team Lead</td><td colspan="2">Clinical Lead</td><td colspan="3">Managerial Lead</td></tr>
<tr><td colspan="3">Geraldine O'Carroll</td><td colspan="2">Sue Gough</td><td colspan="3">Gordon Jones</td></tr>
</table>

KPI 19: Patients identified as at risk of falling to have a care plan in place across the trust – Target 98%

Indicator		Performance Summary					Potential organisational or patient risk factors
Falls Management & Prevention: Of the patients identified as at risk of falling to have a care plan in place		**Latest and previous 3 months**				KPI 19	
RED	**TREND**	Q1	Q2	Q3	Latest		
		66.7%	69.2%	28.6%	50.0%		
		Plan: 98% - 2018/19 YTD reported 55.2% and failed.					

Performance Overview/Issues:
The Trust reported performance well below the 98% target in Q4, 50% but higher than quarter 3 when 28.6% was reported. In quarter 4 there were a total of 6 patients, 3 of which didn't have a care plan in place.
Actions to Address/Assurances:
Ward staff have been emailed and reminded to ensure that all patients identifiying as a falls risk have an appropriate care plan in place.
When is performance expected to recover:
The above action will continue with an ambition to improve performance during 2019/20.
Quality impact assessment:
Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Sue Gough	Gordon Jones

KPI 25 (Keeping nourished) Patients with a score of 2 or more to receive an appropriate care plan – Target 100%

Indicator		Performance Summary					Potential organisational or patient risk factors
Patients with a score of 2 or more to receive an appropriate care plan		**Latest and previous 3 months**				KPI 25	
RED	**TREND**	Q1	Q2	Q3	Latest		
		60.0%	66.7%	50.0%	80.0%		
		Plan: 100% - 2018/19 YTD reported 63.6% and failed					

Performance Overview/Issues:
The Trust reported performance well below the 98% target in Q4, with the above performance reported. Out of 5 patients there was 1 patient who didn't receive an appropriate care plan. The transition to Rio has impacted on MUST KPI's as templates in Rio are different to Epex forms therefore ward teams needed additional support.
Actions to Address/Assurances:
The indicator is number sensitive however to improve KPIs the Dietetic team and Physical Health Performance Nurse are offering a range of support and training to ward staff. MUST training will continue for staff induction.
When is performance expected to recover:
Quarter 1 2019/20
Quality impact assessment:
Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Sue Gough	Gordon Jones

4.2 Learning Disability Health Checks

Indicator		Performance Summary					Potential organisational or patient risk factors
Learning Disabilities Health Checks		**Latest and previous 3 quarters**				People with a learning disability often have poorer physical and mental health than other people. An annual health check can improve people's health by spotting problems earlier. Anyone over the age of 14 with a learning disability (as recorded on GP administration systems), can have an annual health check.	
RED	**TREND**		Q1	Q2	Latest		
			18.5%	40.5%	44.1%		
		Plan: 18.7% 2018/19					

Performance Overview/Issues:

A national enhanced service is place with payment available for GPs providing annual health checks, and CCGs were required to submit plans for an increase in the number of health checks delivered in 2018/19 (target 504 for the year). Some of the data collection is automatic from practice systems however; practices are still required to manually enter their register size. Data quality issues are apparent with practices not submitting their register sizes manually, or incorrectly which is why the 'actual' data in the table above is significantly lower than expected. In quarter 3, the CCG reported a performance of 44.1%, above the plan of 18.7%. However, just 102 patients were registered compared to a plan of 675, with just 45 checked compared to a plan of 126. Quarter 4 data has yet to be published, in which we are expecting the total percentage checked to increase.

Actions to Address/Assurances:

The CCG Primary Care Leads are working with the Council to identify the cohort of patients with Learning Disabilities who are identified on the GP registers as part of the DES (Direct Enhanced Service). The CCG has also identified additional clinical leadership time to support the DES, along with looking at an initiative to work with People First (an advocacy organisation for people with learning disabilities) to raise the importance of people accessing their annual health check. To review reporting to mitigate data quality issues.

When is performance expected to recover:

Performance should improve from Quarter 2 2019/20 onwards.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Sue Gough	Gordon Jones

4.3 Improving Physical Health for people with Severe Mental Illness (SMI)

<table>
<tr><th colspan="2">Indicator</th><th colspan="4">Performance Summary</th><th></th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2" rowspan="3">The percentage of the number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as ‘in remission’ that have had a comprehensive physical health check</td><td colspan="4">Latest and previous 3 quarters</td><td rowspan="3">As part of the ‘Mental Health Five Year Forw ard View ’ NHS England has set an objective that by 2020/21, 280,000 people should have their physical health needs met by increasing early detection and expanding access to evidence-based care assessment and intervention. It is expected that 50% of people on GP SMI registers receive a physical health check in a primary care setting.</td><td rowspan="3"></td></tr>
<tr><td>RED</td><td>TREND</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Latest</td></tr>
<tr><td>  </td><td>  </td><td></td><td>14.5%</td><td>15.3%</td><td>17.2%</td></tr>
<tr><td colspan="6">Plan: 50% - 2018/19 YTD reported 17.2% and failed</td></tr>
<tr><td colspan="8">Performance Overview/Issues:</td></tr>
<tr><td colspan="8">The most recent data period is January to March 2018/19. In the 12 month period to the end of quarter 4 2018/19, 17.2% of the number of people on the GP SMI register in South Sefton CCG received a comprehensive health check. Despite not yet achieving the 50% ambition this is an improvement from the previous quarter (15.3%).</td></tr>
<tr><td colspan="8">Actions to Address/Assurances:</td></tr>
<tr><td colspan="8">A Local Quality Contract (LQC) scheme for primary care to undertake SMI health checks has been developed and agreed by Sefton Local Medical Committee (LMC). EMIS screens to enable data capture are being validated on 3rd June 2019.</td></tr>
<tr><td colspan="8">When is performance expected to recover:</td></tr>
<tr><td colspan="8">Performance should improve from Quarter 2 2019/20 onwards.</td></tr>
<tr><td colspan="8">Quality impact assessment:</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">Indicator responsibility:</td></tr>
<tr><td colspan="2">Leadership Team Lead</td><td colspan="3">Clinical Lead</td><td colspan="3">Managerial Lead</td></tr>
<tr><td colspan="2">Geraldine O'Carroll</td><td colspan="3">Sue Gough</td><td colspan="3">Gordon Jones</td></tr>
</table>

4.4 Cheshire & Wirral Partnership (Adult)

4.4.1 Improving Access to Psychological Therapies: Access

Indicator		Performance Summary					Potential organisational or patient risk factors
IAPT Access - % of people who receive psychological therapies		Latest and previous 3 months					
RED	TREND	Jan-19	Feb-19	Mar-19	Latest		
		1.35%	1.29%	1.28%	1.23%		
		Access Plan: 19.0% - 2019/20 YTD					

Performance Overview/Issues:

The access standard (access being the number of patients entering first treatment as a proportion of the number of people per CCG estimated to have common mental health issues) target for 2019/20 is to achieve 19% (4.75% per quarter) in the firth 3 quarters and 22% Access (5.5% per quarter) in the last quarter. The monthly target for M1 19/20 is therefore approximately 1.83%. Month 1 performance was 1.23% and failing to achieve the target standard.

Actions to Address/Assurances:

Access – Group work continues to be rolled out so as to complement the existing one to one service offer to increase capacity. In addition IAPT services aimed at diabetes and cardiac groups are planned with IAPT well-being assessments will be delivered as part of the routine standard pathway for these conditions. In addition those GP practices that have the largest number of elderly patients are being engaged with the aim of providing IAPT services to this cohort. Additonal High Intensity Training staff are in training (with investment agreed by the CCG) and they will contribute to access rates whilst they are in training prior to qualifying in October 2019 when they will be able to offer more sessions within the service. Three staff returning from maternity leave and long term sickness will have a positive impact on the service capacity. Bi-monthly teleconferences/meetings have been set up with the provider to understand the progress around the access.

When is performance expected to recover:

The above actions will continue with an ambition to improve performance during 2019/20.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll/Karl McCluskey	Sue Gough	Geraldine O'Carroll

4.4.2 Improving Access to Psychological Therapies: Recovery

Indicator		Performance Summary					Potential organisational or patient risk factors
IAPT Recovery - % of people moved to recovery		Latest and previous 3 months					
RED	TREND	Jan-19	Feb-19	Mar-19	Latest		
		50.0%	47.9%	47.4%	38.0%		
		Recovery Plan: 50% - Apr 19 38.0% and failed					

Performance Overview/Issues:
The percentage of people moved to recovery was 38% in month1 of 2019/20. Despite failing to achieve the target in Month 1, data received for month 2 shows early indications of improvement in this area, with a performance of 52.9%
Actions to Address/Assurances:
Recovery – The newly appointed clinical lead for the service will be reviewing non- recovered cases and work with practitioners to improve recovery rates. Bi-monthly teleconferences/meetings have been set up with the provider to understand the progress around the recovery.
When is performance expected to recover:
The above actions will continue with an ambition to improve performance during 2019/20.
Quality impact assessment:
Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll/Karl McCluskey	Sue Gough	Geraldine O'Carroll

4.5 Dementia

Indicator		Performance Summary				IAF	Potential organisational or patient risk factors
Dementia Diagnosis		Latest and previous 3 months				126a	
RED	TREND	Jan-19	Feb-19	Mar-19	Latest		
		63.51%	64.08%	65.00%	64.17%		
		Plan: 66.7%					

Performance Overview/Issues:
The latest data on NHS Digital shows South Sefton CCG are recording a dementia diagnosis rate in April of 64.17%, which is under the national dementia diagnosis ambition of 66.7% although a slight decrease on last month when 65% was reported. CCG believes that coding issues in primary care may be impacting on performance. In addition there may be care home residents who may not have a diagnosis of dementia.
Actions to Address/Assurances:
The CCG has completed the Dementia Self-Assessment Tool requested by NHS England, which has full details of the planned actions being undertaken by the CCG. Work is being undertaken to identify any coding errors that will have a negative impact of Dementia Diagnosis rates. The CCG is also exploring the feasibility and costs of identifying care homes in South Sefton that could be targeted to be included in diagnosis registry / identification. South Sefton CCG funds a Care Home liaison service that could be utilised to support dementia diagnosis rates.
When is performance expected to recovery:
Plans are in place to achieve by the end of Q2, 2019/20.
Quality impact assessment:
Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Jan Leonard	Sue Gough	Kevin Thorne

5. Community Health

5.1 Adult Community (Mersey Care)

The CCG and Mersey Care leads continue to meet on a monthly basis to discuss the current contract performance. Along with the performance review of each service, discussions regarding 2019/20 reporting requirements are being had. The service reviews are now complete and the Trust and CCG community contract leads have had a number of meetings to discuss outcomes and recommendations. A detailed action plan has been developed by the Trust to support this and regular meetings with the CCG have been arranged. It has been agreed that additional reporting requirements and activity baselines will be reviewed alongside service specifications and transformation. A discussion regarding ICRAS reporting took place at the April information sub group and amendments to the current report were agreed to meet CCG requirements.

5.1.1 Quality

The CCG Quality Team and Mersey Care NHS Foundation Trust (MCFT) are in the process aligning the Quality Schedule, KPIs, Compliance Measures and CQUIN for community services with Liverpool CCG for 2019/20. In terms of improving the quality of reporting, providers are given quarterly feedback on Quality Compliance evidence which will feed through CQPG/ CCQRM. Providers are asked to provide trajectories for any unmet indicators and or measures.

5.1.2 Mersey Care Adult Community Services: Physiotherapy

<table>
<tr><th colspan="2">Indicator</th><th>Performance Summary</th><th>RAG</th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">Mersey Care Adult Community Services: Physiotherapy</td><td>Previous 3 months and latest</td><td rowspan="3"><=18 weeks: Green
> 18 weeks: Red</td><td rowspan="3"></td></tr>
<tr><td>RED</td><td>TREND</td><td>Incomplete Pathways (92nd Percentile)
Dec-19 | Jan-19 | Feb-19 | Latest
23 wks | 23 wks | 23 wks | 20 wks</td></tr>
<tr><td>  </td><td>  </td><td>Target: 18 weeks
(reported a month in arrears)</td></tr>
<tr><td colspan="5">Performance Overview/Issues:</td></tr>
<tr><td colspan="5">March’s incomplete pathways reported above the 18 week standard with 20 weeks, an improvement on last month. The longest waiter on the incomplete pathway was 4 patients at 27 weeks. Completed pathways reported a 95th percentile of 27 weeks, also showing an improvement on last month. The Trust has reported that capacity issues due to staff sickness and vacancies have resulted in increased waiting times.</td></tr>
<tr><td colspan="5">Actions to Address/Assurances:</td></tr>
<tr><td colspan="5">Remedial actions have focussed on workforce and review of processes to manage referrals:
- Implementation of single point of contact for all South Sefton OT & Physio referrals
- Recruitment completed and waiting for new starters to commence in post
- In interim agency physiotherapists are being used to address long waits - ongoing
- Band 7 co-ordinator recruited to support triage and prioritisation of referrals and overall management of lists - to start in June 19</td></tr>
<tr><td colspan="5">When is performance expected to recover:</td></tr>
<tr><td colspan="5">Trajectory identifies return to 18 weeks in July 2019 following implementation of all actions. The CCG are working closely with the</td></tr>
<tr><td colspan="5">Quality impact assessment:</td></tr>
<tr><td colspan="5">The Trust has advised that all referrals are triaged by senior clinicians so that risks are identified and urgent referrals are seen appropriately.</td></tr>
<tr><td colspan="5">Indicator responsibility:</td></tr>
<tr><td colspan="2">Leadership Team Lead</td><td>Clinical Lead</td><td colspan="2">Managerial Lead</td></tr>
<tr><td colspan="2">Karl McCluskey</td><td>Sunil Sapre</td><td colspan="2">Janet Spallen</td></tr>
</table>

5.1.3 Mersey Care Adult Community Services: Occupational Therapy

<table>
<tr><th>Indicator</th><th colspan="2">Performance Summary</th><th>RAG</th><th>Potential organisational or patient risk factors</th></tr>
<tr><td>Mersey Care Adult Community Services: Occupational Therapy</td><td colspan="2">Previous 3 months and latest</td><td rowspan="3"><=18 weeks: Green
> 18 weeks: Red</td><td rowspan="3"></td></tr>
<tr><td>GREEN</td><td>TREND</td><td>Incomplete Pathways (92nd Percentile)
Dec-19 | Jan-19 | Feb-19 | Latest
20 wks | 22 wks | 22 wks | 18 wks</td></tr>
<tr><td>  </td><td>  </td><td>Target: 18 weeks
(reported a month in arrears)</td></tr>
<tr><td colspan="5">Performance Overview/Issues:</td></tr>
<tr><td colspan="5">March’s incomplete pathways have shown an improvement in March reporting 18 weeks. The longest waiter on the incomplete pathway in March was at 24 weeks. Completed pathways reported a 95th percentile of 25 weeks, a slight improvement on last month. The Trust has reported capacity issues due to sickness and vacancies which have resulted in increased waiting times.</td></tr>
<tr><td colspan="5">Actions to Address/Assurances:</td></tr>
<tr><td colspan="5">Remedial actions have focussed on workforce and review of processes to manage referrals:
- Implementation of single point of contact for all South Sefton OT & Physio referrals
- Sickness has resolved and a phased return has been in place for staff members
- Band 7 co-ordinator recruited to support triage and prioritisation of referrals and overall management of lists - to start in June 19</td></tr>
<tr><td colspan="5">When is performance expected to recover:</td></tr>
<tr><td colspan="5">Month 1 data received for 2019/20 identifies that waiting times are back within target of 18 weeks. There are still further improvements to be made in line with above action plan which should improve throughput further. The CCG are working closely with the Trust in regard to therapy waiting times and are assured that all action is being taken to address workforce issues. Ongoing challenge will be to sustain workforce improvements.</td></tr>
<tr><td colspan="5">Quality impact assessment:</td></tr>
<tr><td colspan="5">The Trust has advised that all referrals are triaged by senior clinicians so that risks are identified and urgent referrals are seen appropriately.</td></tr>
<tr><td colspan="5">Indicator responsibility:</td></tr>
<tr><td colspan="2">Leadership Team Lead</td><td>Clinical Lead</td><td colspan="2">Managerial Lead</td></tr>
<tr><td colspan="2">Karl McCluskey</td><td>Sunil Sapre</td><td colspan="2">Janet Spallen</td></tr>
</table>

6. Children's Services

6.1 Alder Hey Children's Mental Health Services

6.1.1 Improve Access to Children & Young People's Mental Health Services (CYPMH)

<table>
<tr><th colspan="2">Indicator</th><th colspan="4">Performance Summary</th><th></th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">Percentage of children and young people aged 0-18 with a diagnosable mental health condition who are receiving treatment from NHS funded community services</td><td colspan="4">Latest and previous 3 quarters</td><td rowspan="3"></td><td rowspan="3"></td></tr>
<tr><td>RED</td><td>TREND</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Latest</td></tr>
<tr><td rowspan="2">  </td><td rowspan="2">  </td><td>11.3%</td><td>5.5%</td><td>5.8%</td><td>6.8%</td></tr>
<tr><td colspan="4">Access Plan: 32% - 2018/19 reported 29.4% and failed</td></tr>
<tr><td colspan="8">Performance Overview/Issues:</td></tr>
<tr><td colspan="8">The CCG has now received data from a third sector organisation Venus. This Provider has not yet submitted data to the MHSDS although this is a work in progress. These additional figures have been included in the table above thus increasing the CYP Access performance and creating a variation in previous data.

The CCG still failed to achieve the target of 8% in Q4 with 6.8%; a total of 181 children and young people were receiving treatment out of a total 3,121 with a diagnosable mental health condition. This is an increase on the5.8% of children and young people receiving treatment in quarter 3. The CCG is narrowly failing to meet the year to date target of 32% (yearly performance being 29.4%).</td></tr>
<tr><td colspan="8">Actions to Address/Assurances:</td></tr>
<tr><td colspan="8">Additional activity has been commissioned and mainstreamed from the VCF in 19/20 which is South Sefton targeted. Figures for 18/19 are big improvement from previous years.</td></tr>
<tr><td colspan="8">When is performance expected to recover:</td></tr>
<tr><td colspan="8">Additional activity to be implemented for 19/20. Online counselling for Sefton is being jointly commissioned and will come online in 19/20. AHCH has submitted business cases to increase CYP Eating Disorder activity and Crisis/Out of Hours support during 19/20. These will make notable improvements to access rates in South Sefton.</td></tr>
<tr><td colspan="8">Quality impact assessment:</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">Indicator responsibility:</td></tr>
<tr><td colspan="3">Leadership Team Lead</td><td colspan="3">Clinical Lead</td><td colspan="2">Managerial Lead</td></tr>
<tr><td colspan="3">Geraldine O'Carroll</td><td colspan="3">Sue Gough</td><td colspan="2">Peter Wong</td></tr>
</table>

6.1.2 Waiting times for Routine Referrals to Children and Young People's Eating Disorder Services

Indicator		Performance Summary					Potential organisational or patient risk factors
Number of CYP with ED (routine cases) referred with a suspected ED that start treatment within 4 weeks of referral		**Latest and previous 3 quarters**				Performance in this category is calculated against completed pathways only.	
RED	**TREND**	Q1	Q2	Q3	Latest		
		100.0%	100.0%	90.9%	92.3%		
		Access Plan: 100% - 2018/19 reported 95.56% and failed					

Performance Overview/Issues:

In quarter 4 the Trust fell under the 100% plan, out of 26 routine referrals to children and young people's eating disorder service, 24 were seen within 4 weeks recording 92.31% against the 100% target. Both breaches waited between 4 and 12 weeks. Reporting difficulties and the fact that demand for this service exceeds capacity are both contributing to under performance in this area.

Actions to Address/Assurances:

Work is being under taken by the Provider to reduce the number of DNAs. The Sevice works with small numbers and a single case can creat a breach for this KPI, which is understood nationally. Activity commissioned on nationally indicated levels. The last year has seen activity levels exceed these levels by over 100%. Risk is being managed and is part of national reporting. AHCH submitted business case for extra capacity which will be considered by SMT in June - further discussions about detailed cse being made at Clinical Advisory Group (CAG) and Quality, Innovaton, Productivity and Prevention Committee (QIPP).

When is performance expected to recover:

Improvement is dependent upon extra capacity being considered and agreed by the CCG in June.

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Sue Gough	Peter Wong

6.1.3 Waiting times for Urgent Referrals to Children and Young People's Eating Disorder Services

Indicator		Performance Summary					Potential organisational or patient risk factors
Number of CYP with ED (urgent cases) referred with a suspected ED that start treatment within 1 week of referral		**Latest and previous 3 quarters**					
RED	**TREND**	Q1	Q2	Q3	Latest		
		100.0%	100.0%	80.0%	66.7%		
		Access Plan: 100% - 2018/19 reported 88.89% and failed					

Performance Overview/Issues:

In quarter 4, the CCG had 3 patients under the urgent referral category, 2 of which met the target bringing the total performance to 66.67% against the 100% target. The patient who breached waited between 1 and 4 weeks. Reporting difficulties and the fact that demand for this service exceeds capacity are both contributing to under performance in this area.

Actions to Address/Assurances:

Work is being under taken by the Provider to reduce the number of DNAs. The Sevice works with small numbers and a single case can creat a breach for this KPI, which is understood nationally. Activity commissioned on nationally indicated levels. The last year has seen activity levels exceed these levels by over 100%. Risk is being managed and is part of national reporting. AHCH submitted business case for extra capacity which will be considered by SMT in June - further consideration of detailed case to be made in July at Clinical Advisory Group (CAG) and Quality, Innovation, Productivity and Prevention Committee (QIPP).

When is performance expected to recover:

Improvement is dependent upon extra capacity being considered and agreed by the CCG in June.

Quality impact assessment:

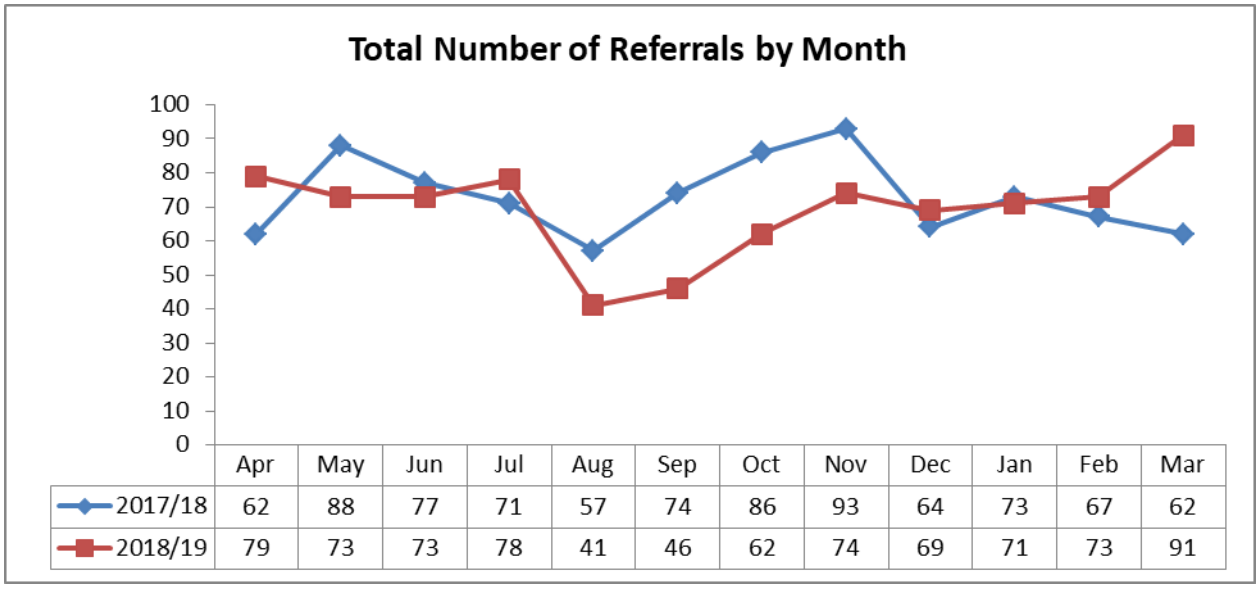
Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Sue Gough	Peter Wong

6.2 Child and Adolescent Mental Health Services (CAMHS)

The following analysis derives from local data received on a quarterly basis from Alder Hey. The data source is cumulative and the time period is to Quarter 4 2018/19. The date period is based on the date of Referral so focuses on referrals made to the service during January to March 2018/19. Data includes both South Sefton CCG and Southport and Formby CCGs.
It is worth noting that the activity numbers highlighted in the report are based on a count of the Local Patient Identifier and there may be patients that have more than one referral during the given time period. The 'Activity' field within the tables therefore does not reflect the actual number of patients referred.

Figure 13 – CAMHS Referrals



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	62	88	77	71	57	74	86	93	64	73	67	62
2018/19	79	73	73	78	41	46	62	74	69	71	73	91

Throughout quarter 4 2018/19 there were a total of 235 referrals made to CAMHS from South Sefton CCG patients. The monthly number of referrals remained stable between November and February then saw a subsequent increase in March 2019.

During the fourth quarter of 2018/19 there were no DNAs, which is an improvement from the last quarter.

The remaining tables within this section will focus on only the 78 Referrals that have been accepted and allocated.

Figure 14 – CAMHS Waiting Times Referral to Assessment

Waiting Time in Week Bands	Number of Referrals	% of Total
0-2 Weeks	30	38.5%
2-4 Weeks	33	42.3%
4- 6 Weeks	6	7.7%
6-8 weeks	0	0.0%
8- 10 weeks	5	6.4%
Over 10 weeks	4	5.1%
Total	**78**	**100%**

The biggest percentage (42.3%) of referrals where an assessment has taken place waited between 2 and 4 weeks from their referral to assessment. 94.5% of allocated referrals waited 10 weeks or less from point of referral to an assessment being made.

Of those referrals that waited over 10 weeks, there was one referral that waited 94 days (13.4 weeks) which was the longest wait during this quarter.

An assessment follows on from the Triage stage when the clinical risk is assessed and patients are prioritised accordingly. At the point of assessment the child/young person meets with a clinician to discuss their issues and it is possible to determine whether the CAMHS is appropriate. At this stage it may be that the child/young person is signposted to another service rather than continue to an intervention within the service.

Alder Hey has received some additional funding for staff for CAMHS services, and additional funding for neurodisability developmental pathways (ADHD, ASD). These should contribute to reducing CAMHS waiting times.

Figure 15 - CAMHS Waiting Times Assessment to Intervention

Waiting Time in Week Bands	Number of Referrals	% of Total	% of Total with intervention only
0-2 Weeks	10	12.8%	23.8%
2-4 Weeks	9	11.5%	21.4%
4- 6 Weeks	14	17.9%	33.3%
6-8 weeks	5	6.4%	11.9%
8- 10 weeks	0	0.0%	0.0%
10-12 Weeks	3	3.8%	7.1%
Over 12 Weeks	1	1.3%	2.4%
(blank)	36	46.2%	
Total	**78**	**100%**	**100%**

An intervention is the start of treatment. If the patient needs further intervention such as a more specific type of therapy then they would be referred onto the specific waiting list. These waiting times are routinely reviewed in local operational meetings.

46.2% (36) of all allocated referrals did not have a date of intervention. Of these, 10 have already been discharged without having had an intervention so are therefore not waiting for said intervention.

The assumption can be made that of the remaining 26 referrals where an assessment has taken place and no date of intervention reported, these are waiting for their intervention. Of the 26 waiting for an intervention, 17 were referred to the service within the month of March 2019 so have been waiting a maximum of four weeks from their referral date to their first intervention.

If the 36 referrals were discounted, 90.5% of the referrals made within Quarter 4 of 2018/19 waited 8 weeks or less from their referral to their first intervention taking place.

The one referral that waited over 12 weeks for an intervention waited for 94 days (13.4 weeks). This is an improvement on the previous quarter when there was 1 referral that waited over 14 weeks.

Performance Overview/Issues
Specialist CAMHS has had long waits, up to 20 weeks.

How are the issues being addressed?
NHSE non-recurrent funding secured and waits are reducing. CCG has jointly commissioned online counselling for 19/20 which will increase accessible support for those with needs but don't meet CAMHS threshold, reducing necessity to refer to CAMHS. AHCH submitted business case for

extending crisis and out of hours support. Additional activity targeted at South Sefton to be brought online in 19/20.

When is the performance expected to recover by?
Impact of NHSE funding will be seen in the first quarter of 2019/20 and the impact of online counselling and additional South Sefton activity will be seen in quarters 2 and 3 of 19/20.

Who is responsible for this indicator?

Leadership Team Lead	Clinical Lead	Managerial Lead
Geraldine O'Carroll	Vicky Killen	Peter Wong

6.3 Children's Community (Alder Hey)

6.3.1 Paediatric SALT

<table>
<tr><th colspan="2">Indicator</th><th>Performance Summary</th><th>RAG</th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">Alder Hey Children's Community Services: SALT</td><td>Previous 3 months and latest</td><td rowspan="3"><=18 weeks: Green
> 18 weeks: Red</td><td rowspan="3"></td></tr>
<tr><td>RED</td><td>TREND</td><td>Incomplete Pathways (92nd Percentile)
Jan-19 | Feb-19 | Mar-19 | Latest</td></tr>
<tr><td>  </td><td>  </td><td>45 wks | 44 wks | 45 wks | 45 wks
Target: 18 weeks</td></tr>
<tr><td colspan="5">Performance Overview/Issues:</td></tr>
<tr><td colspan="5">In April the Trust reported a 92nd percentile of 45 weeks for Sefton patients waiting on an incomplete pathway. The longest waiting patient was 1 patient waiting at 58 weeks. Performance has steadily declined over the past two financial years, with referrals remaining static.</td></tr>
<tr><td colspan="5">Actions to Address/Assurances:</td></tr>
<tr><td colspan="5">Sefton SALT waiting times have been raised formally at the Alder Hey contract meetings. The trust has submitted a recovery plan and the CCG has agreed funding for additional Speech Therapists. The CCG has asked for additional narrative for long waiters and the trust have provided and proposed monthly reports for over 40 week waiters. In addition, the CCG is in discussion with Alder Hey on creating a plan which looks at other services to reduce overall wait times.

June 2019: Business case approved for some non-recurrent and recurrent therapists.

Currently Paediatric speech and language waiting times are reported as Sefton view; the Trust is working to supply CCG level information. This is a legacy issue from when Liverpool Community Health/ Mersey Care reported the waiting time information.</td></tr>
<tr><td colspan="5">When is performance expected to recover:</td></tr>
<tr><td colspan="5">Following investment, target is for reduction to 18 wk RTT by Feb 2020 and sustained thereafter.</td></tr>
<tr><td colspan="5">Quality impact assessment:</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="5">Indicator responsibility:</td></tr>
<tr><td colspan="2">Leadership Team Lead</td><td colspan="2">Clinical Lead</td><td>Managerial Lead</td></tr>
<tr><td colspan="2">Karl McCluskey</td><td colspan="2">Wendy Hewitt</td><td>Peter Wong</td></tr>
</table>

6.3.2 Paediatric Dietetics

<table>
<tr><th>Indicator</th><th colspan="2">Performance Summary</th><th>RAG</th><th>Potential organisational or patient risk factors</th></tr>
<tr><td>Alder Hey Children's Community Services: Dietetics</td><td colspan="2">Previous 3 months and latest</td><td rowspan="2">DNAs
<= 8.5%: Green
> 8.5% and <= 10%: Amber
> 10%: Red

Provider Cancellations
<= 3.5%: Green
> 3.5% and <= 5%: Amber
> 5%: Red</td><td rowspan="2"></td></tr>
<tr><td>RED</td><td>TREND</td><td>Outpatient Clinic DNA Rates
Jan-19 | Feb-19 | Mar-19 | Latest
10.0% | 9.8% | 17.2% | 20.0%
Outpatient Clinic Provider Cancellations
Jan-19 | Feb-19 | Mar-19 | Latest
16.7% | 0.0% | 0.0% | 7.1%

DNA threshold: 8.5%
Provider cancellation threshold: 3.5%</td></tr>
<tr><td colspan="5">Performance Overview/Issues:</td></tr>
<tr><td colspan="5">The paediatric dietetics service has seen high percentages of children not being brought to their appointment. In April 2019 this increased further with a rate of 20%. Provider cancellations also increased significantly in April with 7.1%.</td></tr>
<tr><td colspan="5">Actions to Address/Assurances:</td></tr>
<tr><td colspan="5">The CCG has invested in extra capacity into the service. The CCG is working with AHCH to understand the nature of the DNAs for this service. AHCH has implemented a text appointment reminder system. The CCG will also raise this at the next contract review meeting in June 2019.</td></tr>
<tr><td colspan="5">When is performance expected to recover:</td></tr>
<tr><td colspan="5">To be confirmed following contract revirw meeting in June.</td></tr>
<tr><td colspan="5">Quality impact assessment:</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="5">Indicator responsibility:</td></tr>
<tr><td colspan="2">Leadership Team Lead</td><td colspan="2">Clinical Lead</td><td>Managerial Lead</td></tr>
<tr><td colspan="2">Karl McCluskey</td><td colspan="2">Wendy Hewitt</td><td>Peter Wong</td></tr>
</table>

6.4 Percentage of Children Waiting more than 18 Weeks for a Wheelchair

Indicator		Performance Summary					Potential organisational or patient risk factors
Percentage of children waiting less than 18 weeks for a wheelchair		Previous 3 quarters and latest					
N/A	TREND	Waiting Times					
		Q1	Q2	Q3	Latest		
		Nil Return	Nil Return	Nil Return	Nil Return		
		92% of children should receive equipment within 18 weeks					

Performance Overview/Issues:

Commissioning arrangements are complex; services for South Sefton patients are commissioned by NHS England and services are provided by Aintree Hospital who then submit data to NHS England nationally. Quarter 4 was also a nil return. Quarterly plans have been submitted with the expectation the CCG is to achieve 100% of patients waiting less than 18 weeks.

Actions to Address/Assurances:

When is performance expected to recover:

Quality impact assessment:

Indicator responsibility:

Leadership Team Lead	Clinical Lead	Managerial Lead

7. Primary Care

7.1 Extended Access Appointment Utilisation

<table>
<tr><th colspan="2">Indicator</th><th colspan="4">Performance Summary</th><th></th><th>Potential organisational or patient risk factors</th></tr>
<tr><td colspan="2">Extended Access Appointment Utilisation</td><td colspan="4">Latest and previous 3 months</td><td rowspan="3">Extended access is based on the percentage of practices within a CCG which meet the definition of offering extended access; that is where patients have the option of accessing routine (bookable) appointments outside of standard working hours Monday to Friday.</td><td rowspan="3"></td></tr>
<tr><td>GREEN</td><td>TREND</td><td>Jan-19</td><td>Feb-19</td><td>Mar-19</td><td>Latest</td></tr>
<tr><td rowspan="2">  </td><td rowspan="2">  </td><td>70.6%</td><td>75.5%</td><td>73.5%</td><td>64.6%</td></tr>
<tr><td colspan="4">The CCG should deliver at least 75% utilisation of extended access appointments by March 2020 (if the service went live in 2017/18).
April target 64.5%</td></tr>
<tr><td colspan="8">Performance Overview/Issues:</td></tr>
<tr><td colspan="8">A CCG working group developed a service specification for an extended hour's hub model to provide extended access in line with the GP Five Year Forward View requirements. This service went live on the 1st October 2018 and now all GP practices are offering 7 day access to all registered patients. Therefore the CCG is 100% compliant.

In April South Sefton CCG practices reported a combined utilisation rate of 64.60%, exceeding the 64.5% target. Total available appointments was 1438, with 1040 being booked (72.32%) and 111 DNA's (7.72%). However this shows a decline in utilisation compared to March.</td></tr>
<tr><td colspan="8">Actions to Address/Assurances:</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">When is performance expected to recover:</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">Quality impact assessment:</td></tr>
<tr><td colspan="8"></td></tr>
<tr><td colspan="8">Indicator responsibility:</td></tr>
<tr><td colspan="3">Leadership Team Lead</td><td colspan="3">Clinical Lead</td><td colspan="2">Managerial Lead</td></tr>
<tr><td colspan="3">Jan Leonard</td><td colspan="3">Craig Gillespie</td><td colspan="2">Angela Price</td></tr>
</table>

7.2 CQC Inspections

A number of practices in South Sefton CCG have been visited by the Care Quality Commission and details of any inspection results are published on their website. There has been one recent inspection at Moore Street Medical Centre, this remains good in all areas. All results are listed below:

Figure 16 - CQC Inspection Table

South Sefton CCG								
Practice Code	Practice Name	Date of Last Visit	Overall Rating	Safe	Effective	Caring	Responsive	Well-led
N84002	Aintree Road Medical Centre	19 March 2018	Good	Good	Good	Good	Good	Good
N84015	Bootle Village Surgery	03 August 2016	Good	Good	Good	Good	Good	Good
N84016	Moore Street Medical Centre	30 April 2019	Good	Good	Good	Good	Good	Good
N84019	North Park Health Centre	27 March 2019	Good	Good	Good	Good	Good	Good
N84028	The Strand Medical Centre	04 April 2018	Good	Good	Good	Good	Good	Good
N84034	Park Street Surgery	17 June 2016	Good	Good	Good	Good	Good	Good
N84038	Concept House Surgery	30 April 2018	Good	Good	Good	Good	Good	Good
N84001	42 Kingsway	07 November 2016	Good	Good	Good	Good	Good	Good
N84007	Liverpool Rd Medical Practice	06 April 2017	Good	Good	Good	Good	Good	Good
N84011	Eastview Surgery	11 October 2017	Good	Good	Good	Good	Good	Good
N84020	Blundellsands Surgery	24 November 2016	Good	Good	Good	Good	Good	Good
N84026	Crosby Village Surgery	27 December 2018	Good	Good	Good	Good	Good	Good
N84041	Kingsway Surgery	07 November 2016	Good	Good	Good	Good	Good	Good
N84621	Thornton Practice	16 October 2018	Good	Good	Good	Good	Good	Good
N84627	Crossways Surgery	19 February 2019	Good	Good	Good	Good	Good	Good
N84626	Hightown Village Surgery	18 February 2016	Good	Requires Improvement	Good	Good	Good	Good
N84003	High Pastures Surgery	09 June 2017	Good	Good	Good	Good	Good	Good
N84010	Maghull Family Surgery (Dr Sapre)	31 July 2018	Good	Good	Good	Good	Good	Good
N84025	Westway Medical Centre	23 September 2016	Good	Good	Good	Good	Good	Good
N84624	Maghull Health Centre	07 September 2018	Good	Good	Good	Good	Good	Good
Y00446	Maghull Practice PC24	30 October 2018	Good	Requires Improvement	Good	Good	Good	Good
N84004	Glovers Lane Surgery	27 March 2019	Good	Good	Good	Good	Good	Good
N84023	Bridge Road Medical Centre	15 June 2016	Good	Good	Good	Good	Good	Good
N84027	Orrell Park Medical Centre	14 August 2017	Good	Good	Good	Good	Good	Good
N84029	Ford Medical Practice	15 March 2019	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
N84035	15 Sefton Road	22 March 2017	Good	Good	Good	Good	Good	Good
N84043	Seaforth Village Practice	29 October 2015	Good	Good	Good	Good	Good	Good
N84605	Litherland Town Hall Health Centre PC24	26 November 2015	Good	Good	Good	Good	Good	Good
N84615	Rawson Road Medical Centre	16 March 2018	Good	Good	Good	Good	Good	Good
N84630	Netherton Practice	19 February 2019	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement

Key	
	= Outstanding
	= Good
	= Requires Improvement
	= Inadequate
	= Not Rated
	= Not Applicable

8. CCG Improvement & Assessment Framework (IAF)

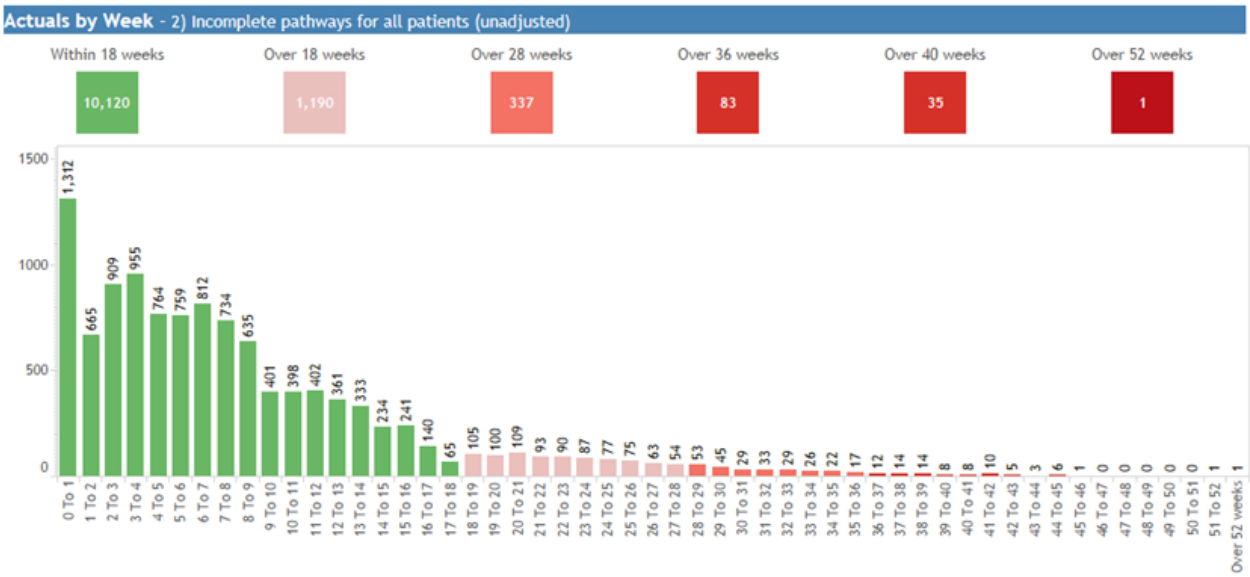
8.1 Background

A full exception report for each of the indicators citing performance in the worst quartile of CCG performance nationally or a trend of three deteriorating time periods is presented to Governing Body as a standalone report on a quarterly basis. This outlines reasons for underperformance, actions being taken to address the underperformance, more recent data where held locally, the clinical, managerial and SLT leads responsible, and expected date of improvement for the indicators.

9. Appendices

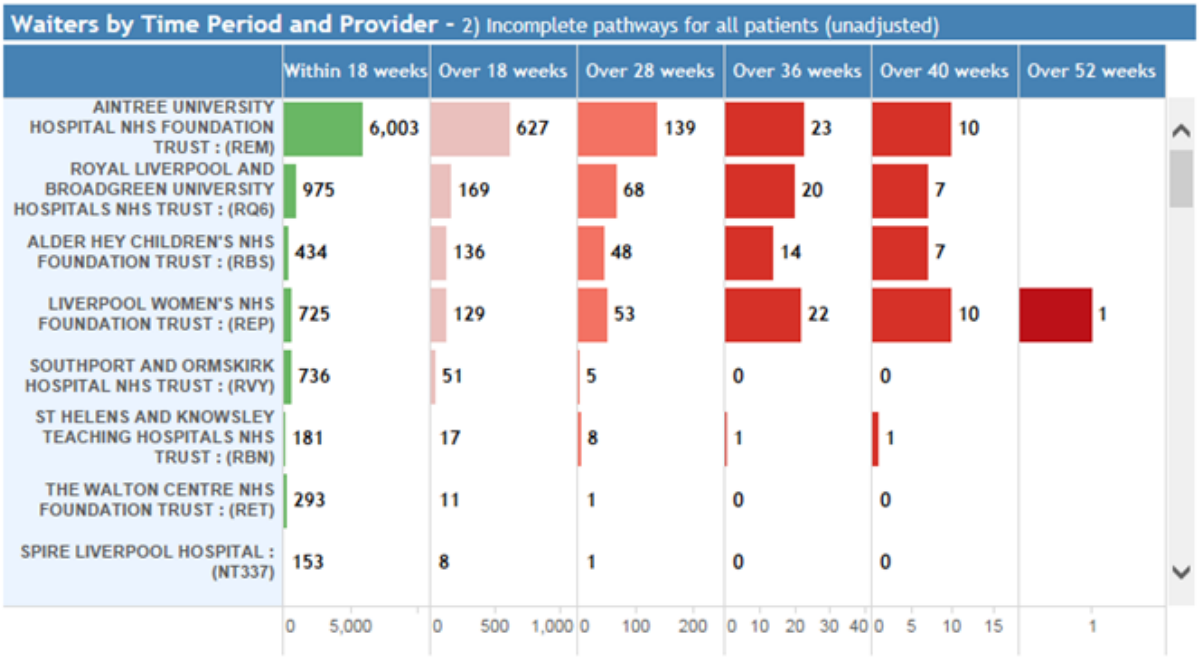
9.1.1 Incomplete Pathway Waiting Times

Figure 17 - South Sefton CCG Patients waiting on an incomplete pathway by weeks waiting



9.1.2 Long Waiters analysis: Top 5 Providers

Figure 18 - Patients waiting (in bands) on incomplete pathway for the top 5 Providers



9.1.3 Long Waiters Analysis: Top 2 Providers split by Specialty

Figure 19 - Patients waiting (in bands) on incomplete pathways by Speciality for Aintree University Hospitals NHS Foundation Trust

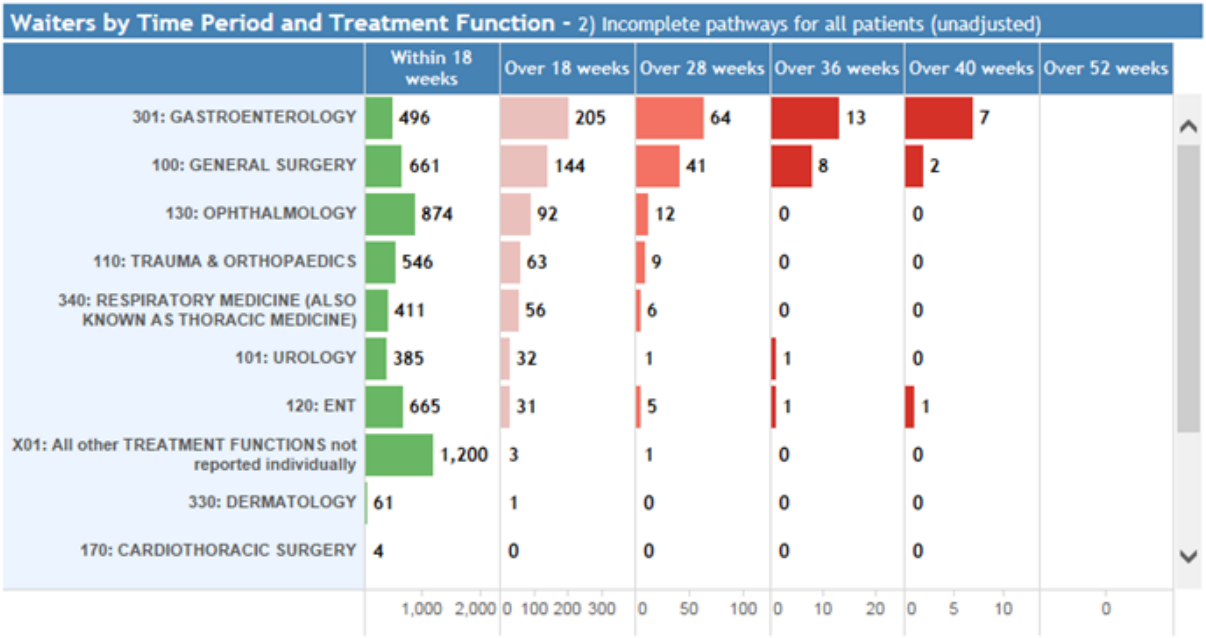
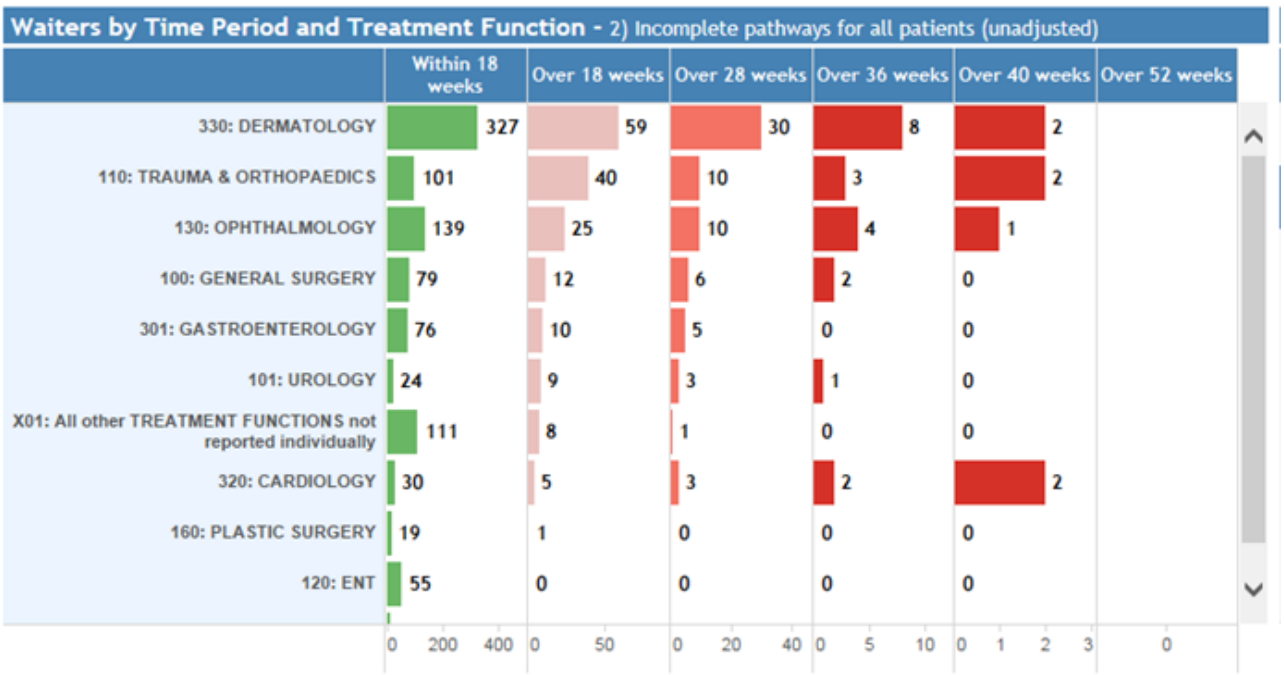
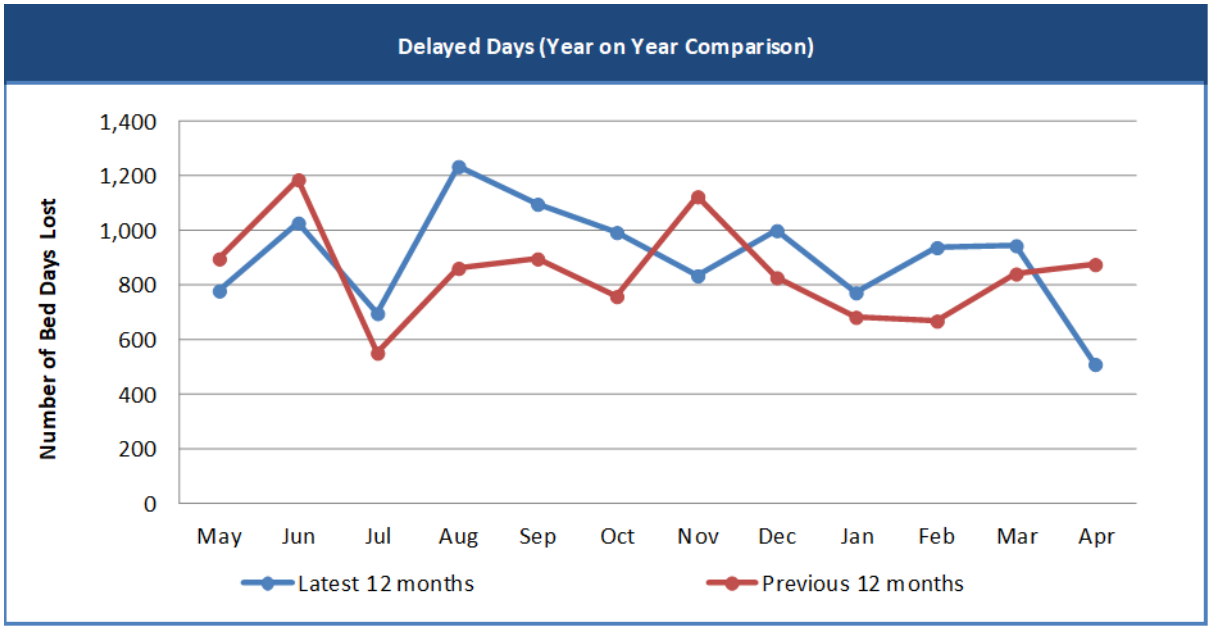


Figure 20 - Patient waiting (in bands) on incomplete pathway by Specialty for Royal Liverpool & Broadgreen University Hospital NHS Foundation Trust



9.2 Delayed Transfers of Care

Figure 21 – Aintree DTOC Monitoring



DTOC Key Stats	This month	Last month	Last year
Delayed Days	**Apr-19**	**Mar-19**	**Apr-18**
Total	506	945	871
NHS	95.1%	92.1%	84.4%
Social Care	4.9%	7.9%	15.6%
Both	0.0%	0.0%	0.0%
Acute	50.0%	54.2%	53.7%
Non-Acute	50.0%	45.8%	46.3%

Reasons for Delayed Transfer % of Bed Day Delays (Apr-19)	
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	
Care Package in Home	4.9%
Community Equipment Adapt	0.0%
Completion Assesment	4.2%
Disputes	0.0%
Further Non-Acute NHS	59.9%
Housing	0.4%
Nursing Home	0.0%
Patient Family Choice	30.6%
Public Funding	0.0%
Residential Home	0.0%
Other	0.0%

9.3 Alder Hey Community Services Contract Statement

Commissioner Name	Service	Currency	2019/20					
			Previous Year Outturn	Plan	FOT	Variance %	Apr	YTD
NHS South Sefton CCG	Paediatric Continence	Caseload at Month End	264	264	269	1.89	269	269
		Total Contacts (Domiciliary)	1,733	1,733	1,788	3.17	149	149
		Total New Referrals	173	173	132	-23.70	11	11
	Paediatric Dietetics	Referral to 1st contact (weeks average)	8.7	8.7	7	-19.54	7	7
		Total Contacts	364	364	324	-10.99	27	27
		Total Contacts (Domiciliary)	66	66	84	27.27	7	7
		Total Contacts (Outpatients)	298	298	240	-19.46	20	20
		Total New Referrals	292	292	228	-21.92	19	19
	Paediatric Occupational Therapy	Caseload at Month End	201	201	153	-23.88	153	153
		Referral to 1st contact (weeks average)	15.9	15.9	14.3	-10.06	14.3	14.3
		Total Contacts (Domiciliary)	4,851	4,851	3,468	-28.51	289	289
		Total New Referrals	618	618	468	-24.27	39	39
	Paediatric Speech and Language Therapy	Referral to 1st contact (weeks average)	24.9	24.9	35	40.56	35	35
		Total Contacts (Domiciliary)	12,718	12,718	12,420	-2.34	1,035	1,035
		Total Contacts Complex Cochlear (N&S Sefton)	507	507	672	32.54	56	56
		Total New Referrals	1,094	1,094	1,092	-0.18	91	91
		Total New Referrals Complex Cochlear (N&S Sefton)	6	6	0	-100.00	0	0

If Plan is <10,000:

- FOT is <10% above or below plan
- FOT is 10%-20% above or below plan
- FOT is > 20% below plan
- FOT is > 20% above plan

If Plan is >10,000:

- FOT is <5% above or below plan
- FOT is 5%-10% above or below plan
- FOT is > 10% below plan
- FOT is > 10% above plan

9.4 Alder Hey SALT Waiting Times – Sefton

Paediatric SALT Sefton	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	18/19 Outturn	FOT 19/20	% Variance
Number of Referrals	144												1,838	1,224	-33.4%
Incomplete Pathways - 92nd Percentile	45												449		
Total Number Waiting	938												9,382		
Number waiting over 18 weeks	519												4,696		
Longest weeks waiting - weeks	58												587		
Longest weeks waiting - patients	1												25		

RAG rating
<=18 weeks
19 to 22 weeks
23 weeks plus

Currently Paediatric speech and language waiting times are reported as Sefton view; the Trust is working to supply CCG level information. This is a legacy issue from when Liverpool Community Health reported the waiting time information.

9.5 Alder Hey Dietetic Cancellations and DNA Figures – Sefton

Outpatient Clinics - DNAs

	13/14 Total	14/15 Total	15/16 Total	16/17 Total	17/18 Total	18/19 Total	Apr-19	19/20 Total
Appointments	327	532	429	647	528	698	52	52
DNA	66	53	41	147	68	116	13	13
DNA Rate	16.8%	9.1%	8.7%	18.5%	11.4%	14.3%	20.0%	20.0%

Outpatient Clinics - Cancs by PROVIDER

	13/14 Total	14/15 Total	15/16 Total	16/17 Total	17/18 Total	18/19 Total	Apr-19	19/20 Total
Appointments	327	532	429	647	528	698	52	52
Cancellations	6	0	5	29	0	44	4	4
Rate	1.8%	0.0%	1.2%	4.3%	0.0%	5.9%	7.1%	7.1%

Outpatient Clinics - Cancs by PATIENT

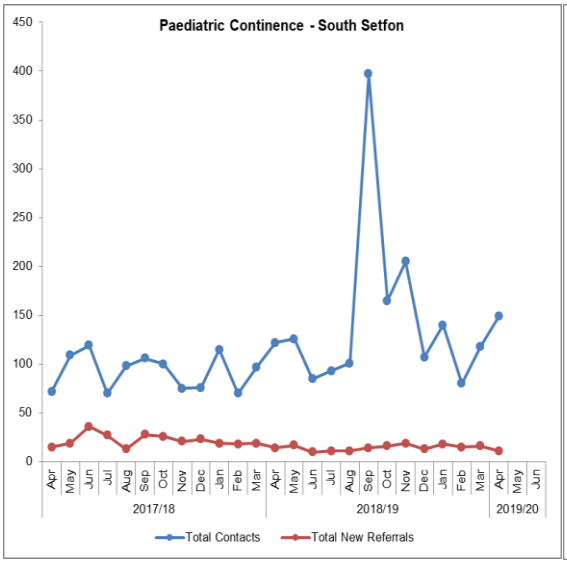
	13/14 Total	14/15 Total	15/16 Total	16/17 Total	17/18 Total	18/19 Total	Apr-19	19/20 Total
Appointments	327	532	429	647	528	698	52	52
Cancellations	27	63	63	207	128	184	10	10
Rate	7.3%	10.6%	12.8%	24.2%	19.5%	20.9%	16.1%	16.1%

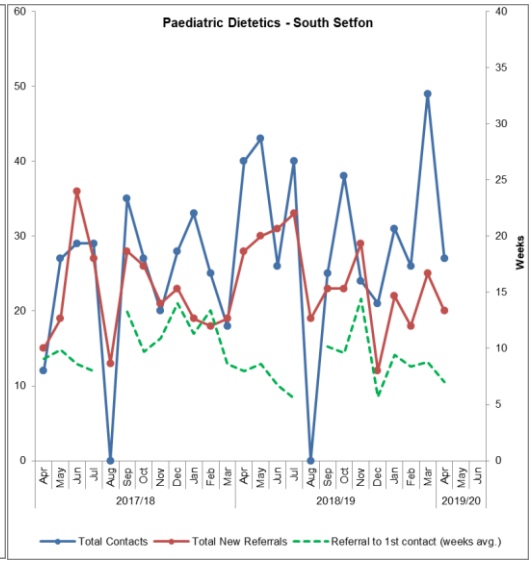
Rag Ratings & Targets 19/20

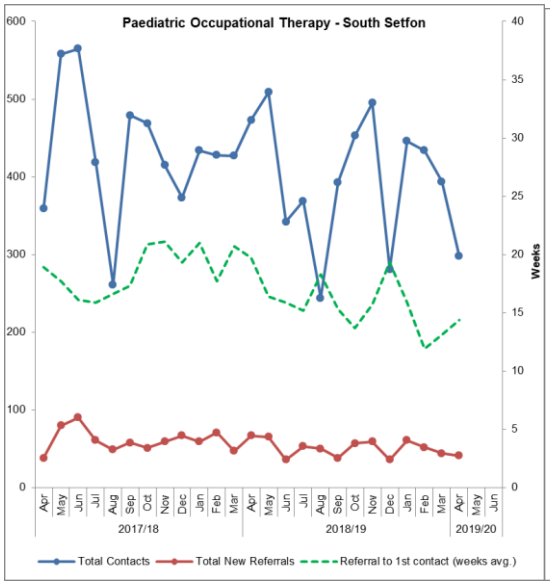
DNAs Outpatients	
<= 8.47%	Green
> 8.47% and <= 10%	Amber
> 10%	Red

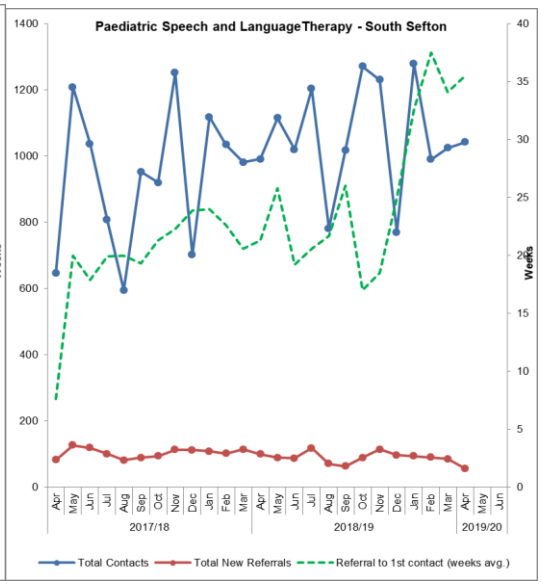
CANCs Outpatients - by Provider	
<= 3.5%	Green
> 3.5% and <= 5%	Amber
> 5%	Red

9.6 Alder Hey Activity & Performance Charts









9.7 Better Care Fund

A quarter 4 2018/19 BCF performance monitoring return was submitted on behalf of the Sefton Health and Wellbeing Board in May 2019. This reported that all national BCF conditions were met in regard to assessment against the High Impact Change Model; but with on-going work required against national metric targets for non-elective hospital admissions, admissions to residential care, reablement and Delayed Transfers of Care. Narrative is provided of progress to date.

A summary of the Q4 BCF performance is as follows:

Figure 22 – BCF Metric performance

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements
NEA	Reduction in non-elective admissions	Not on track to meet target	NHS England set an expectation nationally for growth within Non-Elective admissions, specifically of note is the requirement to increase zero length of stay activity by 5.6% and any admission with a longer length of stay by 0.9%. Despite these growth asks, the CCGs in the Sefton HWBB area have planned for 18/19 growth as follows: South Sefton CCG: 5.12% 0 day LOS, 0.82% 1+ day LOS. Southport & Formby CCG: 1.4% 0 day LOS, 0.4% 1 day LOS. Indicative Q3 YTD data shows a slight increase for the Sefton HWBB NEA position from 25% in Q2 to 27% in Q3 with 34,677 NEA compared to a plan of 27, 310. However, this is measured against BCF original 18/19 plans that were submitted back in 2017, not the latest CCG Ops Plan submissions for 18/19 which were made Apr 18.	There is a continued focus from our ICRAS services around both the S&O and Aintree systems to provide community interventions that support admission avoidance with activity monitored through A&E Delivery Board. SW posts have now also been implemented within localities as part of our place based developments to support early interventions that may avert emergency admission.
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	Sefton's aging in ill health demographics continue to place signifciant additional demand on social care services for older people. Work continues to provide a home first culture and maintain people at home where possible. This is a key aspect of our Newton Decision Making action plan in regard to hospital discharge. Reablement, rehabilitation and ICRAS services all help to support our care closer to home strategy.	Implementation of enabling beds within Chase Heys and James Dixon care homes is an example of model of care designed to increase independence and avoid permanent placements.
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Not on track to meet target	Review of reablement service ongoing but recruitment of workforce continues to be a challenge. Recruitment events underway to strengthen workforce. Plans to develop reablement 'offer' available to community cases - such as people in crisis and/or who are at risk of Hospital admission.	Agreement to conduct a Pilot Scheme around rapid response - meeting held with Providers, CCG and Lancashire Care to discuss approach and next steps.
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Not on track to meet target	Following Newton Europe Review of delayed transfers of care across system we have reviewed recommendations of report with action plans developed for the three key areas.	At an operational and strategic level there has been enhanced partnership working around the S&O and Aintree systems to address delayed transfers of care. There are weekly calls between partners, MDT flying squads to target patient areas, increased focus on 7 and 21 day + LOS and actions to progress discharge.

Figure 23 – BCF High Impact Change Model assessment

						Narrative	
		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Current)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Milestones met during the quarter / Observed impact
Chg 1	**Early discharge planning**	Plans in place	Plans in place	Plans in place	Established		This Chg is in already established for SFCCG area and work continues to progress to move to maturity though implementation of MADE recommendations. Aim to move to one system for S&O across into W.Lancs. For SSCCG area this has been implemented through the ICRAS programme and the discharge lanes/SAFER system within Aintree.
Chg 2	**Systems to monitor patient flow**	Plans in place	Plans in place	Plans in place	Established		Currently established in Southport and Formby in S&O and system working well to monitor capacity and demand. In Aintree there has been a re-focus in Q4 on use of the Medworxx system in conjunction with the SAFER and discharge lanes approach. Band 4 discharge posts have been introduced attached to wards to support patient flow but also provide additional support to data capture. Ongoing work will aim to develop a mature system with peer support from the Royal Liverpool who also use Medworxx as part of planned merger work.
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Plans in place	Plans in place	Established	Mature	Assessment of mature is based on robust implementation of the ICRAS model (Integrated Community Reablement & Assessment Services) within Sefton but also across North Mersey. It is an example of collaboration designed to introduce consistency in approach and pathways across a larger geographical footprint. Further evidenced by linking our ongoing MDT development work to Newton Europe findings to improve Sefton service provision. Again work carried out locally but in conjunction with similar work underway across North Mersey. Shared learning and peer support has been an important part of our development.	Significant progress has been made in regard to multi-disciplinary / multi-agency discharge teams across Sefton. Our ICRAS model (Integrated Community Reablement & Assessment Services) has been key in facilitating joint working arrangements between health and social care and third sector partners with robust pathways in place to support step down from hospital and admission avoidance/step up if required from community. Areas developed in Q4 include our reablement bed based service pathway (Chase Heys & James Dixon Court) developed through collaborative working of all partners. The MDT approach has also been the focus of collaboration with primary care. Examples of this include the pilot work for Integrated Care Communities which is being implemented. During the last quarter activity in the South of the borough has included the identification of resource to support the work this includes two dedicated Primary Care Link Workers who will work across four health localities. This pilot work is being scoped further in terms of monitoring
Chg 4	**Home first/discharge to assess**	Established	Plans in place	Plans in place	Established		In Q4 we have achieved our plan to develop short stay enablement beds with model of care and pathway now in place. Work involved inputs from partners across acute, community and primary care (Chase Heys and James Dixon Court pathways referenced in Change 3). The newly introduced enablement bed provision complements our Home First service and our intermediate care beds and has helped to widen the range of support that we can provide for our Sefton population.

		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 18/19 (Current)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Milestones met during the quarter / Observed impact
Chg 5	Seven-day service	Plans in place	Plans in place	Plans in place	Established		Nurse led discharge and ICRAS services in place at the weekends to support patient flow. Review ongoing of impact alongside social work activity at weekend to move to more mature assesment.
Chg 6	Trusted assessors	Plans in place	Plans in place	Plans in place	Established		Model has been developed within S&O area in past year. For the Aintree catchment a 12 month pilot is being implemented through Mersey Care community trust with consistent approach being utilised which is in place in Knowsley and Liverpool. Domiciliary Care Trusted assessor established across Sefton footprint
Chg 7	Focus on choice	Not yet established	Plans in place	Plans in place	Established		The Choice Policy has been revisited with partners across North Mersey to ensure a consistent approach. In place within S&O and Aintree. The Newton Europe work will focus on strengthening and again ensuring consistency in processes e.g. best interest, capacity assessements. Process is established with opportunity to progress to mature over 19/20 as it is utilised and used positively to support patient flow and decision making.
Chg 8	Enhancing health in care homes	Plans in place	Plans in place	Plans in place	Established		Many key components in place such as Care Home Matrons, Acute Visiting Service (South Sefton) Red Bag scheme and work planned to move to mature such as on falls, pro-active management and therapy strategy. Focus for the Provider Alliance and further strategic development across the system. This work will continue to be progressed in 19/20.

9.8 NHS England Monthly Activity Monitoring

Two year plans set which started in 2017/18 have been rebased for 2018/19 due to changes in pathways and coding practices, as well as variations in trend throughout 2017/18. The updated plans also include national growth assumptions which CCGs were required to add. The CCG is required to monitor plans and comment against any area which varies above or below planned levels by 2%, this is a reduction against the usual +/-3% threshold. It must be noted CCGs are unable to replicate NHS England's data and as such variations against plan are in part due to this.

Month 12 performance and narrative detailed in the table below.

Figure 24 - South Sefton CCG's Month 1 Submission to NHS England

Month 01	*Month 01 Plan*	*Month 01 Actual*	*Month 01 Variance*	ACTIONS being Taken to Address Cumulative Variances GREATER than +/-2%
Referrals (MAR)				
GP	**2,434**	**2,478**	**1.8%**	GP referrals decreased in month 1 to the previous month and were comparable to a current average and planned levels. However, an increase in Other referrals has been apparent and these remain high against the plan as in 1819. The referral patterns identified in 1819 were due in large to changes in the CCGs main provider recording ECG related referrals on the clinical system Medway and rebased plans for 1920 attempted to factor in this change. Local monitoring suggests that increases were evident in month across various providers. However, the total number of Other referrals were not outside of the statistical norm. Discussions regarding referrals are raised at the information sub group with the provider.
Other	**2,158**	**2,739**	**26.9%**	
Total (in month)	**4,592**	**5,217**	**13.6%**	
Variance against Plan YTD	4,592	5,217	13.6%	
Year on Year YTD Growth			9.9%	
Outpatient attendances (Specfic Acute) SUS (TNR)				
All 1st OP	**3,590**	**3,728**	**3.8%**	Although OPFA were higher than planned levels at month 1, appointments decreased from the previous month, were below a current average and within statistical thresholds. Overall outpatient activity is also within the 2% threshold at month 1. CCG planned care leads attend contract review meetings with the lead hospital provider to discuss elements of activity and performance.
Follow Up	**8,533**	**8,595**	**0.7%**	
Total Outpatient attendances (in month)	**12,123**	**12,323**	**1.6%**	
Variance against Plan YTD	12,123	12,323	1.6%	
Year on Year YTD Growth			7.8%	
Admitted Patient Care (Specfic Acute) SUS (TNR)				
Elective Day case spells	1,461	1,477	1.1%	Elective day case admissions are within the 2% threshold against plan at month 1. However, elective ordinary admissions at the main hospital provider have decreased from the previous month across a number of specialities. The activity variances are minimal and total electives are within the expected ranges (within 1% of plan). CCG planned care leads also attend contract review meetings with the lead hospital provider to discuss elements of activity and performance.
Elective Ordinary spells	205	173	-15.6%	
Total Elective spells (in month)	**1,666**	**1,650**	**-1.0%**	
Variance against Plan YTD	1,666	1,650	-1.0%	
Year on Year YTD Growth			2.5%	
Urgent & Emergency Care				
Type 1	**3,655**	**3,825**	**4.7%**	Local A&E monitoring has shown that the CCGs A&E activity has decreased in month 1 from a previously historical high in the last quarter of 1819 (focussed within the main hospital provider). Despite this, attendances remain above an average and above planned levels. However, total A&E activity in month 1 is comparable to plan with a small variance of -0.3%. 4hr performance at the main hospital provider has remained consistent with the previous month at 86.9%. CCG urgent care leads and the main hospital provider continue to work together to understand the increase in attendances and address issues with patient flow in the department. UC leads are sighted on remedial actions implemented to improve flow.
Year on Year YTD			8.5%	
All types (in month)	**4,398**	**4,383**	**-0.3%**	
Variance against Plan YTD	4,398	4,383	-0.3%	
Year on Year YTD Growth			5.8%	
Total Non Elective spells (in month)	**1,797**	**1,616**	**-10.1%**	The CCGs main provider implemented a new pathway (CDU) with activity now flowing via SUS inpatient table from May 2018 and plans have been rebased in 1920 to take this into account. Total non-electives are below plan in month and have now been below the current average for three consecutive months. However, it is not yet possible to confirm if this is statistically relevant and part of an on-going trend. As such, further analysis will be required.
Variance against Plan YTD	1,797	1,616	-10.1%	
Year on Year YTD Growth			31.2%	