NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Thursday, 26th March 2015 at 1300 – 1520 hrs
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

1300 hrs Members of the public may highlight any particular areas of concern/interest and address questions to Board members. If you wish, you may present your question in writing beforehand to the Chair.

1315 hrs Formal meeting of the Governing Body in Public commences. Members of the public may stay and observe this part of the meeting.

The Governing Body

Dr Clive Shaw	Chair & GP Clinical Director	CS
Graham Morris	Vice Chair & Lay Member - Governance	GM
Dr Craig Gillespie	Clinical Vice-Chair & Governing Body Member	CG
Fiona Clark	Chief Officer	FLC
Michelle Creed	Chief Nurse, NHSE (Merseyside) *(co-opted member on behalf of Clare Duggan)*	MC
Roger Driver	Lay Member, Patient & Public Involvement	RD
Debbie Fagan	Chief Nurse & Quality Officer	DF
Margaret Jones	Consultant in Public Health *(co-opted Member on behalf of Dr Janet Atherton)*	MJ
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Dr Dan McDowell	Secondary Care Doctor	DMcD
Martin McDowell	Chief Finance Officer	MMcD
Sharon McGibbon	Practice Manager & Governing Body Member	SMcG
Dr Andrew Mimnagh	GP Clinical Director & Governing Body Member	AM
Peter Morgan	Deputy Chief Executive, Sefton MBC *(co-opted member on behalf of M Carney)*	PM
Dr Ricky Sinha	GP Clinical Director & Governing Body Member	RS
Dr Paul Thomas	GP Clinical Director & Governing Body Member	PT
Dr John Wray	GP Clinical Director & Governing Body Member	JW

In Attendance

Malcolm Cunningham	Head of Contracting & Procurement *for Item 15/55*	MC
Jan Leonard	Chief Redesign & Commissioning Officer *for Item GB 15/53*	JL
Karl McCluskey	Chief Strategy & Outcomes Officer *for Items 15/54 and 15/56*	KMcC
Melanie Wright	Lead for Intermediate Care *for Item 15/51*	MW

Presentation on "Mental Health Transformation"

No	Item	Lead	Report	Receive/ Approve	Time
Governance					
GB15/41	Apologies for Absence	Chair	-	R	3 mins
GB15/42	Declarations of Interest	Chair	✔	R	1 min
GB15/43	Hospitality Register	Chair	✔	R	1 min
GB15/44	Minutes of the Previous Meeting	Chair	✔	A	5 mins
GB15/45	Action Points from Previous Meeting	Chair	✔	A	5 mins
GB15/46	Business Update	Chair	Verbal	R	5 mins
GB15/47	Chief Officer Report	FLC	✔	R	10 mins

No	Item	Lead	Report	Receive/ Approve	Time
GB15/48	GP Pressures and Supporting Practices	All	Verbal	R	5 mins
GB15/49	Committee in Common	FLC	Verbal	R	5 mins
Service Improvement/Strategic Delivery					
GB15/50	Draft CCG Quality Strategy	DF	✔	A	10 mins
GB15/51	Safeguarding Strategy	DF	✔	A	10 mins
GB15/52	Sefton Joint Intermediate Care Strategy	MW	✔	A	10 mins
GB15/53	Breast Care Services Engagement and Equality Report and Recommendations	JL	✔	R	10 mins
GB15/54	2015/16 Planning Submission	KMcC	✔	A	10 mins
GB15/55	Home Oxygen Assessment Service Contract	MC	✔	A	10 mins
Finance and Quality Performance					
GB15/56	Integrated Performance Report	KMcC/ MMcD/ DF	✔	R	10 mins
For Information					
GB15/57	Emerging Issues	ALL	Verbal	R	5 mins
GB15/58	Key Issues reports from committees of Governing Body: a) Finance & Resource Committee b) Quality Committee c) Service Improvement & Redesign Committee d) Audit Committee		 ✔ ✔ ✔ ✔	 R R R R	5 mins
GB15/59	Finance & Resource Committee Minutes	-	✔	R	5 mins
GB15/60	Quality Committee Minutes	-	✔	R	
GB15/61	Service Improvement Redesign Committee Minutes	-	✔	R	
GB15/62	Audit Committee Minutes	-	✔	R	
GB15/63	Locality Meetings: a) Seaforth & Litherland Locality b) Bootle Locality c) Crosby Locality d) Maghull Locality	 - - - -	 ✔ ✔ ✔ ✔	 R R R R	
Closing Business					
GB15/64	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting.*				5 mins
GB15/65	Date, Time and Venue of Next Meeting *Thursday 28th May 2015 at 13.00 at Boardroom, Merton House, Bootle*				-
Estimated meeting close					15.20

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

NHS
South Sefton
Clinical Commissioning Group

Hospitality Register
February 2015 – March 2015

Recipient	Nature of Gift / Hospitality	Date Received	Approximate Value	Donated by
-	-	-	-	-

No hospitality received

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
DRAFT Minutes

Date: Thursday, 29th January 2015 at 13.00 – 15.00 hrs
Venue: Boardroom, 3rd Floor, Merton House, Bootle, L20 3DL

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

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Dr Paul Thomas	GP Clinical Director & Governing Body Member	PT
Dr John Wray	GP Clinical Director & Governing Body Member	JW

In Attendance

Malcolm Cunningham	Head of Contracting & Procurement *for Re-procurement of P TS & NHS 111 Service*	MC
Karen Garside	Deputy Designated Nurse Safeguarding Children *for Child Sexual Exploitation & Safeguarding Declaration*	KG
Tracy Jeffes	Chief Delivery & Integration Officer *for Q3 CRR & GBAF*	TJ
Karl McCluskey	Chief Strategy and Outcomes Officer *for Integrated Performance Report & Strategic Plan*	KMcC
Brendan Prescott	Deputy Chief Nurse/Head of Quality & Safety *for Out of Hours Pharmacy Engagement*	BP

No	Item	Time
Governance		
GB15/1	**Apologies for Absence** were received from …	
GB15/2	**Declarations of Interest** All CCG employees holding dual responsibilities declared their interest.	
GB15/2a	**Hospitality Register** – no issues were raised. FLC explained only items over the value of £25 needed to be declared.	
GB15/3	**Minutes of the Previous Meeting** were accepted as true and accurate record of the previous meeting.	

No	Item	Time
GB15/4	**Action Points from Previous Meeting** *14/125 – New Case for Change Process* – done. *14/148 – IM&T* - PS to be asked to give a demonstration of functionality on Ericom – to be brought to a development session of the Governing Body. *14/156 – Commissioning Policy Review* – an update on varicose veins to be brought back to March meeting. *14/158 – Future Financial Allocations* – on agenda.	MM JL
GB15/5	**Business Update** *Clock View* - CS and FLC had recently visited Mersey Care's new Clock View facility, which was extremely spacious and light and a healing environment. The building will be open to the general public in the next 8 to 10 weeks. *GP Vacancies on CCG Governing Body* – discussions are being held with Sefton LMC to see how we can proceed to fill the current GP vacancies on the board. Ricky Sinha has returned to the Board after his sabbatical.	
GB15/6	**Chief Officer Report** *Shaping Sefton - Future Models of Care* – the CCG's strategy has been formulated and an event has been arranged on 12th February in conjunction with The King's Fund and all other interested parties/sectors across Sefton to take the strategic thinking to delivery. *Dalton Review* – Sir David Dalton has produced a report which will be discussed further at the event on 12th February. *Better Care Fund* – the bid has now been formally approved with the outstanding conditions removed. *Financial Allocations* – means in real terms in 15/16 the allocation will be £227.180m, which is a slight increase on last year. MMcD advised it was important to place in context; very little of the £1.9bn nationwide allocation would reach Sefton as it was going to under target CCG's; however the CCG remained committed to funding programmes identified through different routes. Litherland Darzi Practice – NHSE is in consultation around the Litherland Darzi practice. Colleagues from NHSE have been invited to the Wider Constituent meeting to ensure CCG members are updated on the process. *Breast Care Services* – an engagement exercise is currently being undertaken, in conjunction with West Lancs CCG colleagues, which is due to finish towards the end of February. Fiona Clark assured the meeting that any patients who were in the system would get the appropriate follow up and their care would not be compromised. Any new referrals would be offered a choice of hospitals providing that care, although the intelligence gained from the engagement process would help inform services going forward. Maureen Kelly of Healthwatch Sefton confirmed they were monitoring the situation and had received comments on their website.	

	Improving Access to Psychological Therapies (IAPT) – the CCG has awarded the IAPT contract to Cheshire and Wirral Partnership NHS Trust. Malcolm Cunningham has met with them to discuss mobilisation and transition. *North West Commissioning Support Unit (NWCSU)* – the CSU has not been successful in its application for the national Lead Provider Framework. Fiona Clark and Tracy Jeffes met with Leigh Griffin, the managing director, to understand the implications going forward. It is due to be discussed at the next Merseyside CCG Network meeting and Fiona Clark will report back to the Governing Body in due course. *SMBC Budget* - Peter Morgan confirmed £55m, which is 46% of the council's budget, is to be reduced in the coming year. The Council is working together with CCG colleagues to discuss how the implications of these budget reductions can be managed. *Systems leadership* - the CCG has managed to secure £20K to help improve services for the Sefton population, part of which will be used to fund the 'Shaping Sefton – Future Models of Care' event on 12th February. *Youth Service Pledge* – the CCG has signed up to the Youth Offending Service Pledge. Roger Driver asked how this would be disseminated in the CCG. Debbie Fagan confirmed she was currently speaking to the Head of Communications to understand how best to disseminate the information, eg Big Chats, Wider Forums. **Action: The Governing Body received the Chief Officer report.**	
GB15/7	**GP Pressures and Supporting Practices** *Communication Flow with NHSE* – issues were raised over the level of engagement by NHSE with local GP practices in relation to the future of the Litherland Darzi practice. FLC commented on the importance of continuing to maintain and build close relationships with NHSE and will facilitate conversations as soon as possible.	FLC
GB15/8	**Integrated Performance Report** KMcC drew the Governing Body's attention to the fact that for some indicators only month 8 data was available. *A&E* – the A&E data highlights the current pressures in the system. Comparative data across the system is being reviewed to see what else can be done. Debbie Fagan, with NHS England, has undertaken a quality walk round of Aintree A&E from a nursing quality perspective. She confirmed she had not witnessed anything to cause concern. She had also visited the Operating Room, and looked at how their use of IT could aid the review of patient flow. *Refer to Treatment* (RTT) - no patients are waiting over 52 weeks. *Cancer* - year to date performance remains positive except referral from screening to treatment. *Stroke* – a decline in performance relating to stroke indicators has resulted in a patient review at Aintree. It is related to A&E performance pressures. FLC emphasised the importance of understanding the data at a more detailed level and for a discussion with clinical leads to understand it fully to support ongoing discussions with the Trust.	

	NHS 111 Service - Maureen Kelly asked if it was possible to identify if patients from some practices were using the NHS 111 Service more than others. KMcC confirmed that this was possible. *Friends and Family* – Aintree missed the target by 1%. The Quality team was currently triangulating the information and has asked EPEG to review. *Waiting Times for Community Paediatrics* – the Quality team has a meeting with Alder Hey Hospital in the next week to understand any remedial action that needs to be taken in relation to waiting times. **Action: The Governing Body received the Integrated Performance report.**	
GB15/9	**Quarter 3 Update - 2014/15 Risk Assurance Framework & Corporate Risk Register** TJ presented the Governing Body with the six-monthly overview of the Corporate Risk Register and Risk Assurance Framework. Debbie Fagan and Helen Nichols are now holding weekly meetings with the CHC team so they are being held to account on a weekly basis. TJ reported the Corporate Governance Support Group and the Quality Committee had reviewed and commented on the registers, before presentation to the Governing Body. The registers will continue to be reviewed rigorously on a monthly basis at SMT meetings by management leads. **The GB approved and received the report.**	
GB15/10	**Child Sexual Exploitation (CSE)** Debbie Fagan and Karen Garside gave assurance to the Governing Body on the CCG's engagement in the CSE agenda and the report explained the current level of activity, evidence of CSE in Strategic Plans, as well as future commissioning intentions. An action plan has been developed and will be monitored through the Quality Committee. Dr Mimnagh asked how membership of the Maxi Group was comprised and where it would fit in the governance structure. Debbie Fagan confirmed it would be led by Merseyside Police and she would map out the structure. Peter Morgan confirmed the governance was quite 'fuzzy' around this and Louise Casey had been commissioned by the Government to write an overarching report which would be published in 2016. Karl McCluskey confirmed the CCG was well sighted on the issues. **Action: The Governing Body received the report.**	DF
GB15/11	**Care Quality Commission Safeguarding Declaration** The Safeguarding Declaration has been scrutinised by the Quality Committee and is recommended for approval by the Governing Body. **Action: The Governing Body approved the declaration.**	

GB15/12	**Strategic Plan: National Guidance & Implications** FLC outlined the approach the CCG intended to take in reviewing its two year operational and five year strategic plan, to have a balanced financial plan to support the population. Key issues that the CCG needed to consider were highlighted as well as a timetable setting out key national dates and Governing Body dates that need to be considered in reviewing and refining plans. Due to the requirement to conform to the national timetable, the Governing Body will need to consider the delegation of authority to the CCG Chair, Accountable Officer, Chief Finance Officer and Chief Strategy & Outcomes Officer to meet the necessary submission deadlines. All plans and the review of plans will be received by the Governing Body for agreement and endorsement, regardless. **Actions:** **(i) The Governing Body noted the detail contained in the national planning guidance and the implications for the review of existing two year operational and five year operational plans;** **(ii) The Governing Body agreed to support the development of a refreshed five year activity, financial and investment plan which addressed identified QIPP shortfall, with a view to approval being sought via Governing Body, as per the planning timetable;** **(iii) The Governing Body approved delegated authority via the CCG Chair, Accountable Officer, Chief Financial Officer and Chief Strategy & Outcomes Officer to progress the necessary work to enable national return requirements to be met.**	KMcC CS/FLC/ MMcD/K McC
GB15/13	**Out of Hours Pharmacy Engagement Report** Having considered the outcomes of the initial review to decommission the OOH Pharmacy at Litherland Town Hall, the CCGs took the decision in November 2014 to commission an Equality Analysis Report and a borough-wide consultation to further understand how patients might be affected if the service were to be decommissioned. This consultation was undertaken in December 2014 and January 2015. HN asked why the paper had come to the Southport & Formby Governing Body meeting to be discussed if it was fully funded by South Sefton. FLC explained the OOH Pharmacy had been set up as borough-wide service. FLC commented that the Equality Analysis Report was of a particularly high standard. **Actions:** **(i) The Governing Body approved the recommendation to decommission the OOH Pharmacy at Litherland Town Hall;** **(ii) The Governing Body approved the development of an action plan to address the recommendations of the equality analysis report and the results of the public consultation including:** - **working with the Go to Doc GP OOH provider to ensure that the supply of medicines when there is no local community pharmacy open, particularly for those patients with mobility, transport or carer difficulties in accessing the community pharmacy;** - **a targeted patient information campaign focusing on the changes to the OOH Pharmacy at Litherland Town Hall and how patients can access medicines in the OOH period in the future;** **(iii) confirm that Governing Body will receive an update on progress with the action plan at future Governing Body public meetings.**	BP BP

GB15/14	**Re-Procurement of Patient Transport Services** Patient Transport Services (PTS) was first tendered in 2011 with a start date for a new service of 1st April 2012. North West Ambulance Services (NWAS) won the contract for the Cheshire and Merseyside area. The contract was awarded as a three-year contract and is due to be re-tendered this year to enable a re-commissioned service start of 1st April 2016. **Action: The Governing Body approved the recommendation to participate in the North West procurement for patient services, to make amendments to the specification as appropriate; and to report the outcome of the procurement in 2015/16.**	
GB15/15	**Re-Procurement of NHS 111 North West Service** North West CCGs are in the latter stages of the re-procurement exercise for the NHS 111 North West Service and the bids received are being evaluated. The timetable is to ensure that that new contract is operational before winter 2015. This is very tight and as a result delegated authority was sought to sign off the recommendations of the procurement panel in order to ensure that contracts will be in place and the new provider is mobilised to enable the contract start date of October 2015. **Actions: The Governing Body approved the delegated authority to sign off the recommendations of the procurement panel to the Chair and the Chief Officer.**	CS/FLC
GB15/16	**Emerging Issues (from locality meetings)** Karl McCluskey attended the Maghull Locality meeting the previous week where a shift in activity from Aintree to Southport was discussed. This was due to a West Lancs Walk-In Centre in Ormskirk, which is proving to be very valued by patients of Maghull. Karl is linking in with the locality to understand this further.	KMcC
GB15/17	**Key Issues reports from committees of Governing Body:** a) Quality Committee – mortality rate - actions are monitored through the CQPG to the Quality Committee. Dr John Wray attended the meeting as an observer and was impressed with the quality of the Quality Committee. Maureen Kelly asked whether a clinical lead had been identified for neurological services. At present there is no capacity for a specific lead but the work is ongoing.	
GB15/18	**Quality Committee Minutes** – received by the Governing Body.	
GB15/19	**Finance & Resource Committee Minutes** – change to p170 – Lin Bennett and Sharon McGibbon – job title should be changed to Practice Manager.	RM
GB15/20	**Audit Committee** – received by the Governing Body.	
GB15/21	**Service Improvement Redesign Committee Minutes** - received by the Governing Body.	
GB15/22	Locality Meetings: a) Seaforth & Litherland Locality b) Bootle Locality c) Crosby Locality d) Maghull Locality Roger Driver asked if Dr Shaw was happy with attendance levels at locality meetings and whether the same attendance tracker could be used for all minutes so the level of engagement can be identified by members of the Governing Body.	JB
GB15/23	**Any Other Business** There were no additional items.	
GB15/24	**Date, Time and Venue of Next Meeting** *Thursday 26th March 2015 at 13.00 at Boardroom, Merton House, Bootle*	

NHS
South Sefton
Clinical Commissioning Group

Governing Body Meeting in Public
Actions following meeting in January 2015

No	Action	Action
GB14/148	***IM&T -*** S to be asked to give a demonstration of functionality on Ericom – to be brought to a development session of the Governing Body.	PS
GB14/156	***Commissioning Policy Review -*** an update on varicose veins to be brought back to March meeting.	JL
GB15/7	***Emerging Issues - Communication Flow with NHSE*** – issues were raised over the level of engagement by NHSE with local GP practices in relation to the future of the Litherland Darzi practice. FLC commented on the importance of continuing to maintain and build close relationships with NHSE and will facilitate conversations as soon as possible.	FLC
GB15/9a	***Corporate Risk Register & Risk Assurance Framework*** – should be presented to the Audit Committee every 6 months.	TJ/ MMcD
15/9(b)	***Corporate Risk Register & Risk Assurance Framework*** - to be reviewed by SMT on a monthly basis.	TJ
15/10	***Child Sexual Exploitation*** - Dr Mimnagh asked how membership of the Maxi Group was comprised and where it would fit in the governance structure. Debbie Fagan confirmed it would be led by Merseyside Police and she would map out the structure.	DF
15/12(a)	***Strategic Plan: National Guidance & Implications*** - The Governing Body agreed to support the development of a refreshed five year activity, financial and investment plan which addressed identified QIPP shortfall, with a view to approval being sought via Governing Body, as per the planning timetable.	KMcC
15/12(b)	***Strategic Plan: National Guidance & Implications*** - The Governing Body approved delegated authority via the CCG Chair, Accountable Officer, Chief Financial Officer and Chief Strategy & Outcomes Officer to progress the necessary work to enable national return requirements to be met.	CS/ FLC/ MMcD/ KMcC
15/13(a)	***Out of Hours (OOH) Pharmacy*** - The Governing Body approved the recommendation to decommission the OOH Pharmacy at Litherland Town Hall and the development of an action plan to address the recommendations of the equality analysis report/results of the public consultation. Progress on the action plan will be presented at future Governing Body public meetings.	BP
15/15	***Re-Procurement of NHS 111 North West Service*** - The Governing Body approved the delegated authority to sign off the recommendations of the procurement panel to the Chair and the Chief Officer.	CS/ FLC
15/16	***Emerging Issues (from locality meetings)*** - Karl McCluskey attended the Maghull Locality meeting the previous week where a shift in activity from Aintree to Southport was discussed. This was due to a West Lancs Walk-In Centre in Ormskirk, which is proving to be very valued by patients of Maghull. Karl is linking in with the locality to understand this further.	KMcC

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MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/47	**Author of the Paper:** Fiona Clark Chief Officer Email: fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: March 2015	

Title: Chief Officer Report

Summary/Key Issues:

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

Recommendation

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

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
X	Improve quality of commissioned services, whilst achieving financial balance.
X	Sustain reduction in non-elective admissions in 2014/15.
X	Implementation of 2014/15 phase of Virtual Ward plan.
X	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
X	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
X	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
X	Review the population health needs for all mental health services to inform enhanced delivery.

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

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

Report to the Governing Body
March 2015

1. Shaping Sefton – Future Models of Care

A successful event was held on the 12th February facilitated by Prof Chris Ham – King's Fund. Over 200 people attended from a range of organisations including, the local NHS and social care sector, academia, voluntary and private sector, Healthwatch and local CCGs.

The outcome of the day will now allow the refinement of the detailed models of care for both in and out of hospital, which will address the three key strategic areas of the CCG to gain maximum benefit for change in Sefton, aligned to the Sefton Health & Wellbeing strategy.

Work will now be undertaken during April 2015 to establish the relevant governance arrangements, understand the financial plans and create the opportunities to drive forward the required transformational system change.

A full paper will be presented to the May 2015 Governing Body.

2. Planning & Contracting 2015/16 Update

The 2015/16 planning approach and guidance, issued in December 2014 has been challenged by the delay in the agreement and issuing of the provider tariff. As a direct consequence of this the original national timetable has been recently re-issued, with the next submission date for the CCG being 10th April 2015. This will be the final CCG submission, however there remains the opportunity for further reconciliation with provider plans following this. The challenge for NHSE remains around the reconciliation of previously submitted 2 year operational and 5 year strategic plans and those now being submitted for 2015/16. This is fundamentally down to the national decision to use different datasets in the planning for 2015/16. This issue will undoubtedly present challenges to the CCG as NHSE will require assurance on alignment of our plans.

3. NHS 111 Procurement

Further to the commencement of the NHS 111 North West Procurement back in October 2014, the formal stages of the process have been completed. The preferred provider is North West Ambulance Service NHS Trust in partnership with FCMS and Urgent Care 24. The Programme Board will now work closely with the three organisations to harness their expertise in delivering a high quality service to the public across the region. The next steps are to finalise the contract to enable a mobilisation phase to begin from April leading to a phased implementation of the service during October and November 2015.

The NHS 111 North West Programme Board will work with clinical leads, managerial leads, the service providers and other key urgent care stakeholders to determine the detail of mobilisation and this phased introduction.

4. Community Service Transformation Update

The CCG continues to work in conjunction with NHS West Lancashire CCG around the continued transformation of community services in the Southport and Ormskirk Health economy. This work

supports the SFCCG Care Closer to Home objectives. Key areas for development include District Nursing, Treatment Room Services Redesign, Workforce and Leadership Development and Single Point of Access. All areas have clear actions plans with timescales for delivery.

5. Mental Health Task Group Update

The CCG Mental Health Task Group is now drafting a report which brings together the findings from an in-depth review undertaken over the last twelve months. The report will highlight the key issues, priorities and next steps required to transform mental health and dementia care across Sefton. Key areas which have emerged so far are Primary Care, Dementia, Child and Adolescent Mental Health Services, Brain Injury and Outcomes and Recovery. A presentation providing an overview of the work to date will be given at the Governing Body meeting.

6. NHS England – National Public Health Commissioning Intentions

The CCG has received a document which sets out for commissioners and health care providers notice of NHS England's commissioning intentions for Public Health Section 7A Programmes for 2015/16, in support of the ambitions to improve health outcomes, tackle health inequalities and secure best value for money.

In 2015/16 NHS England is focusing on improving access to public health screening programmes overall, and with a specific focus on improving access and uptake for people with learning disabilities; for 2015/16 we expect to commission and make quality improvements in this area. Section 9 documents planned programme changes for 2015/16, including the roll out of the childhood influenza vaccination programme in England with 9 million children and young people offered an influenza vaccination every autumn.

Finally, NHSE indicate that they will continue to work with each Local Authority individually in preparation for the transfer of commissioning responsibility of 0-5 services in October.

7. NHS England Guidance on Quality Accounts

The CCG has received a letter containing the guidance on the reporting arrangements for 2014/15 Quality Accounts which has been sent to all relevant parties.

As is usual the Provider will need to share the Quality Accounts with local commissioners, scrutineers and the local Quality Surveillance Group. Any comments from these parties will be included into the final Quality Account. The Provider will then up load them onto the NHS Choices website by the 30th June 2015.

Oversight of the Quality Account for any NHS and Non NHS provider will be undertaken on behalf of the CCG by the Chief Nurse & Safety Officer-Debbie Fagan and team and aligned into the work programme of the Quality Committee.

8. Annual Report and Accounts

The date for submission of the draft annual report and annual accounts is noon on 23rd April. Governing Body members are reminded that approval of the annual report and accounts has been delegated to the CCG's Audit Committee which will meet on Wednesday 20th May (SF) / Thursday

21st May (SS) to discuss content. The audited report and accounts must be submitted to NHS England by noon on 29th May which is one week earlier than last year's deadline.

9. Dermatology Procurement 2015/16

Following the agreed extension of the community dermatology service contract to March 2016 work is now beginning on detail required for the procurement of the service going forward. Initial plans are to work with Liverpool CCG in agreeing a Merseyside-wide dermatology pathway process. Difficulties in delivering the 2-week wait targets in dermatology are suggesting that this is the best approach. A lead GP from each CCG will need to be identified to support development of specification and to work through the procurement process which will include the evaluation of bids. The bulk of this work will be undertaken during the winter period of this year.

10. North West Commissioning Support Unit

Following discussions with the Governing Body in January and February, the CCG is proceeding with its plans to bring in-house a small number of services lines. The HR arrangements are progressing both in terms of agreeing any TUPE arrangements and recruitment to the new roles.

Following the announcement that North West Commissioning Support Unit (NWCSU) has not been included in the national Lead Provider Framework (LPF), a Transition Board has been set up by NHS England to support Cheshire, Mersey and Greater Manchester CCGs, working with NWCSU colleagues, to move to a new model of commissioning support. The NWCSU has reached an agreement with a "sustainability partner" - a neighbouring CSU - to help maintain existing services. The Merseyside CCG network is working collaboratively to support this transition. It is expected that plans for future service options will be presented to the Governing Body in May 2015.

11. Innovation Fund - Community Sefton Adolescent Service

The Government has made available approximately £30 million in 2014 and significantly more for 2015 to support innovative approaches to some of the seemingly intractable issues facing children's social care. Adolescents in care or on the edge of care are one of the areas to be considered.

The Sefton bid for £1.1m to enable us to develop a Community Adolescent Service has been successful. The new service will target young people aged 12 – 25 who are involved in or susceptible to Child Sexual Exploitation, gun and gangs, crime, missing from school, home or care, at risk of school exclusion and homeless.

To ensure that young people are at the heart of all we do we will facilitate two apprenticeships to be placed within the service. Young people are represented at both the strategic and operational groups.

12. Joint CCG CHC Steering Group

This continues to meet on a weekly basis chaired by Helen Nichols - Lay Member from Southport and Formby CCG. Weekly reporting on the status and progress of the CHC reviews backlog that is to be completed by the end of March 2015 continues. Progress on completing the CHC Restitution Cases continues to be presented on a monthly basis - as this has been outsourced in

order to manage the demand and the performance management of NWCSU for this area of work is undertaken through the CCG SLA meeting. A CHC Service Specification has been developed that is currently being finalised for an 'end to end service'. Locality leadership remains challenging and the CCG are monitoring closely with CSU colleagues the effectiveness of the interim temporary solution that has been put in place. A costed option appraisal will be submitted to the Senior Leadership Team for the end of March 2015 to enable informed decision making for future service options.

13. Quality Surveillance Group

The CCG has been present at a number of Quality surveillance groups which have been reported through to the Quality Committee.

14. Developing Student placements within a Clinical Commissioning Group project

The project was developed through a partnership framework between the two Sefton CCGs, Edge Hill University and the North West Placement Development Network. The aims were to provide pre-registration nursing students the opportunity to gain knowledge and experience of how a CCG operates within a local health economy and its governance processes as well as to develop a mechanism to provide an avenue for newly qualified nurses to explore a future career within a CCG and closer working with HEIs. The CCG hosted the first pre-registration student in the country in January with positive feedback. As a result the CCG have been invited to present the project of partnership working at a Transforming Learning Environments event, hosted by Health Education North West.

15. Sign Up to Safety Campaign

The CCG is committed to Sign up to Safety, a new national patient safety campaign that was announced in March 2014 by the Secretary of State for Health. It launched with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The CCGs are in the process of setting out the actions they will undertake in response to the five Sign up to Safety pledges (See below) and agree to publish this on our website for staff, patients and the public to see.

The CCG are also committed to turn their actions into a safety improvement plan which will show how the organisation intends to save lives and reduce harm for patients over the next 3 years.

The five Sign up to Safety Pledges:

- Putting safety first. How it is committing to reduce avoidable harm in the NHS by half an make public our locally developed goals and plans;
- Continually learning. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are;
- Being honest. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong;
- Collaborating. Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use;

- Being supportive. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

The CCG is leading commissioner and provider steering groups on Health Care Acquired Infections and Pressure Ulcers and these areas it is felt will be the areas of focus for the CCGs sign up to safety. Commissioners are in an excellent position to lead a system change and improve safety for patients across a whole health economy. Catheter care is also an area that will be targeted. AQuA is supporting the ccg in its sign up to safety process. The pledges will be discussed at April Quality committee and at any other committees necessary.

16. Merseyside CCG Network

The Merseyside CCG network is currently hosted by NHS South Sefton CCG and over the past two months has focused its discussions on:

- Improving Maternity Care Experience across Cheshire & Merseyside;
- NWCSU outcomes of the lead Provider Framework;
- Safeguarding hosted service;
- Specialised Commissioning;
- NHS 111;
- Feedback from NHS Clinical Commissioners.

17. Informatics Merseyside Partnership Board

South Sefton CCG is one of six partners of the Informatics Partnership Board. The Board meets quarterly and met on 9th March 2015. Some discussion took place with the partners in light of the ongoing developments with Liverpool Community Healthcare who are one of the current IM partners.

The key issues worthy of note include:

- Governance - the partnership agreement was noted, the Strategic Accountability Framework approved and the underlying operational group work programme agreed;
- Financial/ Business Development - an update was received on the partner SLA 2015/16 and a proposal for business development and benchmarking framework approved;
- Performance - the performance was noted as being on track;
- Communication & Engagement - the Board received a summary document for approval.

Finally, it was agreed that Fiona Clark Chief Officer of South Sefton CCG and Southport & Formby CCG would assume the role of chair for the Board. The Board also congratulated Informatics Merseyside IT service on being the first NHS help desk in England to be accredited with 3-star certification from the Service Desk Institute (SDI).

18. General Update

The CCG is reviewing the use of Litherland Walk in Centre in light of the current Darzi consultation with a view to developing the current service, Dr Andy Mimnagh is the clinical lead.

The North Mersey System Resilience Group is currently reviewing spending plans for 15/16 allocated resilience monies for the system.

The CCG is providing Making Every Contact Count training for practice admin staff starting in April.

Dr Pete Chamberlain and Dr Debbie Harvey are leading an initiative specifically looking at supporting residents in Care Homes. This initiative is known as CHIP (Care Home Innovation Programme).

The CCG is now planning for next year's Local Quality Scheme; Dr Craig Gillespie is the clinical lead.

The CCG has agreed to fund primary care respiratory training programme for all Practice Nurses, HCAs, District nurses, Community Matrons and Community Pharmacy. The aim is to provide updated training to improve the patient pathway in primary and community care which will in-turn reduce unnecessary A&E and inpatient admissions.

19. Governing Body Changes

Dr Clive Shaw, GP Chair of the CCG, will step down from his role as Chair on 31st March 2015. Clive will continue with his governing body work until the next election and will take a lead for a clinical work area. These are currently being worked through with governing body and associate members. Dr Craig Gillespie and Dr Andy Mimnagh have both undertaken Chair development and will undertake a co-chair role from 1st April 2015 subject to ratification with the CCG membership. Working with the LMC, the GP vacancy has been filled by Dr Pete Chamberlain and we are currently seeking expressions of interest from the Practice Managers for the vacancy left by the resignation of Lin Bennett. Both these roles will be subject to ratification by the CCG membership in line with the CCG constitution.

Peter Morgan, Deputy Chief Executive of Sefton MBC who has represented Margaret Carney as co-opted governing body member, will be retiring in April.

On behalf of the governing body I would like to formally thank Clive and Peter for the input into the governing body. I would particularly like to thank Clive for his tenacity and commitment to the role of CCG Chair and for the manner in which he has guided the CCG from its roots in the practice based commissioning group through into the successful CCG.

Fiona Clark
March 2015

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/50	**Author of the Paper:** James Hester Programme Manager Quality & Safety Email: james.hester@southseftonccg.nhs.uk Tel: 0151 247 7000
Report Date: March 2015	

Title: Draft CCG Quality Strategy

Summary/Key Issues:

The CCG Quality Strategy sits alongside the CCG Strategic Plan and 5 year Forward View to enable the CCG to achieve its vision:

''To create a sustainable healthy community based on health needs, with partners; focused on delivering high quality and integrated care services to all, to improve the health and well-being of our population''.

Recommendation

The draft Quality Strategy is submitted to the Governing Body for approval.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Sustain reduction in non-elective admissions in 2014/15.
x	Implementation of 2014/15 phase of Virtual Ward plan.
x	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

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

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

NHS
South Sefton
Clinical Commissioning Group

Quality Strategy 2015 - 2019

Date Approved:

Date for Review:

Chair: Lead:

Chief Officer:

Author & Lead:

Quality Strategy

Contents

Foreword

The first priority of N H S Southport Sefton Commissioning Group (CCG) is to commission services that offer quality for local people – services that are clinically effective, safe, well-led, responsive to patient's needs and offer a positive patient experience.

The drive to secure positive health outcomes for local people and continuously improve the quality of services is at the heart of the work of the CCG. It requires focused leadership by the CCG Governing Body, together with relentless individual and collective commitment across the CCG membership and its management.

Securing and improving quality cannot be achieved by the CCG in isolation. We recognise that our patients' journey cut across primary, secondary and specialist care, health and social care, with services commissioned and delivered by multiple organisations and professions both within and outside the NHS. We appreciate the commitment of our partners to work with us in improving quality. We will continue to support and collaborate with provider organisations to improve the quality of services provided, whilst holding them to account for standards of service delivery.

The appalling failures, at Mid Staffordshire NHS Foundation Trust, Morecambe Bay, the independent hospital Winterbourne View and the review into 14 hospital Trusts in England, highlight the risks if we do not have robust systems and processes to identify and act on quality issues. These examples act as a reminder that when failures in expected standards occur, the consequences are directly felt by patients, service users, their carers and families.

Systematically and continuously improving the quality of services across settings of care represents a significant challenge for the CCG and partner agencies. To ensure value for money in commissioning of care, we need to improve quality and outcomes through innovation in service design, efficiency, and a continued focus on prevention of ill-health alongside treatment and care.

The measures of quality are not static. We know that we need to set standards higher year on year to improve health outcomes and the patient experience. This is likely to require some difficult and courageous decisions by the CCG in the months and years ahead as we seek to reconfigure services and prioritise resources towards areas of greatest health gain and quality improvement for local people in line with our strategic plan and the 5 year forward view.

This Quality Strategy is central to the purpose and work of the CCG, and underpins any strategic plan. It describes our responsibilities, approach, governance and systems to enable and promote quality across the local health economy. The Quality Strategy is, above everything, about people. It describes our approach to provide everyone with the care and compassion they need and enabling their voice to be heard. It supports our commissioning of services to ensure that they are amongst the safest and most effective in the NHS, provided reliably to every patient, every time. The CCG Quality strategy is underpinned by six fundamental values: care, compassion, competence, communication, courage and commitment (6C's) - these six areas of action will help to support the CCG to commission excellent care and promote enduring values and behaviours. The 6C's put into context how delivering health and care support and services involves the CCG working with people in a new partnership, offering and engaging with people in making choices about their health and care, and supporting 'no decision about me without me'. Every patient and person we support can and should expect high quality

Implementation of this strategy will support the CCG to achieve Our Vision:

''To create a sustainable healthy community based on health needs, with partners; focused on delivering high quality and integrated care services to all, to improve the health and well-being of our population''.

Quality Strategy

Introduction:

Commissioning high quality compassionate healthcare is at the heart of everything the CCG strives to achieve for the people across South Sefton.

The Health and Social Care Act 2012 changed the way the NHS in England is organised and run. Certain vital elements have not changed and are the driving force behind the changes in a challenging financial environment:

- Improving quality and healthcare outcomes for patients remains the primary purpose;
- The cultures, values and behaviours of the CCG constituents and staff is the first line of defence in safeguarding quality;
- Greater emphasis on the involvement of clinicians being at the heart of commissioning.

Commissioners' statutory duty and responsibility for:

- Meeting the needs of the local population through commissioning high quality services;
- Obtaining assurance and securing continuous improvement in the quality of commissioned services and the outcomes that are achieved.

The CCG brings together 33 GP surgeries, serving a population of 156,000 stretching from Bootle in the south, Hightown in the north and Melling and Lydiate in the east.

There are a number of distinct environmental and social factors that we must take account of when we are planning health services including:

- Our population is made up of a significantly higher proportion of older residents with an estimated 19.5% (approximately 31,250) of the population over the age of 65, compared to 17.5% aged over 65 nationally. This is expected to grow further to more than 35,400 in the next ten years.
- South Sefton has significantly higher levels of deprivation and child poverty.
- Thirty-three General Practices are constituent members of the CCG, providing a wide range of primary care services to our patients.

Overall, health in South Sefton is getting better, but there are clear areas for improvement:

- Within the areas of South Sefton that are most deprived, average life expectancy is 11 years less than in the more affluent parts of the area.
- Levels of long term health conditions are much higher than the national average; particularly heart disease, respiratory disease, kidney disease, mental health conditions and obesity.
- Levels of early deaths from heart disease have reduced over the last decade as smoking rates have reduced and our patients are better educated about risks to their health and the importance of leading a healthy lifestyle.

The CCG aims to commission services that improve the health and wellbeing of all patients registered with its member practices and those who are unregistered but are resident within the boundaries of the CCG.

Following the reforms outlined in the White Paper '*Liberating the NHS'*, which describes the

move to clinically-led commissioning from April 2013. Southport & Formby GPs have created a Clinical Commissioning Group across the North of the Borough of Sefton with four strong localities:-

- The CCG staff work in a matrix model with colleagues from a number of areas; the Joint Commissioning Unit with Sefton Borough Council, the North West Commissioning Support Unit (NWCSU) and NHS England (NHSE) to ensure a comprehensive approach to commissioning in Southport & Formby.

- It is essential that the CCG has in place robust quality governance arrangements to ensure the commissioning of high quality services which are responsive to the needs of our population.

- The CCG as a statutory body from April 2013 commissions health services from a diverse range of provider organisations across all settings of care (primary, community, secondary and mental health).

- The CCG commissions health care from local acute hospitals, mental health providers, and community providers, independent and social care providers, and the voluntary sector.

- The CCG has demonstrated ownership of the quality agenda throughout the authorisation process, and had no conditions attached at authorisation neither for the new organisation nor since our formal establishment in April 2013.

- In developing this quality strategy, the CCG has identified how it will operate to improve and maintain quality in the context of the legislative framework and in collaboration with partner agencies.

- The CCG believes the use of contractual levers and performance management is one specific process for supporting the CCG in discharging its responsibility for improving quality and quality assurance.

- The CCG is passionate and focused on good quality of services and where necessary will use performance management to improve service quality.

- The CCG does not consider that its presence alone will have the necessary impact on health outcomes; however, based on robust evidence, the CCG has developed a vision of what it aims to deliver.

The quality strategy is integral to the CCG strategic plan and is focused on delivering high quality care and experience, ensuring no harm is done to patients and addressing areas of any concern promptly and effectively. It is underpinned by the 6C's, as outlined in the Chief Nursing Officers paper 'Compassion in Practice- Our Vision and Strategy' which sets out the shared purpose to deliver high quality, compassionate care, and to achieve excellent health and wellbeing outcomes.

The CCG has to maintain safe and effective safeguarding services and to strengthen arrangements for safeguarding adults and children across Sefton, working collaboratively with partner agencies. To do this the human rights, independence and well-being and secure assurance that the child or adult thought to be at risk, stays safe. The CCG safeguarding strategy sets out priorities for the forthcoming years 2015- 2017 and is the start of the journey to plan and commission locally delivered services that drive up quality and ensure our population receives effective, safe and personalised care.

Definition of Quality:

Quality means different things to different people and the NHS is the only healthcare system in the world with a single definition of quality.

At its simplest, Quality is defined as care that is **safe**, **effective** and provides as positive an **experience** as possible. The definition of quality sets out three dimensions to quality:

- **Patient Safety:** commissioning high quality care which is safe, prevents all avoidable harm and risks to the individual's safety; and having systems in place to protect patients;

- **Clinical Effectiveness:** commissioning high quality care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes. Making sure care and treatments achieve their intended outcome;

- **Patient Experience:** commissioning high quality care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what the individual wants or needs, and with compassion, dignity and respect. It's about listening to the patient's own perception of their care.

This simple, yet powerful definition was first set out in *High Quality Care for All* in 2008, following the NHS Next Stage Review led by Lord Darzi. This definition now enshrined in legislation has the patient and the NHS Outcomes Framework at the heart.

The Care Quality Commission (CQC)'s new inspection approach goes further to build on the three dimensions of Quality by adding two additional dimensions:

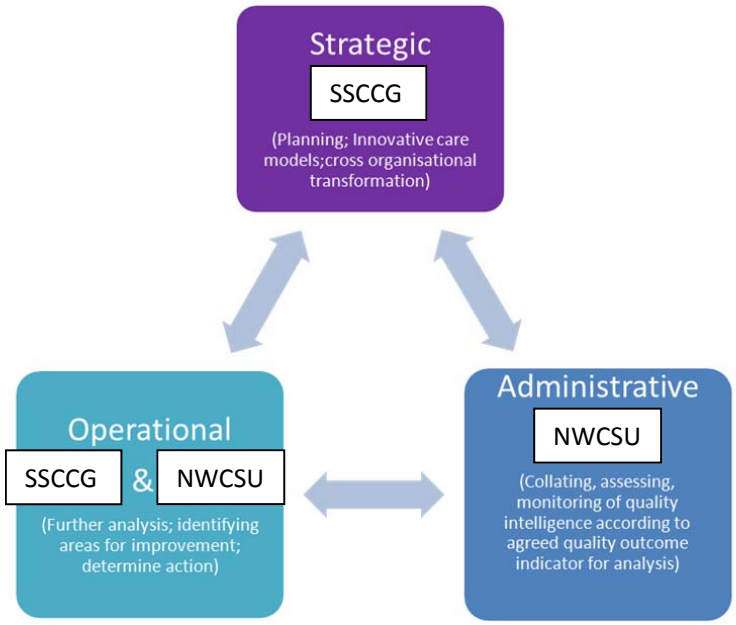
- **Organisational Culture & Leadership:** commissioning high quality care which is well-led;

- **Responsiveness:** commissioning high quality care which is responsive to the needs of patients.

Quality is not an abstract term or concept relevant only in policy debates. It must begin within our own organisation and be apparent within the organisations the CCG commissions services from. It is the measure of how we commission services and how commissioned services are treating and caring for patients in their care. In order for commissioned services to be considered as providing a high quality service, being good in one or two of the above five dimensions of quality is simply not good enough.

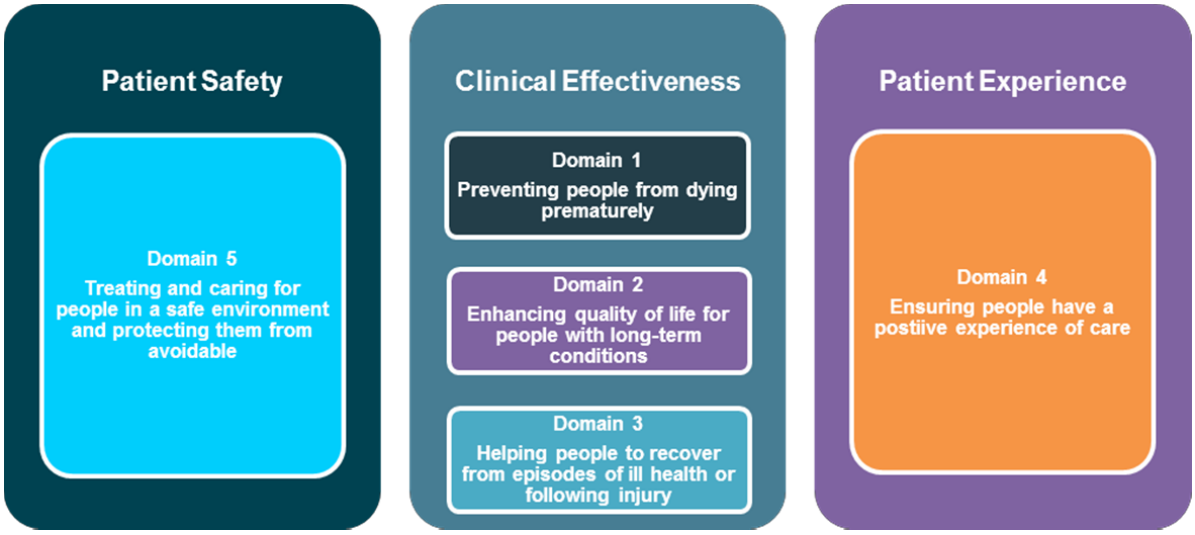

Patient Safety
(Are commissioned services safe?)
Clinical Effectiveness
(Is the care commissioned effective?)
Organisational Culture & Leadership
(Are commissioned services well-led?)
Patient Experience
(Have patients had a good experience)
Responsiveness
(Are commissioned services responsive to people's needs?)
Quality

To ensure the CCG is focused on the five dimensions of quality it needs to have an effective quality control process which is fit for purpose, proactive and reactive and applicable to every directorate within the CCG.



The NHS Outcomes Framework builds on the definition of quality through setting out five overarching outcomes or domains, which captures the breadth of what the CCG is striving to achieve for patients:

- **Domain 1** Preventing people from dying prematurely;
- **Domain 2** Enhancing quality of life for people with long-term conditions;
- **Domain 3** Helping people to recover from episodes of ill health or following injury;
- **Domain 4** Ensuring people have a positive experience of care;
- **Domain 5** Treating and caring for people in a safe environment and protecting them from avoidable harm.


Patient Safety
Domain 5
Treating and caring for people in a safe environment and protecting them from avoidable
Clinical Effectiveness
Domain 1
Preventing people from dying prematurely
Domain 2
Enhancing quality of life for people with long-term conditions
Domain 3
Helping people to recover from episodes of ill health or following injury
Patient Experience
Domain 4
Ensuring people have a postiive experience of care

The domains of the NHS Outcomes Framework are a crucial element of focus for the CCG's commissioning strategic plan, acting as driver for commissioning.

National Quality Drivers

The CCG will drive local health systems towards a sustained focus on quality, guided by several policy drivers. These policies inform the way the CCG continuously monitors, measures and improves the quality of care and experience received by its population:

- *The NHS Outcomes Framework*: sets out the improvements against which NHSE will be held to account. The NHS Outcomes Framework is intrinsically linked to the local and national quality priorities which consist of five domains set across the three dimensions of quality;

- NHS England published its up-dated planning strategy in October 2014 (Five Year Forward View). This places an increasing emphasis on the prevention of ill-health and the role of public health in tackling major causes of disease. This emphasis is consistent with the CCG Strategic Plan and is in keeping with the Better Care Fund plan that has been jointly developed with Sefton Metropolitan Borough Council.

  In addition, the Five Year Forward View places a resounding emphasis on self-care and local support for self-care. This is very much in keeping with the CCG locality model and adds strength to the major transformation schemes (Virtual Ward, Care Closer to Home) within the CCG strategic plan.

- *The Next Stage Review: High Quality Care for All* (2008): sets out a clear quality framework including the components of quality assurance mechanisms. The review placed great emphasis on being more patient centred, clinically driven, valuing people and promoting lifelong learning and improving the quality of commissioned services;

- *NHS Constitution* (2013): establishes the principles and values of the NHS in England. It sets out the pledges the NHS' commitment to operate fairly and effectively, the rights to which patients, the public and staff are entitled. The NHS Constitution is adhered to and reflected within the CCG's mission, vision and values;

- *Quality, Innovation, Productivity and Prevention (QIPP)*: is a large scale transformational programme for the NHS, involving and engaging staff, clinicians, patients and the voluntary sectors in Sefton in improving the quality of care delivered whilst making efficiency savings, leading and supporting change and addressing local quality challenges. In the CCG, QIPP is a well-established programme and the CCG works with its local health partners in developing integrated QIPP plans that address local quality challenges;

- *Commissioning for Quality and Innovation Framework (CQUIN)*: enables commissioners to reward excellence by linking a proportion of healthcare provider's income to the achievement of local quality improvement goals thus enabling providers to act as a vehicle for improving patient safety, experience and outcomes. CQUINs schemes form part of the contract between the CCG and its main providers of healthcare. These are routinely monitored by the NWCSU Contracts team with updates provided quarterly at the commissioned services Clinical Quality Performance Group (CQPG) meeting;

- *Healthwatch England*: is the independent consumer champion for health and social care in England created to ensure that the voices of the public and those who use services reach the ears of the decision makers. Healthwatch Sefton plays a key role at local level in ensuring the views of Sefton's population and people who use commissioned services are taken into account;

- *Quality Premium*: is the incentive payment used to reward CCGs for their performance in achieving specific outcomes related to a number of clinical conditions. The criteria will be developed by NHSE and come from within the overall administration costs limit set in directions for the NHS commissioning system;

- The National Quality Board (NQB) is a multi-stakeholder board established to champion quality and ensure alignment in quality throughout the NHS. The NQB is a key aspect of the work to deliver high quality care for patients.

  The aim of the NQB is to bring together all those with an interest in improving quality, to align and agree the NHS quality goals, whilst respecting the independent status of participating organisations.

- *General Practice (GP) Quality and Outcomes Framework*: is a system to remunerate GPs for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the General Medical Services contract, introduced on 1st April 2004;

- The CCG now commissions GPs to deliver a number of schemes to improve patient care.

- *Care Quality Commission (CQC):* is the independent regulator of health and social care in England. It monitors, inspects and regulates care provided by CCG's commissioned services to ensure they meet fundamental standards of quality and safety;

- *Recent National Reviews*: there is a focus on quality following recent scandals. The recommendations and lessons learned from the following reviews will be fully implemented and signal a shift in how the CCG commission services:

  - Mid Staffordshire NHS Foundation Trust (Francis Report);
  - Review into the quality of care and treatment provided by 14 hospital: Sir Bruce Keogh;
  - Winterbourne View Hospital;
  - Maidstone and Tunbridge Wells NHS Trust;
  - Basildon and Thurrock University Hospitals NHS Foundation Trust;
  - Professor Don Berwick's Review into Patient Safety;
  - Dr David Colin Thomé and Professor Sir George Alberti's Review of Commissioning Roles.
  - Morecambe Bay
  - Saville Enquiry

The CCG Vision, values and objectives as part of its 5 year Strategic Plan

The vision of the CCG is to create a sustainable healthy community based on health needs, with partners; focused on delivering high quality and integrated care services to all, to improve the health and well-being of our population.

The values the CCG hold as part of its 5 year strategic plan are:

- To maintain a local focus, working in partnership
- To be transparent, open and honest
- To be approachable and to listen to our public
- To enable action and prioritise effort to optimum effect
- To act with integrity, act fairly and with respect
- To be accountable for what we do
- To be caring and compassionate

The system objectives the CCG have, aim to:

- Potential rate of years of life lost from causes considered amenable to health care. To significantly reduce hospital avoidable deaths by 142%.
- To improve the health related quality of life for people with one or more LTC by 8%.
- Reducing the amount of time people spend avoidably in hospital. Reduce emergency admissions by 19.7%.
- To improve in-patient experience by 14.5%. The proportion of people reporting poor patient experience of inpatient care.

- Improve patient experience of GP and out of hours care by 32.6% (% reporting poor care to reduce)

The CCG will deliver its strategic plan and vision through Patient Integrated Locality Care. This programme represents the locality delivery model for the CCG. These will focus on delivering enhanced primary and community care with improved access and management of individuals' needs with Long Term Conditions to prevent unnecessary admission to hospital.

The CCG will deliver its strategic plan and vision through the following governance arrangements:

- Sefton Health & Wellbeing Board
- Aintree Strategic Partnership Board
- Health & Wellbeing Board Provider Forum
- CCG Service Improvement & Re-design committee.
- Integrated approach with BCF and Sefton Council through Health & Wellbeing Board.
- Governing Body

The CCG will measure its success in the delivery of its strategic plan using the following criteria:

- All organisations within the health economy report a financial balance in 2018/2019
- Reduction in Unplanned activity by 15%
- No provider under enhanced regulatory scrutiny due to performance concerns
- Achievement of the 5 defined system objectives

The CCG is clear in this strategy that Quality is everyone's responsibility and ensuring that effective mechanisms are in place to proactively monitor, triangulate and ensure continuous improvement is crucial.

The importance of quality is reflected in the CCG's Constitution and in its values and behaviours. The CCG embraces a culture of openness, learning and honest collaboration where individuals and the organisation are transparent about the quality of care being commissioned for patients.

The CCG embraces the principles and values as set out within the NHS Constitution (2013). These act as a guide to the NHS (including CCG staff) in all it does:

Principles:

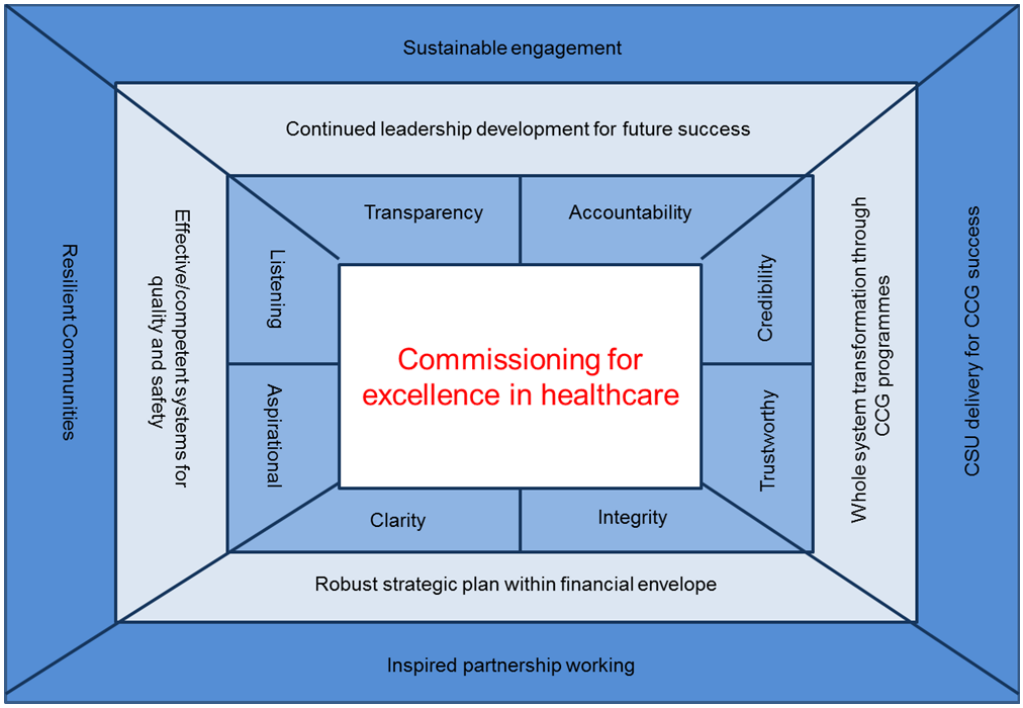
- The NHS provides a comprehensive service, available to all;
- Access to NHS services is based on clinical need, not an individual's ability to pay;
- The NHS aspires to the highest standards of excellence and professionalism;
- The NHS aspires to put patients at the heart of everything it does;
- The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients, local communities and the wider population;
- The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources;
- The NHS is accountable to the public, communities and patients that it serves.

Values:

- Working together for patients;
- Respect and dignity;
- Commitment to quality of care;
- Compassion;
- Improving lives;
- Everyone counts;
- The CCG has gone further in building on the NHS Constitution to describe how it will conduct itself in achieving our vision:

  ''To create a sustainable healthy community based on health needs, with partners; focused on delivering high quality and integrated care services to all, to improve the health and well-being of our population''.

An adherence to Quality for the CCG



The organisation aims to demonstrate the values illustrated when commissioning care on behalf of the CCG and demonstrates 'how we do things' across the constituency.

The CCG believes in order to ensure the delivery of the quality agenda there needs to be commitment to the creation of a culture where our staff are valued and supported.

The CCG enables staff to feel valued and supported with an ethos of:

- Distributed Leadership
- Integration
- Decision making
- Head Space
- Focus
- Senior management support
- Smoother clearer governance

All of which are underpinned by a robust Organisational Plan.

Corporate Objectives

- The focus of the CCG's quality strategy is to support the achievement of the CCG's corporate objectives and vision for its residents of Southport & Formby.

- The CCG's seven corporate objectives form part of the golden thread of quality running through the CCG:

- These corporate objectives will be reviewed on an annual basis and new objectives set accordingly which support the delivery of quality services and improved outcomes for the population

The CCG's aspirations described through the corporate objectives are the key focus for quality and the CCG recognises and accept that to deliver the corporate objectives some difficult and challenging choices will be required.

- Ensuring the CCG achieves its corporate objectives and that patients receive high quality care relies on a complex set of interconnected roles, responsibilities and relationships between the CCG staff, patients and the public, our member practices, professionals, Public Health, commissioned services, other CCG commissioners, professional regulators and other national bodies.

The CCG Governing Body is accountable for driving the quality agenda. The CCG's Quality Committee is the responsible committee (under delegated responsibility from the Governing Body) for the monitoring of the agenda and has key responsibilities to:

- approve arrangements including supporting policies to minimise clinical risk, maximise patient safety and secure continuous improvement in quality and patient outcomes
- approve the arrangements for handling complaints
- approve the CCG's arrangements for engaging patients and their carers in decisions concerning their healthcare
- approve arrangements for supporting NHS England in discharging its responsibilities to secure continuous improvement in the quality of general medical services.

In order to ensure delivery of the quality agenda and corporate objectives and promote a quality focused culture throughout the CCG, the necessary leadership arrangements for commissioning high quality services has been established. The Board has delegated responsibilities to the following committees, groups and forum:

- Senior Management Team/ Senior Leadership Team;
- Finance Resources Committee;
- Audit Committee;
- Quality Committee;
- Service Improvement & Redesign Committee;
- Remuneration Committee;

The CCG itself has to demonstrate that it is operating effectively to commission safe, high quality and sustainable services within their resources.
Internally it demonstrates this in a variety of ways:

- Internally focussed Quality Committee meetings
- Risk Registers
- Governing Body Assurance Framework

In addition the CCG Assurance Framework outlines the process to be used by NHS England to monitor and gain assurance on the performance of CCGs. The CCG assurance process has been designed to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively

This framework sets out six broad 'assurance domains' under which this assessment will be made:

- Are patients receiving clinically commissioned, high quality services?
- Are patients and the public actively engaged and involved?
- Are CCG plans delivering better outcomes for patients?
- Does the CCG have robust governance arrangements?
- Are CCGs working in partnership with others?
- Does the CCG have strong and robust leadership?

A key element of the assurance process is quarterly assurance meetings with the NHS England Area Team, together with the production of a 'delivery dashboard' which provides information on performance against certain targets and metrics

- The CCG understands that effective commissioning cannot be embedded if different parts of the CCG work in isolation, therefore, the CCG have ensured there are robust quality governance arrangement and delivery and assurance structure aligned to ensure systematic reporting and performance monitoring in place. This ensures the CCG focuses on quality improvement through delivery of the corporate objectives in the best interest of patients;

- The CCG reflects the strategic objectives and quality strategy through staff objectives and training strategy in order to embed quality, make quality a reality, promote and deliver the quality agenda;

- The CCG has responsibility for identifying the learning from all newly released national and local reports (e.g. Francis, Berwick, Keogh Reports), guidance and any other relevant documents as appropriate as part of the CCG's assurance process. Such documents have been summarised to include the following and have been presented to the CCG Governing Body and Quality Committee (QC):

- Identified themes;

- Findings of the report;

- Recommendations:

    - CCG reflective review against the report findings, triangulation to support the CCG's assurance of its system and processes and gap analysis to identify areas for improvement.

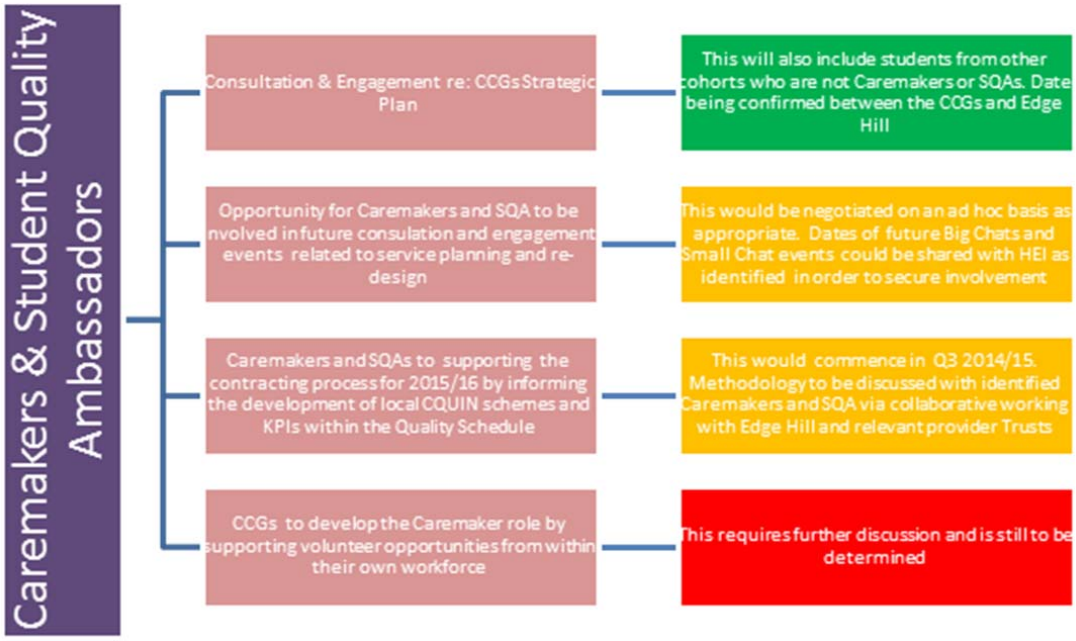
    - The CCG expects commissioned services response to all newly released national reports and inspections carried out by CQC or any other inspectorate bodies to be presented for discussion by the commissioned services' at CQPG meetings.

    - Research – The CCG have a research strategy in place in line with *The Health and Social Care Act 2012.* The CCG are working towards the promotion and enablement of research and evaluation to improve health outcomes. This will be in line with active participation and collaboration with HEIs, Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and North West Coast Academic Health Science Network (AHSN).

    - The CCG has initiated a contact with Edge Hill University and the NHS England NW lead for Care makers and SQAs to explore how both of the above programmes could be introduced within a commissioning setting in order to improve quality of care. Both the HEI and the NW lead confirmed that this hadn't been done before and wished to support the CCGs in being the first 2

known commissioning organisations in the country to develop this initiative further by taking the idea out of the provider and education environment into that of commissioning. The CCG is an accredited hub and spoke placement for students.

Diagram 1 – Illustration of the Care maker / SQA Proposal for within the CCGs



Quality Assurance Framework

As the CCG seeks to do the best for the population it commissions services on behalf of, it recognises that there needs to be an effective framework for how quality assurance will be obtained.
An Early Warning Dashboard highlights the current position for hospital providers of interest to the CCG against a number of quality measures within the following domains:

- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Organisational Quality Measures

The CCG has developed a quality assurance framework adopted from Sir Bruce Keogh's four stage methodology. The CCG believes this methodology is transparent, comprehensive and systematic. The four stages are as follows:

- **Stage 1** Quality Data Analysis
- **Stage 2** Triangulation
- **Stage 3** Multi-disciplinary Reviews
- **Stage 4** Support Improvement

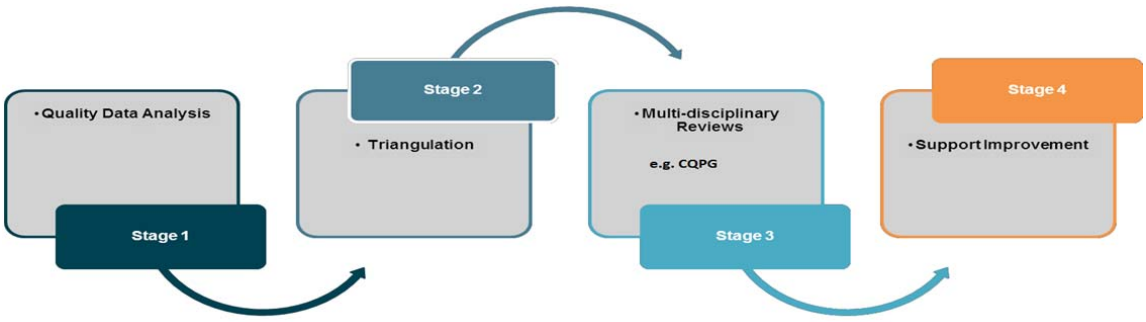
The framework offers the CCG a systematic way of:

- Obtaining quality assurance of commissioned services quality;
- Monitoring quality performance against agreed standards and outcomes and;
- Carrying out quality surveillance of safety, effectiveness, leadership and culture, responsiveness and patient experience intelligence to build a profile of a commissioned service.

Each stage is an important component, equipping the CCG with a range of methods, tools and intelligence when combined together can help commissioners determine the quality of services commissioned.

No quality assurance framework offers a definitive conclusion about the quality of care provided by commissioned services but it allows for questions to be raised, exploratory review to be undertaken and for improvement to be supported.

The CCG's quality assurance framework is designed to encourage clear and effective communication, avoid duplication through collaborative working and focusing on what adds value. Transparency is key to these stages and based on support and improvement rather than blame.



Stage 1: Quality Data Analysis

Quality cannot be improved until there is clear understanding of how to identify and measure if care is of a high standard in the first place. The CCG is aware that poor standards of care do not necessarily show up on quality outcome indicators and across the CCG and externally, there is a wealth of intelligence, gathered formally and informally, about the CCG's commissioned services.

The CCG has gathered, identified and conducted detailed analysis of a vast array of meaningful hard and soft quality intelligence. This includes but not limited to standards from national standard contracts, CQC essential standards, etc.

This quality intelligence in isolation will not draw definitive conclusions or judge the quality of care and is only as good as what you do with it. Instead, the CCG uses them as an 'early warning system' which will start to sound if commissioned services are outside the expected range of standards.

It allows for key lines of enquiry to be analysed and turned into knowledge which can then be triangulated with other information (stage 2). It paves the way for penetrating questions to be

asked during relevant multi-disciplinary reviews (stage 3). The intelligence is then used to judge a commissioned service's performance, determine effectiveness and drive quality improvement (stage 4) in a consistent way.

Hard and soft intelligence required are identified within the quality schedule that is agreed with each commissioned services through the contracting process. Nationally, the NHS Standard Contract and national drivers provides the CCG with a mechanism for setting consistent quality requirements.

Stage 2: Triangulation:

Quality cannot be seen in isolation but as a part of a broader concern about cost, performance and contracting. Stage 2 allows for continuous monitoring, linking the data gathered (stage 1) from our commissioned services against standards sets in the contracts/national standards, identifying where data link with each other to enable us to dive deeper to identify potential areas for improvement to be delivered.

Often the information that one directorate alone has, will not cause concern, however, when systematically combined and triangulated, with intelligence that another part the CCG system and/or external source may have, might point to a potential problem that should be investigated further.

For e.g., the quality committee would analyse and discuss quality alert concerns around discharge. Combined and triangulated with the discharge information held by the Experience and Patient Engagement Group (EPEG) via patient feedback and the Strategy & Outcomes directorate via performance meeting can identify improvement areas and they can be presented to providers.

For stage 2 to work, all the different directorates within the CCG and external colleagues NHS Trust Development Authority (NTDA), NHSE, Healthwatch Sefton, CQC Inspections, routinely and methodically together to align and share intelligence to identify good practice and any potential or actual quality failure without undermining or overriding individual accountabilities.

Reports produced by external colleagues regarding commissioned services quality will be presented by the commissioned services during the CQPG (stage 3). Intelligence obtained from these reports would be used to triangulate with intelligence held within the CCG.

Any intelligence triangulated with other sources of information ensures that any challenge provides a strong evidence base. The triangulated data is then discussed at multi-disciplinary reviews (stage 3) coordinated through various routes with commissioned services.

Stage 3: Multi-disciplinary Review

There are different types of multi-disciplinary reviews used by the CCG to work with commissioned services to ensure quality is maintained and continuously improved. These set out a model for proactively working, sharing and discussing available intelligence in detail on quality of commissioned services.

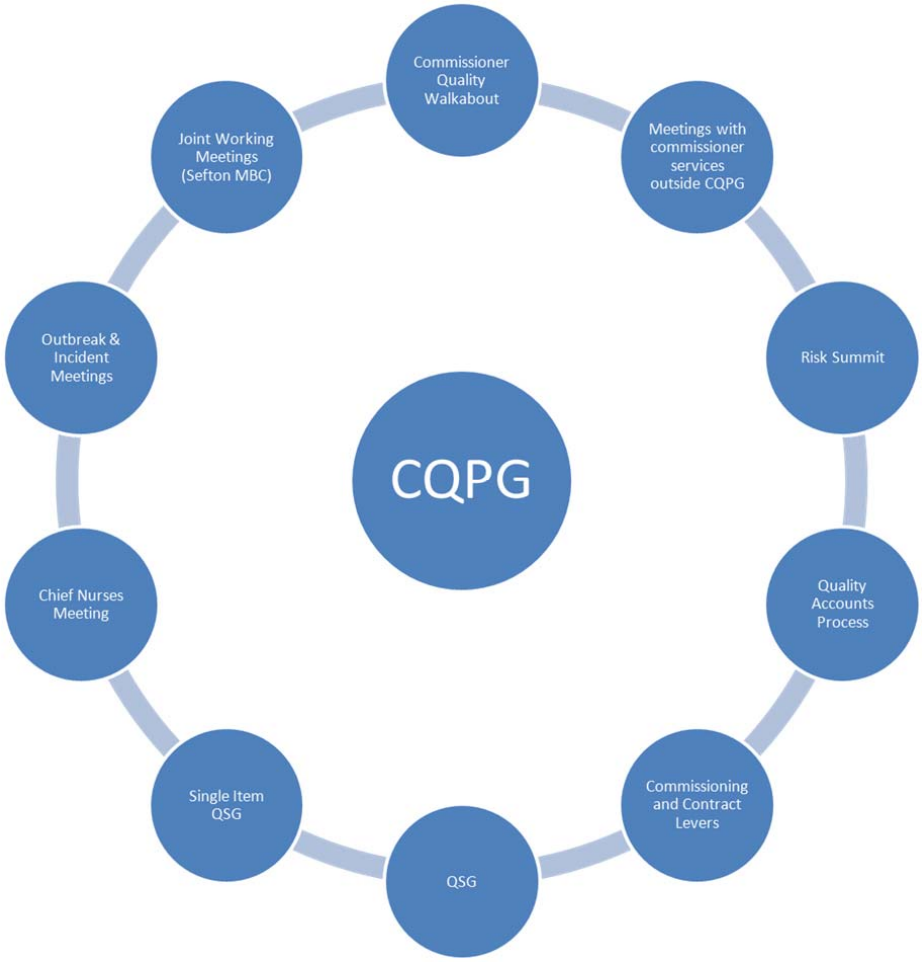
Quality outcomes obtained from data analysis (stage 1) and triangulated information (stage 2) will be discussed and scrutinised through the multi-disciplinary review meetings such as:

Clinical Quality Performance Group Meetings (CQPG):

These are formal dedicated meetings held regularly with all commissioned services where the CCG is the lead commissioner to monitor and discuss all aspects of quality of care provided and the quality element of the contract. In commissioned services where the CCG is

not co-ordinating commissioner but an associate commissioner, the CCG works closely with other commissioners to receive assurance.

CQPG meetings are part of the national contracts and contract monitoring process for all the major commissioned services. These meetings are critical and form part of the CCG's detailed oversight and scrutiny process and are also used to celebrate improvements and discuss new quality developments. The commissioned services engagement diagram below demonstrates how all engagement activities lead back to the commissioned services' CQPG.



CQPG meetings in place depend on the complexity of the contract and with smaller contracts, where a CQPG meeting is not viable; quality is incorporated into the overall contracting arrangements led by a Contract Manager who will work closely with the quality team when issues are identified and will ensure the CCG are informed of issues and risks. For some of the larger independent sector contracts, CSU quality team input into the regular contract meetings which incorporate quality oversight.

CQPG meetings are chaired by clinicians; coordinating a programmed annual plan of review which enables the commissioned services to prepare the information required and, as much as possible, ensure this fits with existing reporting cycles for the CCG Board and other committees to minimise duplication of work unnecessarily. Any quality challenges and/or proposals that arise from CQPG meetings will be presented to CCG Quality Committee (QC) for an agreed approach. Where performance issues arise, plans are put in place to achieve compliance and unresolved issues are escalated to QC and the CCG Governing Body as appropriate. Key issues of the CQPG are brought to the attention of the QC. All commissioned services submit a quality dashboard with supporting quality report against agreed quality outcomes indicators identified.

Commissioner Quality Walkabout:
These are quarterly informal dialogue assurance visits jointly coordinated by the provider and the CCG's Quality Team around observation of patient pathways and care environment and hearing from front line staff and patients. These walkabouts are used as interactive, engaged and visible indicator of CCG's commitment to quality that has been identified as a key element of a good safety culture and form part of the CCG's broader improvement programme.

They are useful, practical and a visual method of triangulating the evidence and allow for the opportunity of observation outside of executive reports statistics and levels of assurance, to see if quality outcomes on the front line are being realised by both practitioners and patients. The intelligence obtained from the visit is fed back to the commissioned service, CQPG and CCG's QC. Any identified follow up actions will be monitored through the CQPG.

The CCG will from time to time conduct ad-hoc Quality Walkabouts if it is felt that there are specific concerns with a provider in general or with a certain service, department or ward. This demonstrates a proactive approach to Quality Walkabouts as well as a reactive one outlined above.

Quality Account Process:
Quality accounts demonstrate commissioned services' commitment to achieve and improve outcomes for all of Sefton patients. All commissioned NHS services are required to provide an annual quality account for the public to read about the quality of their services. The CCG's process for reviewing and commenting on all commissioned services' quality account: the commissioned service representative will present their draft quality account at joint CCG specific meetings. The CCG's collated triangulated summary of the quality account would be fed back to the commissioned service, and submitted to the Chief Nurse or Director of Quality of the commissioned service by the Chief Nurse of the CCG.

Commissioning and Contracting Levers:
Contract monitoring is akin to quality assurance by holding commissioned services to account for delivery of contractual obligations and quality standards. The CCG is committed to using its commissioning levers through multi-disciplinary review (stage 3) to drive up quality of care for the residents of Sefton who use local health services. In order to realise the full potential of the quality strategy, the CCG ensures that quality is embedded throughout the commissioning and contracting cycle. Improved commissioning specifications for commissioned services add clarity to quality outcomes.

Quality specifications, quality review arrangements, other contractual levers, penalties and incentives such as CQUIN payment scheme are all being used to different degrees across the range of commissioned services. The CCG's commissioning, contracting, performance and quality teams work closely together through regular monitoring and review of quality reports and ensuring that the Planning Guidance is consistent with specifying the CCG's quality requirement over and above the 'essential standards of quality and safety' set by the CQC. Including that the contract is best used to support improvement in quality. Monthly contract monitoring meetings are part of the contract management process with most of the CCG's commissioned services.

Outbreak and Incidents Meetings:
These are commissioned services' meetings with the involvement and support of the CCG and NWCSU (e.g. infectious outbreak and incidents). These meetings are determined by the commissioned service.

NHS Merseyside Quality Surveillance Group (QSG):
Is a bi-monthly meeting of all commissioners, NHSE Merseyside and regulators to review and share intelligence on commissioned services. This also includes suggestions of actions to be taken where required. QSG should function as follows:

- Patient focused – members are grounded in the fact that their purpose is to maintain good quality services for patients
- High trust – an environment which facilitates open and honest conversations about quality
- Inclusive – all members feel able to contribute to discussions
- Challenge – Members feel able to offer constructive challenge to colleagues to get to the bottom of the issues and identify suitable actions
- Action orientated – all members come away from meetings with clarity as to the actions agreed and who is taking them forward
- Well informed – QSGs receive reports and data-packs which present information in a useful and distilled format to members which enable them to identify the potential quality risks
- Comprehensive – QSGs have a planned and defined business cycle which enables them to consider potential risks in all providers within their geography, across all sectors QSGs operate at two levels: locally, on the footprint of NHS England's 27 area teams.

Single Item Quality Surveillance Group (SIQSG):
Provides forum to discuss an individual provider where issues, concerns have been raised by a number of performance measure but does not constitute a risk summit. The area team will facilitate a SI QSG. An outcome of a QSG may be to present an action plan to provider, convene a SI QSG with provider present or convene a risk summit on the provider if agreed as appropriate

SIQSG with Provider Present:
Provides a forum to discuss issues and concerns which have been raised by a number of performance measures, with the provider which the issues and concerns relate to. The area team will facilitate a SI QSG. A provider may be asked to present at the meeting, an action plan which addresses the concerns and issues highlighted and assure the group that they are mitigating the risks.

An outcome of the SI QSG may be to convene a risk summit on the provider if agreed as appropriate.

Risk Summit:
Provider concerns may escalate to the establishment of the risk summit process involving the CQC. This is led and/or undertaken by NHSE North. A risk summit will be called so that the issue can be focussed on in detail and a plan of action developed.

Joint Working Meetings:
The CCG is keen to learn from others and engage in collaborative partnership working arrangements and networking opportunities across other CCGs, Healthwatch Sefton, Local Authority, NHSE, CQC, NTDA, other partners, etc. This allows for streamlining arrangement, understanding the needs for different services benchmarking and a more consistent approach to raising standards and maximising contributions to commissioning.

The Francis Report (February 2013) emphasises that commissioners should have a primary responsibility for ensuring quality as well as providers, and systemic learning is a critical

function of the CCG's commitment to the safety of patients for whom it commissions services. Promoting patient safety by reducing errors is also a key priority for the NHS. When errors do occur, the CCG supports the view that the response should not be one of blame and retribution, but of organisational learning with the aim of encouraging participation in the overall process and supporting staff, rather than exposing them to recrimination.

Chief Nurses Meeting:
Focuses on compassion in practice (2012), which sets out the requirement for all organisations to promote the 6Cs; care, compassion, competence, communication, courage and commitment. The CCG nursing workforce will support the monitoring of measures to improve nursing care, standards, workforce development and promote the implementation of the 6Cs within commissioned services.

Stage 4: Support Improvement:

The CCG has identified the improvements it wishes to secure in the quality of services commissioned and using the commissioning process to drive continuous quality improvement. Continuous quality improvement requires health services to search for and apply innovative approaches to delivering healthcare, consistently and comprehensively across the system.

The CCG has structured payments and incentives to encourage commissioned services to continuous quality improvement to meet future challenges, using these payment mechanisms to contract for the delivery of high quality care and to manage those contracts. CQUINS is used to incentivise commissioned services to deliver high quality care, drawing on NICE Quality Standards and are monitored with commissioned services through CQPGs.

The CCG has identified a number of specific areas requiring managerial and clinical expertise to bring about both transactional and transformational change in how health services are delivered for the population of Sefton. GP clinical leads work in partnership with the CCG managerial locality leads to bring about these changes.

The CCG has appointed Clinical Directors / GP Clinical leads for Quality; The Clinical Director for Quality, in addition to their duties as a GP Governing Body member, will:

- work closely with the lead manager(s) within the Quality Team and the GP Clinical Lead for Quality to drive forward and deliver on key aspects of an agreed work programme for their area, in the context of the 2 and 5 year strategy

- agree a set of related personal objectives through the Personal Development Review (PDR) process

- regularly report on progress to the Governing Body and other groups as appropriate

It is also important that that the Clinical Director for Quality is able to remain in tune with member practices, truly engage with patients and communities, and actively reflect the Nolan Principles of Public Life in their leadership role, as they work with others to commission high quality services and improve health and wellbeing.

Safeguarding vulnerable adults and children

The CCG ensures that its providers have arrangements in place to safeguard and promote the welfare of adults and children in line with national policy, guidance and locally identified areas of concern. Providers identify safeguarding issues relevant to their area and we challenge providers to demonstrate that policies and procedures are in place and implemented. We review staff training to ensure staff are appropriately trained, supervised and supported and

know how to report safeguarding concerns. The CCG requires providers to inform them of all incidents involving children and adults including death or harm whilst in the care of a provider. Full information can be found in our Safeguarding Strategy. The CCG works closely with our partners to participate in Serious Case Reviews and Domestic Homicide Reviews and ensure findings are included in our triangulation of data. Through partnership working with other agencies, the CCG, as a member of the Sefton Local Safeguarding Children Board (Sefton LSCB) and Sefton Safeguarding Adult Board (Sefton SAB). (LSCB/SAB) will be engaged in debate and discussion in order to improve the quality of practice and subsequent outcomes for children, young people and adults at risk in Sefton.

Equality & Diversity

The CCG understands that in order to meet the needs of a diverse community and improve access and outcomes for patients who experience barriers and disadvantage, it must be cognisant of its Public Sector Equality Duty (Section 149 Equality Act 2010).

The E&D agenda supports the quality strategy through:

- triangulation : evidence of barriers and discrimination will be highlighted to the Quality Committee via EPEG
- Commissioning and contract levers: providers are monitored on a number of E&D quality indicators
- Equality Delivery Systems 2 findings and recommendations will be highlighted within the quality committee structure
- Equality assessment findings and recommendations will be highlighted within the quality committee structure

Patient and Public Involvement

Sefton has a diverse population and the CCG must engage with a range of people from all backgrounds, ethnicities, ages, genders and geographical locations. The CCG is committed to working with the people and communities of Sefton in an open and transparent way and has been creative in its approach to embed PPI into its work. The establishment and successful working of the multi-stakeholder Experience and Patient Engagement Group (EPEG), provides a forum and task group for this work to develop and flourish.

Patient's experience and involvement means more than simply engaging people in discussions about commissioned services. Involvement means listening to the patient voice and ensuring that the experience of individual patients and communities are heard at every level.

The CCG has designed a structure to embed listening to the patients' experience and PPI in all groups and processes that influence commissioning priorities. This structure acknowledges that there are many different ways that people can make their views heard.

The CCG Communications and Engagement Strategy gives more details of our approach to Public and Patient Involvement

Event of Serious Quality Failure

No system can be 100% failsafe and where a problem or failure does occur there needs to be CCG-wide response and approach with three key objectives:

- Safeguarding patients;
- Ensuring continued provision of services to the population; and
- Securing rapid improvements to the quality of care at the failing commissioned service.

Such problems may relate to a specific service or be indicative of even more serious and systemic problems within a commissioned service. The CCG will reactively respond to such concerns which might arise as a result of whistleblowing, routine sharing of intelligence or new intelligence coming to light separately by working with the commissioned service where concerns have been raised to address any quality problems as far as possible. Initial concerns will be addressed by the Senior Management Team (SMT)/ Senior Leadership Team (SLT);

A failure by any of the CCG's commissioned services to meet any quality requirements in their contract, over and above the 'essential standards of quality and safety', amounts to a contractual failure rather than a quality failure, i.e. it will not attract regulatory enforcement action;

Although, given that the requirement to meet the 'essential standards' set by CQC is built into the NHS Standard Contract, a failure to meet these also amounts to a contractual failure. In the case of care homes this will attract regulatory enforcement action in collaboration with Sefton Local Authority. High risk concerns with the potential of attracting media attention will be notified to the CCG SMT/SLT as and when necessary with support from communications management at NWCSU;

Once a judgment has been taken by the CCG SMT that there has been a breach, or that there is the potential to be or actual serious quality failure has come to light. The CCG's system, jointly with external colleagues relevant to the commissioned service will proactively and reactively work. This would enable and facilitate rapid, collective and informed judgments about quality and to ensure an aligned response between those with performance management, commissioning and regulatory activities to maintain quality without undermining or overriding individual accountabilities;

The CCG SMT identified lead will determine what action needs to be taken forward. The package of actions should include:

- Carrying out a rapid impact assessment of any potential regulatory action to be considered with the CQC, Local Authority and NHSE;
- Actions to be taken forward within defined timeframes: includes action to safeguard patients and improve quality of care, ensure continued service provision, securing improvements;
- How the action will be coordinated: who is the lead commissioner coordinating the process during collective discussions;
- Meeting at regular and appropriate intervals until action has been taken.

Serious Incidents:

Serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent

harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm);

- A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, IT failure or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- Allegations of abuse;
- Adverse media coverage or public concern about the organisation or the wider NHS;
- One of the core set of never events.

Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.

The CCG has in place a Serious Incident Policy which sets out it is accountable for effective governance and learning following all Serious Incidents (SIs) relating to its commissioned services and is committed to working closely with all provider organisations and commissioning staff members to ensure SIs and Never Events are reported, investigated and acted upon by provider organisations with whom the CCG commissions/contract services

Supporting Quality Improvement in General Practices

From the 1st April 2013, Clinical Commissioning Groups (CCGs) have had a statutory duty regarding the continuous improvement of primary care. Following collaboration with a variety of stakeholders, a three year strategy focusing on quality areas for improvement based on safety, clinical effectiveness, and patient experience has been developed, and implemented. Recognising the current challenges of an increasing elderly population, rising numbers of patients with multiple long term conditions, and fragmentation of services, the strategy focuses on 5 key areas:

- Practice Demographics
- Workforce Development
- Clinical Services
- Estates / IT
- Health Outcomes

Providing an excellent service is key to the CCG's values, therefore as a member organisation securing continuous improvement in the quality of general practices would allow members to set the highest example to colleagues in the NHS.

The CCG takes its responsibility for supporting quality improvement outcomes and a positive patient experience in general practice very seriously. Supporting improvement within general practice will contribute to making the care received by the population much more sustainable.

The CCG recognises that it is important to support general practice to gain the right skills, capacity and capability to deliver high quality services and this can be done by working with the four CCG Localities to agree quality improvement plans.

A three year Local Quality Contract (LQC) has been implemented from August 1st 2014 to include services that go beyond those that practices are expected to provide under the GP contract. These services have been developed to fulfil the NHS Outcome Framework domains objectives, support the CCGs strategic priorities, and in response to patient needs. A key element of the LQC is additional access provided at GP surgeries across the CCG from October 2015. Outcomes will be measured, and an annual review of each area undertaken.

- List of schemes below

South Sefton	Southport and Formby
Primary Care Access	Primary Care Access
Review of A+E Attendances	Review of A+E Attendances
Exception Coding	Exception Coding
Community Health	Community Health
Phlebotomy	Phlebotomy
Shared Care	Shared Care
Drug Administration	Drug Administration
Data Validation	Data Validation
Ankle Brachial Pressure Index	Travellers / Gypsy Scheme
Practice Improvement Goals	Practice Improvement Goals

- CCG's Primary Care and Quality Team, supported by the Locality Managers, GP Education and Practice Development Leads are the identified leads for improving the quality of general practice.

- There are four Locality Management Team and Locality Clinical Leads with specific responsibilities around identifying needs, monitoring progress and providing the support needed to ensure continuous quality improvement in their locality for all general practices in their area.

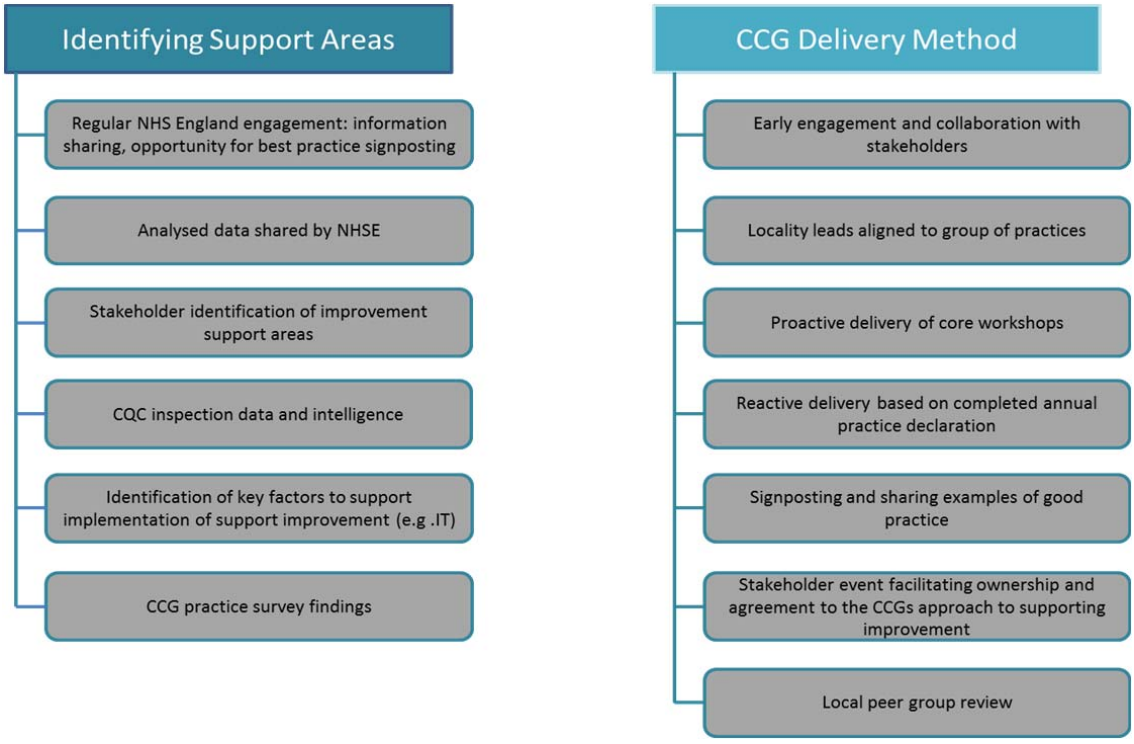
- The Locality Clinical Lead is an elected GP from the locality who also sits on the Locality Members Forum and is entitled to attend the CCG Board.

- Every GP Practice is represented on the Locality members' forums and at Locality Management Teams. There are also separate Practice Nurse Forums and Practice Managers Forums. The locality clinical leads with the locality management teams may review quality information from various sources.

- Joint working between Primary Care and Quality Team, will enable the effective delivery of the general practice support framework.

    - **The CCG is not responsible for the following:**
        - Performance and contract management of practices. This is the responsibility of the NHSE's Merseyside Area Team;
        - Identifying improvement intervention needed;
        - General practice estates management;
        - Training and development within the core contract;
        - Practice accreditation, revalidation and performer's list.

- The CCG's coordinated approach to supporting quality improvement within general practice will be through two elements as outlined below:



- The CCG will work with its member practices to highlight the areas where the CCG can best support and facilitate improvement and to initially seek to do this via protected learning time (PLT) wider group meetings.

- The CCG will be able to offer advice and guidance to individual practices in matters concerning quality.

Future Developments

- The Practice Nurse Facilitators support nurses in general practice deliver high quality care and have a key role in the development of PLT. The Quality Team will further develop links with local HEI partners, NHSE, providers, Health Education England to support the development of the workforce of the future to deliver on the desired outcomes as identified within the strategic plan and beyond. The CCG is committed to developing the commissioning workforce of the future and is working in partnership to become an accredited hub and spoke site for student placements.

- This quality strategy will help the CCG in embedding quality into its "business as usual" by making quality the focus of every aspect of service.

- The CCG will continue to learn new and sophisticated ways of ensuring quality assurance from a commissioning perspective and from best practice.

- Or the quality strategy to be effective and successfully implemented further development needs to take place and is very much dependent on the CCG's ethos, values and actions of people matrix working across the CCG's system and at every level.

- This Quality Strategy is a live document and will be reviewed annually in line with the CCG strategy and monitored through the CCG Quality Committee to ensure momentum is maintained as it describes CCG's system.

- This quality strategy, the associated quality outcomes indicators agreed in commissioned services contract, CQC essential quality and safety standards etc. and the analysis findings against the quality strategy demonstrated within the diagram below underpins the development of the quality work plan highlighting our agreed priorities for development over the next 12 months.

- The CCG will continue to work with the LA to develop joint Quality Standards

- The CCG is committed to *Sign up to Safety*, a new national patient safety campaign that was announced in March 2014 by the Secretary of State for Health. It launched with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The CCG will commit its Safety Pledges in Q1 of 2015/16 detailing how it is:

  - Putting safety first. Commit to reduce avoidable harm in the NHS by half an make public our locally developed goals and plans

  - Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are

  - Being honest. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong

  - Collaborating. Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use

  - Being supportive. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/51	**Author of the Paper:**
Report Date: March 2015	South Sefton CCG Safeguarding Team Email: des.nurses@nhs.net Tel: 0151 495 5649

Title: CCG Safeguarding Strategy

Summary/Key Issues:

The purpose of this paper is to present NHS South Sefton CCG's Safeguarding Strategy (2015-17) to the Governing Body for approval.

Recommendation

The Governing Body is asked to approve the CCG Safeguarding Strategy.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
	Sustain reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Virtual Ward plan.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees	X			Presented to the Quality Committee in February 2015 – approval recommended by the Governing Body

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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
March 2015

1. Executive Summary

This safeguarding strategy sets out priorities for the forthcoming years 2015- 2017 and is the start of the journey to plan and commission locally delivered services that drive up quality and ensure our population receives effective, safe and personalised care.

2. Introduction and Background

2.1 The need to develop a Safeguarding Strategy was a recommendation from the CCG Safeguarding Peer Review commissioned by South Sefton, Southport & Formby and Liverpool CCGs.

2.2 The Strategy has been developed as a Merseyside wide document and reference is made within the document to the delivery of local priorities and partnership working via the Local Safeguarding Children Board and Local Safeguarding Adult Board.

2.3 The vision for NHS South Sefton CCG is to maintain safe and effective safeguarding services and to strengthen arrangements for safeguarding adults and children across Sefton, working collaboratively with partner agencies. To do this the human rights, independence and well-being and secure assurance that the child or adult thought to be at risk, stays safe.

3. Conclusions

The strategy will be delivered through development and implementation of a work-plan and working alongside existing partnerships for both children and adult safeguarding. This will be monitored and reviewed through the CCG Quality Committee.

4. Recommendations

The Governing Body is asked to approve the Safeguarding Strategy.

Appendices

Appendix 1- NHS South Sefton CCG Safeguarding Strategy (2015-17)

CCG Safeguarding Team
March 2015

NHS South Sefton Clinical Commissioning Group

SAFEGUARDING STRATEGY

2015 - 2017

Safeguarding service/ January 2015

NHS South Sefton Commissioning Group Safeguarding Strategy

1. Introduction

This safeguarding strategy sets out our priorities for the forthcoming years 2015- 2017 and is the start of the journey to plan and commission locally delivered services that drive up quality and ensure our population receives effective, safe and personalised care. We will work in partnership to safeguard children and adults, enhancing health and well-being and protecting the rights of those in the most vulnerable situations. Patients and the quality of their care, is the focus of everything we do. We must ensure that we commission services based on the quality of care they deliver and ensure that individuals are empowered to choose services on the basis of quality and outcomes. This involves providing clear information to the public about the quality of services which are commissioned on their behalf, including information about poor quality, unexplained variation and differential health outcomes.
In addition to promoting on-going quality improvement, as commissioners, we need to be assured that existing services meet acceptable standards. Whilst regulators play a key role here, commissioners must still actively monitor the quality of services delivered by our providers. Where we are not assured about the quality of any of the services we commission, detect early warnings of a potential decline in quality or suspect a breach of unacceptable standards we have a responsibility to intervene.

1.1. NHS South Sefton Clinical Commissioning Group (CCG) holds the value that living a life that is free from harm and abuse is a fundamental right of every person. It acknowledges its statutory responsibility to promote the welfare of children and young people and to protect adults from abuse and risk of harm.

1.2. NHS South Sefton CCG will work with the Safeguarding Boards, statutory agencies and its provider organisations to ensure the effectiveness of multi-agency arrangements to safeguard and promote the well-being of children, young people and adults at risk from harm or abuse.

1.3. Evidence of continuous improvement and compliance in quality and safety outcomes for commissioned services will be achieved through the use of specific contractual arrangements and metrics with provider organisations. This will include having in place: Key Performance Indicators (KPI), CQUIN targets, quality schedules, systems to embed learning from incidents and complaints, comprehensive single and multiagency safeguarding policies and procedures and a safeguarding training strategy and framework.

1.4. In addition the CCG will support specific Francis recommendations relating to improving safety for vulnerable groups to develop an on-going culture of quality across the health economy economy including assurance in relation to the legal requirements for Duty of Candour.

1.5. Safeguarding priorities are central to ensuring high quality and safe care. This strategy has been developed with reference to NHS England, Outcomes Framework 2014/15, particularly:

- Domain 4: Ensuring people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.

1.6. This safeguarding strategy must be read in conjunction with the CCG Safeguarding Policy, Safeguarding Training Strategy and other relevant policies.

1.7 This strategy has been developed in collaboration with both local safeguarding boards and groups and key stakeholders locally

2. Responsibilities

2.1 Overall accountability for safeguarding within South Sefton CCG rests with the Accountable Officer (AO). The Chief Nurse (CN) is responsible for senior clinical leadership and advocating for vulnerable groups across the CCG health economy.

2.2 The AO and CN are responsible for ensuring that robust constitution and governance arrangements are in place and maintained, and include succession planning, to ensure the delivery of all safeguarding duties and objectives.

2.3 As statutory bodies, CCGs have a responsibility for improvements in the quality of primary medical services and safeguarding services across the local economy.

2.4 NHS England and the CCG will work closely with the local authorities, Local safeguarding Children & Adult Boards to ensure there are effective NHS safeguarding arrangements across the health communities, whilst at the same time, ensuring absolute clarity about the underlining statutory responsibilities that each commissioner has for the services that they commission, together with a clear leadership role for NHS England.

3. Background

3.1. The publication of the Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework (March 2013), stated that

the CCGs have the statutory responsibility for ensuring that the organisations from which they commission services, will provide a safe system that safeguards children and adults at risk of harm. The Mandate from the Government to the NHS Commissioning Board (NHS CB) for April 2013 to March 2015 (published in November 2012) says:

"We expect to see the NHS, working together with schools and children's social services, supporting and safeguarding vulnerable, looked-after and adopted children, through a more joined-up approach to addressing their needs."

*The above quote was prior to NHS CB becoming NHS England, and as such reflects the terminology of the time.

The Mandate also sets the Governing Body a specific objective of continuing to improve safeguarding practice in the NHS, reflecting also the commitment to prevent and reduce the risk of abuse and neglect of adults.

3.2. For children and young people, the key legislation includes the Children Act (1989) and the Children Act (2004). Section 10 of the 2004 Act creates a statutory framework for local co-operation between local authorities, partner agencies and other bodies including the voluntary and community sector in order to improve the wellbeing of children in a local area.

3.3 Statutory guidance such as 'Making arrangements to promote the welfare children under section 11 of the Children Act 2004' (2007) reinforces and describes the duties of health services. Working Together to Safeguard Children (2013) recognises the changing commissioning arrangements within the health service and lays out the role of the CCGs.

3.4 The Care Act (2014), of which Part 1 is due to be enacted in April 2015, introduces statutory arrangements in relation to adults at risk of harm and replaces the No Secrets (2000) guidance that previously provided the framework for adult safeguarding. The Care and Support statutory published by the Department of Health in October 2014 supports the implementation of part 1 of the Care Act.

3.5 NHS South Sefton CCG is a core member of the Sefton Safeguarding Adults Board which is leading on the implementation of the Care Act on a multi-agency basis and the CCG is undertaking preparatory work in readiness for April 2015. Further key related legislation and guidance that supports safeguarding includes: Clinical Governance and Adult Safeguarding: An Integrated Process (DH, 2010) the Human Rights Act (1998) Mental Capacity Act (2005), Deprivation of Liberty Safeguards (2007) and the Domestic Violence Crime and Victims Act (2004) PREVENT (2012). This strategy recognises that this is not an exhaustive list.

3.6 Although the safeguarding frameworks for adults and children are managed separately, nationally they do often link/crossover or can run concurrently, for example in domestic abuse concerns, the Multi-Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conferences (MARAC).

3.7 The lead agency for safeguarding children and adults is the local authority whilst the National Probation Service leads on MAPPA, the Police lead on MARAC and the Community Safety Partnerships lead on domestic abuse and Domestic Homicide Reviews. Health commissioners and providers are expected to contribute to all safeguarding processes and have lead persons identified to support MAPPA and MARAC and have policies in place to respond to domestic abuse.

4. Strategy

4.1. Vision & Aim

4.1.1 The vision across NHS South Sefton CCG is to maintain safe and effective safeguarding services and to strengthen arrangements for safeguarding adults and children across South Sefton, working collaboratively with partner agencies.

4.1.2 The CCG will need to commission services that promote and protect individual human rights, independence and well-being and secure assurance that the child or adult thought to be at risk, stays safe. They will also need to ensure that children and vulnerable adults are effectively safeguarded against abuse, neglect, discrimination, embarrassment or poor treatment, are treated with dignity and respect, and enjoy a high quality of life.

4.1.3 We know we will have achieved our vision when:
People who live and work in South Sefton know what signs and indicators of abuse to look out for and who to contact for advice and support.

- Local health organisations respond in a timely and effective way to concerns about abuse.
- Children and adults at risk have access to the support and services that they need from health agencies.
- Children and adults at risk have their voices heard within safeguarding procedures and services. We maximise their rights to choice and control, within the confines of their mental capacity and competence.

- Children and adults are protected when necessary and have improved quality of life as a result.

4.1.4 The CCG recognises that safeguarding children and adults is a shared responsibility and will ensure appropriate arrangements are in place to co-operate with the local authority in the operation of the safeguarding boards.

4.2. Strategic objectives

The key strategic objectives are to:

4.2.1. Provide senior and board-level leadership

- Senior leadership responsibility and lines of accountability for the CCG safeguarding arrangements are clearly outlined to employees and members of the CCG as well as to external partners
- Contribute to the work of the LSCB and LSAB and their Safeguarding Strategic Plan and provide support to ensure that the boards meet their statutory responsibilities. This would include engagement with specific work streams such as Child Sexual Exploitation (CSE), the PREVENT Agenda, and implementation of the Care Act 2014 agenda which are key priority areas for Local safeguarding boards and CCGs including preparation for inspections across health and local authority .
- Support designated individuals to contribute to the work of the LSCB and LSAB subgroups and other national and local safeguarding implementation networks.

4.2.2. Ensure safeguarding arrangements are in place

- Integrate safeguarding within other CCG functions, such as quality and safety, patient experience, healthcare acquired infections, management of serious incidents
- Secure the expertise of designated professionals. This includes the expertise of a designated doctor for children and for looked after children and a designated paediatrician for unexpected deaths in childhood.
- Safeguarding professionals have appropriate amount of time and support to complete both individual management reviews and health overview reports
- All relevant actions identified through Serious Case Reviews (SCRs), Domestic Homicide Reviews (DHRs), Management Reviews etc. are carried out according to the timescales set out

by the LSCB, LSAB and the Community Safety Partnerships (for Domestic Homicide Reviews) Panels scoping and Terms of Reference.

- There is a safeguarding adult lead and a lead for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007.
- Ensuring key priorities such as Child Sexual Exploitation, PREVENT and Female Genital Mutilation are delivered effectively locally.
- Staff including Governing Bodies are trained to embed safeguarding within the commissioning process and are able to recognise and report safeguarding concerns.
- The CCG, through its designated professionals, will actively work to raise awareness of, and ensure robust arrangements are developed and in place, to address the risk and harm associated with both national and local issues.
- The CCG publicise on its website contact details for staff with specific safeguarding responsibilities, disseminate key learning and themes from local and national inquiries and provide links to signpost CCG staff and members of the public to organisations and support to safeguard adults and children at risk of or who have suffered significant harm.

4.2.3. Commission safe services:

- Ensure that all safeguarding elements are incorporated in all existing provider contracts and Service Level Agreements
- Service developments take account of the need to safeguard all patients, and are informed where appropriate, by the views of service users and by a Quality Impact Assessment
- Strengthen contractual arrangements for children and adults in 'out of area' provision for LAC and or / residential care for adults with some elements of specialist health need
- Have a clear strategy for Looked after Children (LAC) and the commissioning of appropriate services.
- Processes in place to disseminate, monitor and evaluate outcomes of all Serious Case Reviews and Domestic Homicide Reviews recommendations and actions plan within the CCG and with providers
- Commission services which employ staff in accordance to the safer recruitment guidance.
- That demonstrates compliance with the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards 2007.

- Processes in place to ensure that adult care placements (such as care homes, nursing homes or independent hospitals) are based on knowledge of standards of care and safeguarding concerns by utilising intelligence from monitoring partners, such as Care Quality Commission (CQC).
- Ensure that there are effective arrangements for sharing information with partners for the protection of children and adults.
- Monitoring systems for safeguarding training and developments for all NHS providers are undertaken by the designated professionals.
- Seek assurance that commissioned providers are meeting their statutory safeguarding responsibilities, and in particular that staff are following approved NICE guidance, and considering transition of young people to adult services.

5. Deliver the strategy

5.1 A timescale will be agreed against each strategic objective and a responsible lead identified through a safeguarding work plan. This work will include additional activities as required through any review processes or changes to local and national guidance and requirements.

5.2 The CCG will ensure that its designated clinical experts are integral to decision making within the CCG and have the authority to work across local health economies, to influence and shape the culture and practice within provider services.

5.3 The CCG will, through the designated professionals, work alongside the neighbouring CCGs and Safeguarding Boards to ensure that a proactive approach is maintained both through specific work streams and also in the commissioning of services for children, looked after children and for services for adults at risk of abuse.

5.4 The strategy will be delivered through development and implementation of a work-plan and working alongside existing partnerships for both children and adult safeguarding. This will be monitored and reviewed through the CCG Quality and Performance Committee.

5.5 A timescale will be agreed against each priority, and a responsible lead identified through the safeguarding work-plan. The work plan will develop and emerge over time to include additional activity as required through any review processes or changes to either local or national guidance or requirements.

6. Monitor Assurance

6.1 The delivery of the strategy will be monitored through the Quality Committee and the development of specific action plans to report progress and provide assurance regarding delivery.

6.2. Service specifications and contract quality schedules will include clear service standards and KPIs (key performance indicators) for safeguarding Children & Adults and promoting their welfare, consistent with the LSCB/ LSAB procedures and regular reporting on KPI compliance will be made to the CCG. The KPIs will be agreed with the provider as part of contractual negotiations and will include training level requirements, safer recruitment, supervision of staff, voice of the child, early recognition, Looked after Children, PREVENT and CSE action plans.

6.3 Service specifications and service level agreements will be reviewed annually via completion of the safeguarding audit tool to ensure safeguarding and quality elements of care are monitored effectively and consistently within provider contracts.

6.4 Contract monitoring through regular contract management meetings with providers

6.5 Where appropriate quality assurance visits to commissioned services and independent providers will be undertaken and the collation of quality and patient safety data and 'soft' intelligence will facilitate the identification, monitoring and analysis of safeguarding concerns in relation to vulnerable groups.

6.6 An Annual Report will be provided to CCG Governing Body and the Local Safeguarding Children and Adults Boards.

6.7 In line with national guidance for monitoring Quality and recognition of early warnings of service failure NHS South Sefton CCG will ensure the provision of safeguarding assurance for its providers through the NHS England local Quality Surveillance Group.

6.8 NHS South Sefton CCG will take an active role through the CN and Designated professionals in the local safeguarding assurance process with NHS England.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/52	**Author of the Paper:**
Report date: March 2015	Melanie Wright Lead for Intermediate Care Email: Melanie.wright@southseftonccg.nhs.uk Tel: 01704 38 7028

Title: Sefton Joint Intermediate Care Strategy

Summary/Key Issues:

This paper presents the Governing Body with Sefton's Joint Intermediate Care Strategy, which has been developed in partnership between both Sefton CCGs and the Local Authority.

Recommendation

The Governing Body is asked to approve the Joint Intermediate Care Strategy.

Receive	
Approve	x
Ratify	

Links to Corporate Objectives	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Sustain reduction in non-elective admissions in 2014/15
x	Implementation of 2014-15 phase of Care Closer to Home
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

Process	Yes	No	N/A	Comments/Detail
Patient and Public Engagement			x	Presentation at "Big Chat", plus "Mini Chats" and other listening activities. Further, more specific engagement events planned as part of wider patient engagement process 2015/16.
Clinical Engagement	x			
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered	x			
Locality Engagement			x	
Presented to other Committees	x			SMT, 10 March 2015.

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

Sefton Council

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Sefton Joint Intermediate Care Strategy

2015-2019

Version 2
Date: March 2015

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Contents

Intermediate Care in Sefton

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

1. Executive Summary

This strategy is the product of collaborative working with a range of professionals in both health and social care organisations during 2014. It is a combination of recommendations, values and beliefs, an understanding of what works well and what offers value for patients and these will shape the future development of an Intermediate Care Model for adults within Sefton.

This strategy sets out work undertaken to date and will lead to the delivery of a new model of service delivery, designed to rebalance hospital and community care, provide rapid response, rehabilitation, avoid unnecessary admission to hospital and accelerate discharge from hospital, while ensuring that no long-term decisions about care and independence are taken in a hospital setting.

Both health and social services are committed to making a real difference to the way services are delivered and the quality of the patient's individual experience of health and social care provision in Sefton.

Fiona Clark
Chief Officer
NHS Southport and Formby CCG
NHS South Sefton CCG

Dwayne Johnson
Director, Older People
Sefton Council

2. Introduction

2.1. *Definition of Intermediate Care*

Intermediate care was defined by the Department of Health (2001)[1] and "Halfway Home" (2009)[2] as a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

Intermediate Care services should:

- be targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care;
- be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;

[1] Intermediate Care Guidance (DH 2001)
[2] Intermediate Care – Halfway Home (DH 2009)

- have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home;

- be time-limited, normally no longer than six weeks and frequently as little as a few days;

- involve cross-professional working, with a single assessment framework, single professional records and shared protocols;

- inclusive of older people with mental health needs, either as a primary or secondary diagnosis.

Intermediate Care services may also:

- form part of the pathway for end of life care, if there are specific goals for the individual or carer that could be addressed in a limited time; or

- link with longer term plans for support.

There is also a national emphasis on delivering care away from a hospital setting, wherever safe to do so, closer to people's homes and centred around the needs of the individual.[3]

In May 2010, the Secretary of State indicated that Health and Social Care economies must be influenced by the following emerging priorities:

- patients must be at the heart of everything, not just as beneficiaries of care, but as participants, in shared decision-making. As patients, there should be no decision about them, without them;

- the focus for Health and Social Care should be to seek to achieve continuously improving outcomes. Not simply measuring inputs or constant changes to structures, but a consistent, rigorous focus on outcomes which achieve results for patients;

- professionals are empowered to deliver. This is the only way we can secure the quality, innovation, productivity and safe care, all of which are essential to achieving those outcomes;

- as a society, focus should concentrate on improving the health and well-being and of preventing ill-health more effectively, of families and communities. This will result more in the overall health outcomes being sought, not just good health services but good population-wide health outcomes, and reduce the inequalities in health, which so blight our society;

- health and social care should be more integrated. Whether provided by their families, by carers, by support workers or by health professionals, all are part of a spectrum of care for those in need. There is a need to reform social care alongside healthcare, so that we can support and empower people – not least as individuals – to be more safe and secure and, themselves, to be able to exercise greater control over their care.

Partnership working is key to successful delivery of intermediate care and work is under way in Sefton to further align services in health and social care.

This strategy was developed by Southport and Formby CCG and South Sefton CCG in partnership with Sefton Council.

[3] Putting People First – Transforming Adult Social Care (DH 2009)

2.2. *Types of Intermediate Care*

Halfway Home states that the services that might contribute to the Intermediate Care function include:

- rapid response teams to prevent avoidable admission to hospital for patients referred from Primary Care, Accident and Emergency or other sources, with short-term care and support in their own home;
- acute care at home from specialist teams, including some treatment such as administration of intravenous antibiotics;
- residential rehabilitation in a setting such as a residential care home or community hospital, for people who do not need 24-hour consultant-led medical care but need a short period of therapy and rehabilitation, ranging from one to about six weeks;
- supported discharge in a patient's own home, with nursing and/or therapeutic support, and home care support and community equipment where necessary, to allow rehabilitation and recovery at home. The arrangements may work well in specialist accommodation such as extra care housing;
- day rehabilitation for a limited period in a day hospital or day centre, possibly in conjunction with other forms of intermediate care support.

Those accessing Intermediate Care services should not be in need of 24-hour access to consultant-led medical care, however, they may have medium to long-term medical conditions that make them liable to relapse.

3. Vision

Both Southport and Formby CCG and South Sefton CCG, together with Sefton Council, envisage appropriate, co-ordinated care for patients via integrated services and responsiveness to patients' needs, while ensuring the best possible use of resources, avoiding fragmentation of services and reducing the complexity of the patient journey.

This duly aligns with the Sefton Health and Wellbeing Board's vision of delivering "personalised coordinated care, health and wellbeing services with, and around, the person" as set out in the Better Care Fund submission, of which Intermediate Care forms a key scheme.

4. Context

4.1. *Strategic Aims and Objectives*

This strategy has been informed by ongoing discussions with patients, carers, local residents and a wide range of stakeholders through the CCGs' "Big Chats", "Mini Chats" and other listening activities and is congruent with the CCGs' strategic priorities of:

4.1.1. Frail Elderly: to support the frail elderly, with long term conditions, to optimise self-care based in the community or home setting, while preventing unnecessary and unplanned admission to hospital;

4.1.2. Unplanned Care: to support patients of all ages to manage their healthcare needs at home or in the community setting, while preventing unnecessary and unplanned admission to hospital;

4.1.3. Primary Care Transformation: to support the healthcare needs of the population through enhanced primary and community care services, supporting self-care and enabling appropriate intervention at home or in the community and preventing unnecessary and unplanned admission to hospital.

Further, as part of the Intermediate Care and Reablement Scheme of the Better Care Fund for Sefton, the main scope of this scheme is to reduce hospital admissions and readmissions, reduce the need for ongoing care and support and to reduce the number of admissions into long term residential and nursing care.

4.2. *Care Closer to Home/Virtual Ward*

This strategy is cognisant of the Care Closer to Home Strategy and Virtual Ward Strategy, particularly in relation to Community Based Step Up and Step Down Facilities.[4]

4.3. *Current and Future Demand*

The Sefton Strategic Needs Assessment[5] identifies the following key facts.

- The population of Sefton in 2010 was 272,900. The latest 2010 based population projections suggest an increase in population year on year rising by 5% to 288,000 in 2035. The biggest percentage increase is estimated to be among residents aged 65 and over, with this age group expected to rise by more than 40% from 59,000 in 2012 to 83,000 by 2035 (from 20% of the population to almost 30% of the population). Every quinary age group above 65 is projected to have a significant increase, in particular those aged 85-89 projected to increase by 84% and those aged 90 and over by 170%.

- Sefton's 65+ population is 56,300 accounting for 21% of the total population and largely accounts for the projected future increases in the total population.

- Sefton already has a sizeable population of older people. As this grows, it will have a large impact on services and their ability to cope.

- Sefton has the highest proportion of residents aged 65+ and 75+ than all local and comparable local authorities.

- An increasingly elderly population are likely to attend A&E and be admitted to hospital as a result of falls - 28% more by 2030.

- By 2030, it is projected that 34% more people aged 65 and over will have dementia. This will impact on their wider health and their care needs.

- By 2015, over 2,300 people are forecast to be living in a care or nursing home – this will rise by over a quarter by 2030.

By way of summary, the Sefton Strategic Needs Assessment identifies Sefton as having a growing elderly population. Older people are more likely to develop complex and long term health conditions, which lead them to require increased health and social care.

Managing such increased demand will necessitate a new approach to service planning, enabling people to maximise their independence and decrease reliance upon acute and social care services.

[4] Care Closer to Home Strategy 2013-2018 (2014 refresh), Southport & Formby and West Lancashire Health Economies

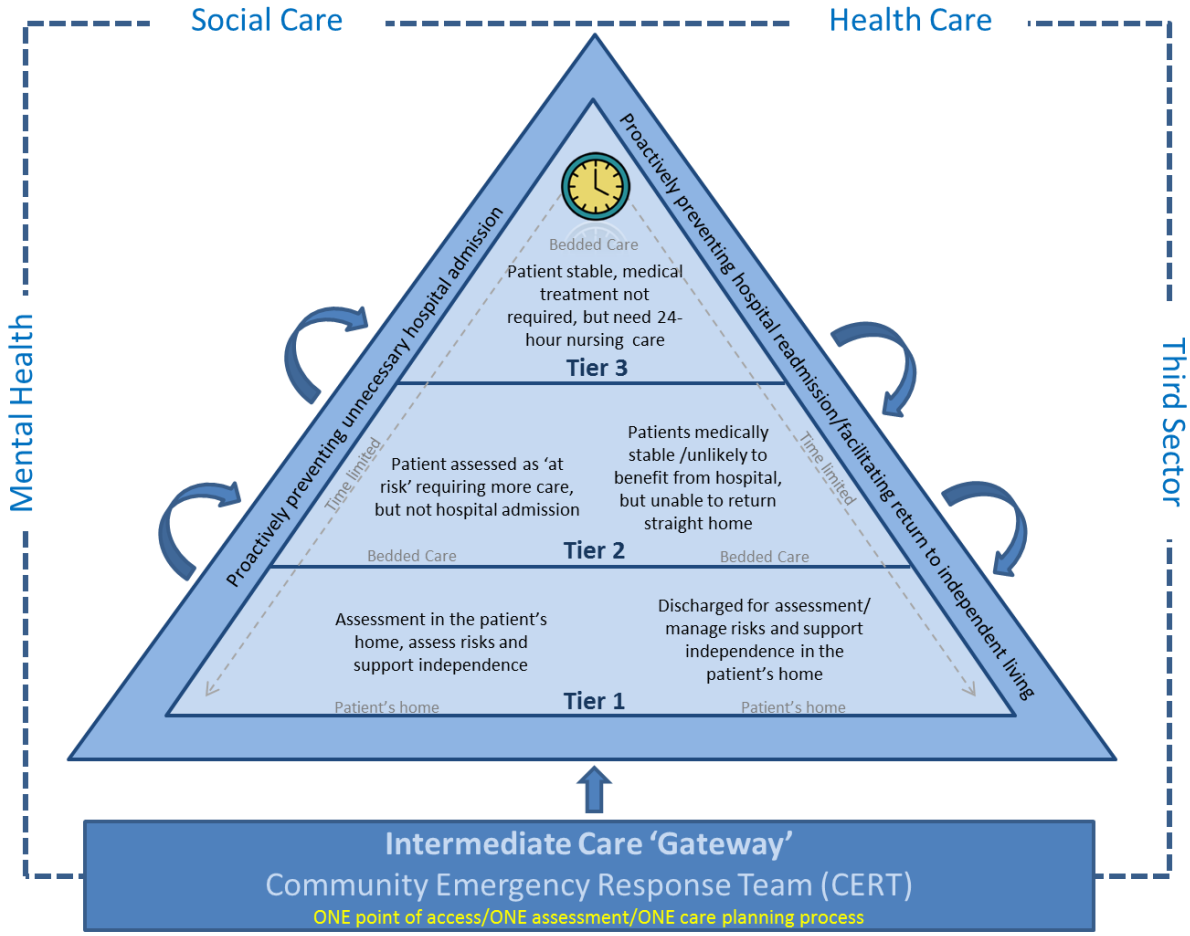
[5] Sefton Strategic Needs Assessment 2012-2013, Business Intelligence & Performance on behalf of Sefton Council in partnership with Sefton Public Health, NHS Sefton, South Sefton and Southport and Formby Clinical Commissioning Groups, Sefton CVS, Sefton Drug Action Team

5. Service Model

The local approach in Sefton is that intermediate care delivery is provided via a single point of access or "gateway", which includes a multi-disciplinary health and social care team and works cohesively with other community and third sector services, to provide a seamless intermediate care experience for Sefton patients.

Following entry via the gateway, Intermediate Care required is provided in three 'tiers', with patients being "stepped up" or "stepped down" the model as appropriate. Figure 1 describes the model of Intermediate Care for Sefton.

Figure 1: a Model of Intermediate Care for Sefton



5.1. *WHO will deliver the care?*

Key to delivery of this model is an Intermediate Care 'Gateway' who will act as the 'gatekeeper' or single point of access to the Intermediate Care Service, facilitating the "one assessment, one care planning process" approach.

The Gateway will comprise an integrated, proactive, multi-agency and multi-disciplinary team providing holistic short-term care and rehabilitation – it is not a series of standalone teams. The team will comprise:

- Nurses
- Occupational Therapists
- Physiotherapists

- a GP or Geriatrician
- Social Workers
- Mental Health Workers
- Technical Instructors
- Health Care Assistants
- Third sector representatives (ie, community, volunteer or faith services).

The Gateway will establish links with a variety of additional key health and social care community services to include, *inter alia*, stroke, falls, continence and respiratory services, together with Sefton Council's Reablement and Continuing Health Care Teams, will ensure that each individual's care is person-centred and that their journey through the Intermediate Care pathway is timely and seamless.

5.2. *WHERE care will be provided*

Intermediate care will largely be provided in the person's own home (Tier 1), but for those assessed as at risk if 24-hour care is not provided or their home is unsuitable, an intermediate care bed in a residential setting (Tier 2), or with some nursing care (Tier 3) may be the only viable option to avoid hospital admission.

5.3. *WHEN care will be provided*

Step up: the service will provide a proactive "rapid response" assessment within two hours of referral, providing an intervention in people's homes (or place of residence) with a view to avoiding admission to hospital.

Step down: the service will also 'in reach' into local acute services with a view to facilitating early discharge. Decisions relating to long term care will not be made in a hospital environment, but in the patient's home environment to promote and sustain independence and wellbeing.

5.4. *HOW LONG will care be provided for?*

Intermediate care is a time-limited service with the intention of preventing unnecessary hospital admission, reducing lengths of stay in hospital and enabling patients to return home quickly by providing support in the community for a short period while on-going packages of care are commissioned from Adult Social Care.

It is goal-focussed and provides time for assessment and invention based on specific, agreed outcomes to be achieved within days and weeks, supporting people to return to self-care.

6. The Intermediate Care Pathway

The streamlined care pathway will ensure a flow through intermediate care for the patient at a time and level as their need dictates. To be effective, the pathway relies on the interdependence and close alignment of health and community services, together with third sector services to ensure there all gaps in services are bridged and there are no delays in transfers of care.

7. Outcomes

7.1. *Ensuring individuals receive care at the right time in the right place, reducing acute hospital admission and manage the projected increase in demand*

- We will agree a model across Sefton, in partnership between health and social care and the third sector to agree a single model for intermediate care.
- We will review and develop team capacity in the community, together with community bed provision to take account of the projected increase in the elderly and frail population, while demonstrating value for money and effectiveness in reducing hospital admission.
- Organisational boundaries will not be allowed to obstruct or delay operation of the system. A cohesive team will ensure effective co-ordination and accountability for all members of the intermediate care teams.
- Develop clear and consistent referral pathways between intermediate care services, primary and secondary care and the Social Services, ensuring the single point of access is promoted widely.
- The strategy will be delivered through a patient-centred approach and implemented through working in a collaborative manner.

7.2. *Ensuring decisions about long term care are made only when individuals have had an opportunity for rehabilitation and recovery*

- We will ensure that patients are not transferred directly from a hospital ward to residential care (unless in exceptional circumstances) without being offered a period of intermediate care and reablement.
- We will ensure that individuals with complex health needs are treated fairly and offered rehabilitation prior to any decision being made about their long term needs.

7.3. *Increase patient satisfaction and maximise independent living*

- We will continue to monitor and review the pathway to ensure a fully integrated service.
- We will ensure our services are patient centred.
- We will introduce a new series of measures to performance manage the operation and delivery of the service, which will include continuous assessment of the patient experience.
- We will ensure patients do not become delayed in the system or access intermediate care services for longer than necessary.

8. Conclusion

Delivery of this Intermediate Care Strategy will be crucial in supporting the delivery of the CCGs' strategic aims and it is the aim of the Health and Wellbeing Board, in an environment where the elderly and frail population is projected to rise significantly and there are an increased number of people living longer with more complex health needs.

Our challenge is to commission a service upon which there will be growing demand, which offers a high standard of care within the current financial constraints. Integration between health and social services will be key to delivery of this strategy.

The benefits for patients will be an increased quality of care and not being admitted to hospital unless it is absolutely necessary and if admitted to hospital, ensuring patients are discharged quickly and are supported to resume independent living.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/53

Report date: March 2015

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Title: Breast Care Services Engagement and Equality Report and Recommendations

Summary/Key Issues:

Following the closure of the breast care services to new patients at Southport and Ormskirk Hospital NHS Trust, Southport & Formby and West Lancashire CCGs launched a collaborative engagement programme to help inform how these services might be provided in the future.

The detail and outcomes of the engagement and the associated recommendations are outlined in this report, which the Governing Body is asked to receive for information due to the small flow of patients from bordering populations, who have been included in this exercise.

Recommendation

The Governing Body is asked to receive this report.

Receive	x
Approve	
Ratify	

Links to Corporate Objectives *(x those that apply)*	
x	Improve quality of commissioned services, whilst achieving financial balance.
	Sustain reduction in non-elective admissions in 2014/15.
	Implementation of 2014/15 phase of Virtual Ward plan.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
Patient and Public Engagement	x			A full Engagement Report can be found in Appendix 1
Clinical Engagement	x			
Equality Impact Assessment	x			The Equality Assessment (Appendix 2) highlights that Public Sector Equality Duty has been met, subject to the Governing Body approving the recommendations
Legal Advice Sought	x			
Resource Implications Considered				
Locality Engagement				
Presented to other Committees				

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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
March 2015

1. Executive Summary

Following the closure of the breast care services to new patients at Southport and Ormskirk Hospital NHS Trust, NHS Southport & Formby and NHS West Lancashire CCGs launched a collaborative engagement programme. This aimed to inform people of the changes to local breast care services, explain why these have come about and to hear people's views and experiences of breast care services to help inform how these services might be provided in the future.

The attached engagement report provides a comprehensive overview of the engagement and the related findings which are summarised below.

The Governing Body is asked to receive the outcomes of the engagement and the Equality Assessment and approve the recommendations below.

2. Introduction and Background

The breast care service at Southport and Ormskirk Hospital NHS Trust was closed to new patients with effect from the 1st September 2014. This was because the Trust was unable to recruit a specialist breast radiologist which was required in order for the service to run safely. Around 40 - 50 patients were referred to the service each week by their GP, of these approximately 140 patients were diagnosed with breast cancer in a year.

GPs were briefed on the availability of other local providers, and the providers were contacted and made aware of the situation and to ensure they had capacity to take additional referrals. The majority of new patients chose to be referred to Aintree University Hospital NHS Foundation Trust and Wrightington, Wigan and Leigh Hospitals NHS Trust.

Follow-up breast care patients continued to receive their treatment at Southport and Ormskirk Hospital NHS Trust. Follow up patients include those patients continuing to receive treatment, patients being followed up because of a family history of breast cancer and patients whose active treatment has ended and are under surveillance for up to 5 years.

To assist the CCGs in shaping the model of future breast care services, a collaborative engagement programme with West Lancashire CCG was launched on 19 January 2015 to seek the opinions, views and suggestions of the local population. This closed on 5 March 2015.

The engagement was carried out using a variety of methods to ensure that the programme was as far reaching and inclusive as possible and invited groups and individuals to get involved, including all patient groups, support groups, carers, cancer networks, minority groups, MPs/councillors and local healthcare organisations and any other groups/individuals with an interest in local healthcare. People were asked what they found positive about breast care services, what they felt could be improved and what they found most valuable in terms of after treatment support.

The methodology, complete list of stakeholders and engagement outcomes are outlined in detail in the attached engagement report (Appendix 1).

3. Key Issues

The majority of participants in the engagement programme were existing breast care patients from Southport and Ormskirk Hospital. This group also took the opportunity to share the following:

- Their disappointment and frustration around the sudden closure of the service to new patients;
- The lack of communication by Southport and Ormskirk Hospital before and following the closure of the service;
- Their concerns around the lack of certainty about their future care in terms of who it would be delivered by and where this would take place.

4. Conclusions

During the course of the engagement, over 3,700 contacts were made and 342 surveys were completed. This generated thousands of comments relating to the local population's thoughts and experiences of local breast care services.

From an in-depth analysis of the feedback, the main themes were identified as follows:

- No matter which hospital people had been treated at, respondents had very positive experiences of the breast care services available, and in particular spoke very highly of the breast care nurses;
- People want a local breast care service in the Southport, Formby and West Lancashire areas that at least provides follow up care and support;
- Perceived travel problems if services were to be provided out of the local area. This was from both a practical point of view and also from an emotional and financial aspect;
- Speed of referral into the service and access to 'one stop shop' style diagnostics and treatments are important;
- Better communication, information and consistent messages across the healthcare economy are required.

It is important to note that whilst many respondents acknowledged the reasons why a full breast care service could not return to Southport and Ormskirk, a number continued to challenge this.

An integral part of the engagement analysis was an evaluation of the equality implications of the changes to the service and its future development. This provides the CCG with guidance and recommendations for consideration to mitigate the difficulties that may be experienced by certain groups. A summary of these are as follows:

- **Travel and transport**: consider the views and experiences of patients in relation to travel, as identified in the Equality Assessment and which responds to the report's recommendations (Appendix 2);

- **Provision of local service**: where possible, provide access to elements of the breast care service in the Southport and West Lancashire areas;
- **Accessibility**: ensure access to treatments for new patients are cognisant of patient need;
- **Continuity of care**: to be addressed for existing follow-up patients as soon as possible;
- **Communication and engagement:** a comprehensive engagement feedback and communications plan is required for all stakeholders including minority groups;
- **Support services/groups:** ensure that these continue to be available in local community;
- **Public Sector Equality Duty (PSED) requirements:** The attached Equality Assessment highlights key recommendations that need to be approved to ensure the Duty is met (Appendix 2);

5. Recommendations

In response to the engagement feedback and the future development of this complex service, the CCG recommends the following plan to the Governing Body for its consideration and approval:

- The CCG, in collaboration with West Lancashire CCG, continue to review and develop the breast care pathway, taking into consideration the following:
    - evidence based clinical guidelines to ensure that the pathway offers the best clinical outcomes for the local population;
    - the need for a local service, balanced against clinical outcomes associated with more specialised breast care services;
    - the engagement feedback and equality analysis recommendations.
- In collaboration with service providers and West Lancashire CCG, prioritise communication to existing follow-up patients about their ongoing care;
- The CCG provide a further report to the Governing Body following the pathway review with recommendations for the commissioning process;
- The CCG, in collaboration with West Lancashire CCG, develop an appropriate engagement and communications plan to feedback the outcomes of the engagement exercise and the decisions regarding the future of the service.

Appendices

Appendix 1 – Breast Care Services, Engagement Report (44 pages)
Appendix 2 – Breast Care Services, Equality Assessment (8 pages)

Jan Leonard
March 2015

NHS
West Lancashire
Clinical Commissioning Group

NHS
Southport and Formby
Clinical Commissioning Group

Breast Care Services
Southport and Ormskirk Hospital

Engagement Report

March 2015

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1. EXECUTIVE SUMMARY

The breast care service at Southport and Ormskirk Hospital NHS Trust was closed to new referrals with effect from the 1 September 2014. The hospital was unable to recruit a specialist radiologist and as a result it could no longer continue to run the service safely. NHS Southport and Formby CCG and NHS West Lancashire CCG worked quickly with other nearby hospitals to ensure there was sufficient capacity to receive additional referrals, and GPs were informed of the arrangements for their patients. Southport and Ormskirk Hospital undertook to continue the care of all patients referred to them prior to 1 September 2014.

An engagement programme was launched on 19 January 2015 to seek the opinions, views and suggestions of the local population and enable them to shape the model of future breast care services. This was carried out using a variety of methods to ensure that the programme was as far reaching and inclusive as possible. There were over 3,750 contacts, which generated thousands of comments relating to the local population's thoughts on and experiences of local breast care services.

People were asked what they found positive about breast care services, what they felt could be improved and what they found most valuable in relation to after treatment support. From the feedback the main themes were:

- The vast majority of people who contributed in the engagement programme have had very positive experiences of the breast care services available, no matter which hospital they were treated at and in particular spoke very highly of the breast care nurses.
- People want a local breast care service in the Southport, Formby and West Lancashire areas that at least provides follow up care and support.
- Perceived travel problems if services were to be provided out of the local area. This was from both a practical point of view and also from an emotional and financial aspect.
- Speed of referral into the service, the need for a one stop shop model and then the speed of access to additional diagnostics and treatment is important.
- Better communication, information and consistent messages across the health economy are needed.

An Equality Analysis report was also produced which provides recommendations for consideration to mitigate the difficulties experienced by certain groups within the localities.

2. BACKGROUND

2.1 In September 2014, the decision was made by Southport and Ormskirk Hospital Trust to no longer accept referrals for patients requiring breast care services. The two CCGs ensured that GPs were briefed on the availability of other local providers and also that patients continued to have the right to choose from any of these alternative providers. Other local providers were contacted and made aware of the situation and to ensure their capacity to take additional referrals. Southport and Ormskirk Hospital NHS Trust put in place mechanisms to ensure that any referrals made to the Trust would be redirected promptly and the patient's GP informed.

2.2 Southport and Ormskirk Hospital NHS Trust made a commitment to write to all patients currently receiving care within the breast service to reassure them that their care would not be affected by the changes.

2.3 NHS Southport and Formby CCG with NHS West Lancashire CCG continue to work alongside local providers looking at the options for future commissioning, including best practice pathways of care. To inform this, an extensive engagement programme was launched on 19 January 2015 to seek the views and experiences of patients, carers and the local population. The engagement closed on 2 March 2015.

2.4 Updates and reports on the service changes and engagement activity were received and noted by the following health and social care bodies:

- NHS West Lancashire CCG Governing Body, 23 September 2014
- NHS Southport and Formby CCG Governing Body, 24 September 2014
- Sefton Overview and Scrutiny Committee for Health and Social Care, 21 October 2014, 6 January 2015, 3 March 2015
- Lancashire Overview and Scrutiny Committee Steering Group, Friday 28 November 2014
- Sefton Consultation and Engagement Panel, 23 January 2015
- Engagement and Patient Experience Group, monthly meetings December 2014 through to March 2015

3. ENGAGEMENT PROCESS

3.1 Aims of Engagement

Following the closure of breast care services to new patients at Southport and Ormskirk Hospital, NHS Southport and Formby and NHS West Lancashire CCGs undertook a collaborative engagement exercise which aimed to:

- inform patients and other interested groups of the changes
- explain why these have come about
- hear from individuals and groups about their views and experiences of breast care services to help inform how these might be provided in the future

As the service was closed for clinical safety reasons, there was no requirement to hold a formal public consultation. However the CCGs were committed to ensuring patients and local people were involved in future developments. Although there was no opportunity to affect clinical aspects of the service, the CCGs were keen to understand what aspects of the breast care services people found valuable and any suggestions for improvement.

3.2 Methodology

The methodology was agreed and developed to ensure that the aims of the engagement were met, and to capture the diverse patient experiences and knowledge of the various aspects of the service.

The key aspects of the methodology were as follows:

3.3 Focus and Methods of Engagement

- The process focused primarily on engaging with the various patient groups, including current and former patients, follow-up patients and those patients with a family history of breast cancer, informing them of the recent changes to breast care services and listening to their experiences. Letters were sent to all patients in these groups informing them of the engagement and how they could get involved. The letter was sent to approximately 1,800 patients.
- A survey was developed and was available to complete online and via hard copies. An information leaflet supported the survey and was developed with feedback from Southport and Ormskirk Hospital, other providers and patient representatives
- Other interested individuals and groups were identified e.g. carers, support groups, cancer networks, minority groups, MPs/councillors and local healthcare organisations and groups with an interest in local healthcare. Information and letters of invitation were sent to groups and individuals to cascade where appropriate, and all information was available on the CCGs' websites.
- Focused engagement via meetings/focus group settings was the preferred method of engagement as the changes to the service were varied and in some cases complex; these could be clearly explained and discussed in these settings and patients and others had the opportunity to openly feedback their own experiences and opinions of the service. To facilitate this, a series of meetings were organised mainly via support groups, several of which were open meetings for anyone to attend. These meetings were led by a senior member/s of one or both of the CCGs and, where possible, a clinician.
- To further facilitate focused engagement, the CCGs attended the hospital clinics to discuss the changes with individual patients/carers.
- A news release was issued to all local media.
- Southport and Ormskirk Hospital Trust shadow foundation trust members received an invitation to participate in the engagement: 1,026 members were emailed an invitation and 184 foundation trust members were sent a letter.
- The engagement was further promoted at other local public events which are listed in Appendix A
- The engagement was also supported by the Cheshire and Merseyside Commissioning Support Unit (CSU) Patient Experience Team who provided telephone support for the engagement, including information on how people could get involved, taking bookings for open meetings, completing questionnaires and fielding any queries to the CCGs. Their contact details were included in all information and provided a channel for those who could not access the internet.

3.4 Equality Analysis

- A pre-engagement equality analysis was undertaken and identified several minority groups that would require specific consideration when developing the engagement plan, including the migrant

worker population and Lesbian, Gay, Bisexual and Transgender (LGBT) groups. The assessment also identified higher incidence of breast cancer in specific groups i.e.; the female elder population, Jewish Ashkenazi females and LGBT groups. Due consideration was given to these groups, and bespoke methods of engagement and specific meetings were set-up.

- To ensure that the engagement process was representative of the affected groups, the questionnaire also included an Equality and Diversity monitoring form which captured the profile of the respondents and formed an integral part of the analysis.
- The Equality and Diversity monitoring form also requested postcode information which was used to identify any specific geographic issues, and also enabled the two CCGs to identify their respective CCG residents.

3.5 Capturing Feedback

- To standardise and facilitate a robust approach to engagement, and enable all participants and different patient groups to readily record their views and experiences, a short qualitative questionnaire enabling free text responses was developed. This was used to facilitate all focused discussions and was also available on line to complete.
- To understand the context of individual responses, the questionnaire asked specific information about the respondents' relationship to the service e.g.; patient, carer, personal interest and the name of the provider to which their responses related.
- To ensure accessibility for all, including individuals and groups who were unable to attend a meeting or engage in any other way, all information including the questionnaire was made available via the respective CCG websites.

3.6 Analysing Engagement and Feedback

- During the analysis phase, emerging shared themes and issues were discussed between the two CCGs.
- The CCGs will feedback the outcomes of the engagement publicly and to respondents, indicating how the outcomes will influence the future of the service. 200 respondents provided their contact details so that they can be kept informed of the outcomes of the engagement and future developments.

3.7 Stakeholders

- To maximise the reach of the engagement programme and to ensure that all identified groups were informed, the information such as the dedicated breast care service leaflet and survey, were shared with a wide range of stakeholders as listed in Appendix B.

3.8 Engagement/Communication Timeline

- Staff briefings were held in mid-January with Aintree University Teaching Hospital and Southport and Ormskirk Hospital; these were followed by a range of public events and also attendance at breast care clinics at Southport and Ormskirk Hospital. These ended on 28 February 2015. See Appendix A for a full list of engagement events and clinics.

- An online survey was available on both CCG websites and throughout the engagement period and closed on 2 March 2015.

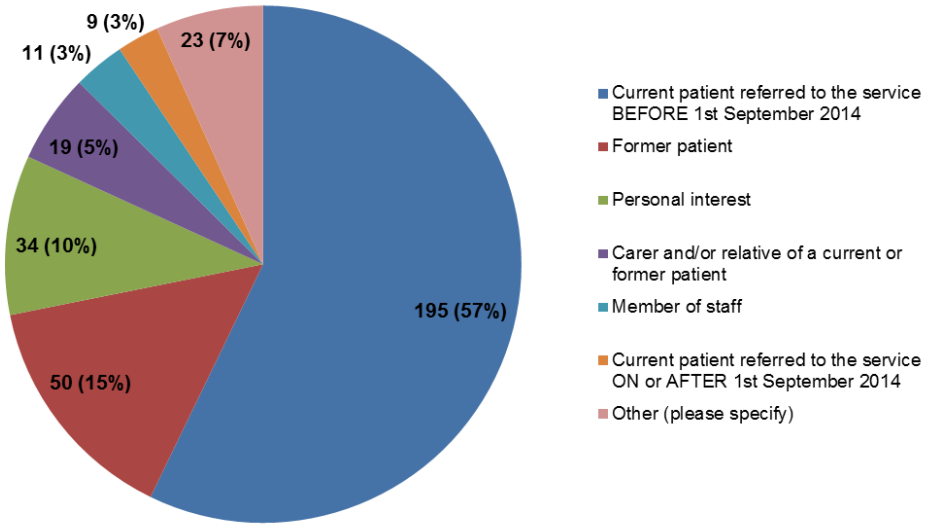
4. ENGAGEMENT OUTCOMES

4.1 Survey responses and questions

A total of 342 survey responses were received.

People were asked how they knew about breast care services in order to identify the different perspectives e.g. a former or current patient, a career, a member of staff etc. It was also ascertained which breast care services respondents had experience of:

4.1.1. In terms of the breast care services, which of the following best describes how you know about them?



The majority of the respondents were existing Southport and Ormskirk patients who were referred before 1st September 2014 (57%), followed by former patients of a breast service (15%).

Those who answered "other" included local residents, patients who attended screening appointments and a former member of staff.

4.1.2 Which breast services do you have experience/knowledge of?

	Response Percent	Response Count
Ormskirk and District General Hospital	79%	240
Southport and Formby District General Hospital	64%	194
Clatterbridge Cancer Centre	52%	157
Linda McCartney Unit, Royal Liverpool University Hospital	20%	62
Christie Hospital NHS Foundation Trust	6%	19

Royal Edward Albert Infirmary, Wrightington, Wigan and Leigh NHS Foundation Trust	5%	16
Other (please specify)		82
answered question		305

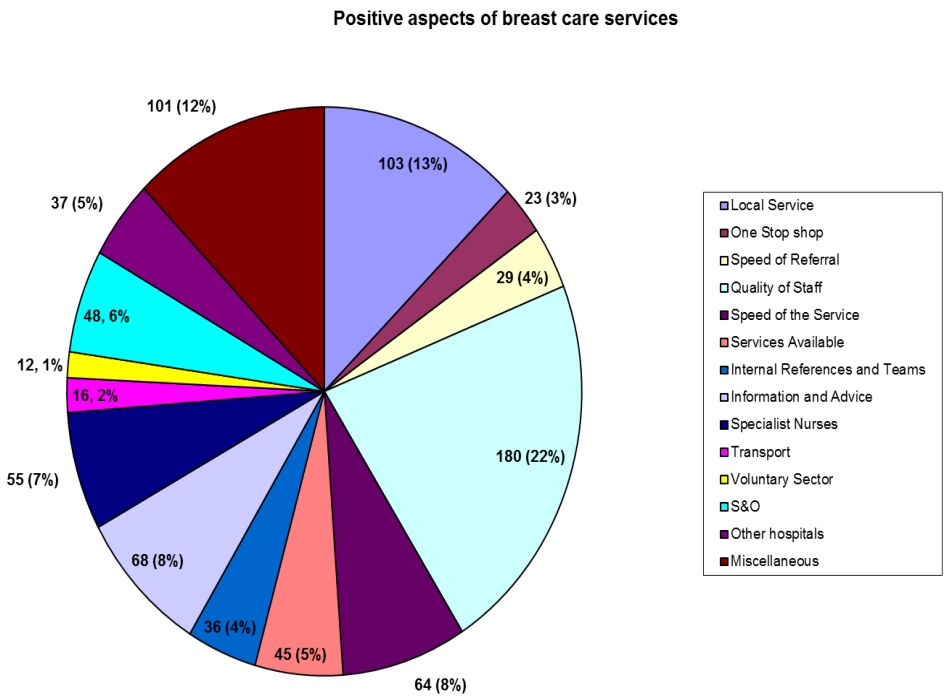
The majority of respondents had experience/knowledge of Ormskirk (79%) and Southport (64%) hospitals, and 52% of the Clatterbridge centre.

The 82 responses in the "other" section included Aintree, the Marina Dalglish centre, the mobile screening units, Royal Preston Hospital and Whiston (St Helens and Knowsley Teaching Hospital NHS Trust).

4.1.3 Please tell us about the positive aspects of your experiences/knowledge of local breast care services.

Over 800 positive experiences were reported from 314 responses. The responses can be grouped into the themes shown in the following diagram:

Diagram 1:



Local service and a "one stop shop"
Having a local service was seen as very important to 103 respondents, where 23 replies also indicated their preference for the "one stop shop" approach to service provision.

"Being close to home when undergoing treatment, such as chemotherapy, cuts down on the negative aspects of travelling when unwell. Transport links and costs can also be a problem if too far away, so travelling to Southport was helpful as I was able to arrange lifts that did not cause inconvenience to others. The mammogram appointments at Ormskirk have been good. No waiting and able to walk there from work. Staff very nice in all local services. Encouraging to have support close to home."

"At a time of great worry and trepidation the fact that all clinics and support was LOCAL was of vital importance. Diagnosis, treatment and follow up clinics, mammograms and check-ups that are local have been a great benefit."

"I had six months of chemotherapy for breast cancer at Southport and Formby District Hospital. Having my treatment and being able to see my oncologist in Southport where I live, made this difficult treatment so much more bearable. Some treatment days could last up to 6 hours and if I then had to travel back home from another hospital further away from my home this would have added to the stress. The team I had at Southport where a constant support at the most difficult time in my life."

"One stop care - I had the mammogram, FNA and core biopsy all at the new patient appointment. I got the results of the first two tests before I left, you don't get the results of the core biopsy at the appointment. It's good to know results before you leave so that you are not going away for a week or two and worrying. You've got consultants, nurses and breast care nurses and you can access these if there are any concerns, at short notice over the phone or in clinic, especially when just starting treatment as very scary. The breast care nurses can also allocate to consultants' clinic list and if it was something they could not deal with. It's close to home."

Speed of referral and quality of staff
Respondents (29) commented on the speed with which people could access the service, with the highest response, 180 replies, highlighting the overall quality of staff providing services, across all locations.

"Everything is positive. Doctors, nurses, breast care nurses - all are excellent. we don't want change."

"Team have been excellent, doctors, nurses, surgeons. I have been well informed along the patient journey. Ormskirk is a better hospital in every aspect. It is very clean."

"Familiarity - staff know you, you know them. Friendly, caring Good care received, Peace of mind. They do what they can to fit in with you if you are working regarding appointments."

"Everybody is so nice- you are taken like somebody special from room to room, each service, each person gives you VIP treatment - it was like you were the only one who mattered. Privacy and dignity maintained constantly even in people's volume of speech. The breast care nurse is always there when needed. I had a card with her details on it. She knew me."

"Breast care nurses and consultants go that extra yard for you. I saw the GP yesterday and had an appointment 11am today it's been very quick and put my mind at rest. The surgery for breast removal went fantastically well, a really, really good package of care. I received help to bathe, to improve the mobility in my arm as the cancer had a knock on effect on my muscles."

"Clinic Apt offered quickly after seeing GP. Results given same day after scan and needle biopsy. Support from Specialist Nurse - excellent support during appointments, checking my understanding, clarifying uncertainties, answering questions - felt like she was my 'advocate', asking questions for me if I forgot or was unsure about something. Also made it clear I could contact anytime or seek help and advice."

Speed of the service and services available

Once services had been accessed, 64 replies, commented upon the speed with which results and a range of services could be provided. Particular reference was made to the scope of services available, where provision across a number of sites was recognised, with the preference for these to be on either the Southport or Ormskirk locations.

"Operation Date offered within month but delayed at my request, after asking for advice for." "A friend was fast-tracked after finding a lump. The service was very quick and friendly (Linda McCartney centre)"

"Treated very quickly since phoning the doctor both in Southport and Ormskirk hospitals."

"Clear treatment plan explained. Quick referral into service initially then shore wait for surgery, results etc. Very trusted and will renowned breast care service at Aintree and trusted surgeons. Availability of the Marina Dalglish Unit for Chem and MD volunteers for invaluable complimentary therapies."

"Excellent and quick treatments once diagnosed. Surgical team very good. Oncologist excellent. Breast care nurses fantastic and so necessary."

"Exceptional care and sensitivity throughout. Speed of diagnosis; excellent communication; successful procedure followed by exceptional care on Ward H, Ormskirk. All of the above gives reassurance at what would otherwise be a very worrying time. Thank you."

Internal communications and team working

Service users complimented the way referrals were made across different clinical disciplines and how teams were used to maximise skills and the patient experience.

"The breast care service at Ormskirk hospital sent me for physio, addressed my pain relief, arranged a lighter weight prosthesis to help fibromyalgia, sent

me for a proper bone scan - I received a fuller package of care at Ormskirk, they addressed all of my needs, not just the immediate ones, e.g. the surgeon was in touch with the pain clinic - it works here!"

"Experienced and highly dedicated team, from the Consultants, Specialist Nurses to the admin person booking the target referrals. A huge loss to the local population when it closed."

"Very quick diagnosis and got appointments for x- rays/ mammograms/ ultrasound very quickly through the breast care nurses. All very helpful with information and making arrangements.

Information and advice

The provision and quality of information was welcomed by 68 respondents, examples of which include:

"All staff involved are supportive and answer any questions. I've always felt fully informed every stage of the way, aware of options, possibilities and what might be/might not be?"

"The whole process from diagnosis through to treatment could not have been better every process was explained from start to finish and no matter what questions arose there was someone ready and willing to answer and explain and more importantly allay the fears."

"Easy read breast screening booklet"

Support from the voluntary sector

The role of the voluntary sector in providing support was also recognised in 12 of the responses.

"I joined the lift up group after my initial treatment. At the time meetings were held in the hospital which probably slowed my joining of the group as I'd seen enough of the hospital environment. Meetings are now held outside the hospital which is good. I have enjoyed the group support both when I was a new member and could ask how others were coping and am now able to offer help to newer members still in the throes of treatment."

"Support provided by charitable organisations such as Big Sista Love which offer an art therapy , less traditional approach to breast cancer survivors."

"Sarah's Stars. St Rocco's Hospice provided counselling for my daughter who was 11 years old and took it hard. They also gave me physio when I needed it."

"Headstrong Pamper group in Marina Dalglish on Tues am, Reiki, Nails, Facials, Arm Massage, Support Session, Hope Course, Support Group, Own Macmillan nurse, Support and Welcoming staff (talk about anything)"

Specialist nurses

Over 50 respondents were highly complementary about the specialist breast care nursing team and the assistance they gave to patients, across all elements of their clinical journey.

"I found my treatment which began 12 years ago to be good. From my GP through to surgery and aftercare I felt supported but especially from the breast care nurses."

"She came to visit me at home during treatment so I was able to talk in a relaxed and non-pressurized environment about my concerns and fears. As my treatment continued with follow ups at regular intervals at the local hospital, the breast care nurses were always there to support."

"Really good experience I've felt as if I've been' looked after' the nurses are really good they explained everything and the follow up care has been really good."

"With the breast care nurses you don't feel like there are any stupid questions."

Transport

Where services were provided away from Southport and Ormskirk the provision of either transport assistance or the facilities on these other sites was regarded as important (16 responses).

"Transport – Patient Transport Service has really helped to get to Clatterbridge and Ormskirk. Everything else is fine too."

"Attended Aintree daily for 1 month. Transport excellent Treatment at Aintree excellent"

Hospital sites

Respondents indicated 48 positive comments about services on the Southport and Ormskirk sites with 37 indicating positive experiences at the other sites contributing to the overall service offer.

"Surgery at Southport, it's local and not difficult for relatives to visit." Aintree was excellent. I was impressed with the radiotherapy service, how the staff explained things - so pleasant and very personal. Ormskirk is good too."

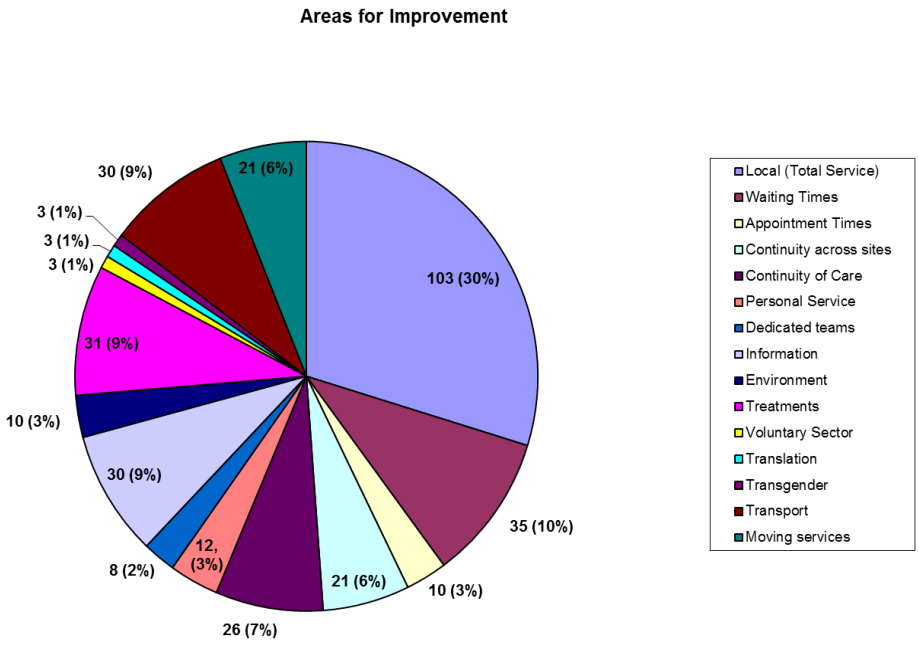
Miscellaneous

In the miscellaneous comments, most of these related to single entries where patients commented on the overall provision of service

4.1.4. Please tell us what aspects of the services could be improved.

Over 300 suggestions were made from nearly 260 responses to the survey. The following themes were noted:

Diagram 2



Local service and movement of services

The majority response was the need to ensure that there was a strong local service, 103 responses, with a further 21 responses challenging the movement of services away from the Southport and Ormskirk sites.

"A more dedicated team offering the fullest range of services. More services delivered from Ormskirk and Southport."

"To have more services locally e.g. having radiotherapy at Southport and Ormskirk rather than Clatterbridge."

"Please keep aftercare local with full support from people we can learn to know and trust so can talk freely and easily about our concerns and feelings."

"I received a follow up appointment at Wigan. A local, Ormskirk clinic would be more convenient. However, Wigan staff & DR were fantastic. I had utmost trust in their experience."

"Maintain all services at Ormskirk Hospital and Fazakerley Hospital for any current treatment."

"It would be ideal to keep review appointments at Ormskirk in the future it's good that it's local"

"Being kept local! If you have been told you have CANCER you don't need the extra trauma of having to travel, for treatment. Ops and clinics."

"The distance travelled and the time it took to get to my daily treatments at the Marina Dalglish centre was on occasions very tiring."

"Retain the breast care service at Southport & Ormskirk - for distance / congestion reasons - travel to either Preston or Liverpool takes a large portion of the day and when trying to work full time is not feasible."

Waiting times and appointment times

Patients were looking for improved waiting times, especially for follow ups and more regular screening. They were looking for longer appointment times and greater flexibility with appointment times. (35 and 10 responses)

"After my check up with the Oncologist (after Operation) I waited quite a number of weeks before I had to ring Ormskirk hospital to remind them about my follow up appointment with the surgeon - that probably was because of the closure of the department and my surgeon left the hospital."

"Reduce the waiting time for diagnostics e.g. I was advised I needed an MRI scan but I was initially advised this would take place in 3-4 weeks. For peace of mind I would have liked this sooner."

"Waiting times. Chemotherapy and consultant appointments, and sometimes blood testing, always involved a long wait at Southport. Some follow up appointments for consultation at Ormskirk (2013/14) involved many hours of waiting prior to seeing a consultant for an appointment that lasted five minutes. Being local to home though meant I was able to pop home for a cuppa and drive back in time for my place in the queue!"
"When I was going through my Chemotherapy treatment I found the waiting around very difficult I had to wait for the drugs to arrive each time before I could start"

"Occasionally consultant appointments in the afternoon can be up to 2 hours after scheduled time due to over-running clinics in the morning at other NHS locations."

"Waiting times for results is an issue. I was waiting in the consultant's room for what felt like ages waiting for results of a test it looked like everyone knew it was bad news but no one wanted to tell me they left me waiting instead."

Continuity, personalised service and dedicated teams

Respondents are asking for priority to be given to ensuring continuity of care when services are provided across a number of sites (21 replies) with 26 patients stressing the need for continuity of care based on a person centred approach (12 replies) provided by dedicated teams (8 replies)

"I feel you need continuity with the team of consultant and staff who were with you from the start."

"Continuity when staff are on leave/off sick - I experienced a gap during a period of staff sickness. Not being told when mammograms are due - I attended today and was told I should have already had a mammogram. Mr

Haq has now left and gone to Birmingham as there is no work for him here - it should be a priority to keep doctors."

"Post-surgery I was upset that I did not receive a phone call to follow up. It would have been good to talk to someone."

More follow ups/contact/ appointments with breast nurse.

"The Royal, Liverpool. Three years ago I went there for breast surgery. I was shovelled into a side room to wait, other patients were allowed their husbands to stay but my sister wasn't allowed to stay. I went for the injection, then went back in to the waiting room. Seven hours passed until I got a bed.

There was then a two hour wait before surgery - no real explanation was offered, no-one checked on me I was just advised I "was last on the list". I was discharged later than planned so I hadn't ordered any lunch, but they would not get me any. There was nobody around at the time of discharge so when my lift arrived other visitors helped me put my coat on and carry my bags. I have a lot of pain from the fibromyalgia, in addition to the pain from surgery. The team there didn't acknowledge the fibromyalgia. I had problems with pain relief and my regular medication was not sorted out. I am allergic to lignocaine, but there were no other alternatives available and so I was advised to come back another time. From March to November I did not have a prosthesis as the invite letter was not sent to me to go for a fitting. The staff were off hand with me at the bra fitting service."

"Communication between departments, support after treatment finished - felt "left to get on with it" - I sort out support group but not everyone would do this."

"Communications between hospital, GP, District Nurses and patient need improvement. Protocols appear different between different sectors providing care. There was confusion re anticoagulant administration as different surgeons used different protocols. District Nurses used different drain rate to indicate time to remove - not same as hospital."

Information and environment

The provision of appropriate and supportive information was highlighted by 30 respondents where 10 people felt that adjustments were needed to the environment in which services were delivered.

"More information from breast surgeon or breast care nurse tailored to individual needs. e.g. for me - services available for younger women - Facebook group (YBCN), Willow Foundation."

"Signposting to free support services, complimentary therapies, support groups etc."

"More specific short-term information i.e. The process of "What's going to happen next?"" how long do I wait in the hospital room, who and what am I waiting for, what do I wear, why/ when should I contact a nurse, what should I try to do by myself, when can I go home..."

"From point of finding out about my diagnosis up to my actual surgery information and communication from breast nurses and doctors was limited. Also the aftercare was limited; leaflets were the only information that I could source help. So information and communication needs to improve."

"I was admitted to Southport hospital over a weekend due to a high temp through casualty. This experience was frightening as I was alone in a side-ward as a range of different doctors came and went and stuck needles in me. They were friendly but I got little explanation of what they were doing and why or if I would need to stay in or for how long. I was put in 2 different wards and was very unhappy and worried that, due to low immunity (following chemo) I would catch something from the other patients and the smell of patients using commodes in the bays surrounding me seemed to linger and was really unpleasant. Nurses were busy ""handing over"" and filling in forms and had little time to see to patients. At night, doors and curtains were closed and restricted their vision of what was going on in the wards. Patients were waiting for help to go to the loo etc. and my drips remained attached for long periods of time after they were finished. "Ring the bell when it's finished and I'll come and take it out for you" would have helped. Rather than feeling like I was an inconvenience when I did ask or ring the bell."

"A walk in centre where people could meet and just talk when the terrors of the disease got the better of them."

"Routes for advice were very unclear and no one seemed sure how to deal with queries. Each time I seemed to go around the houses to get an answer."

"Patients leaving after receiving their results may well be extremely distressed. They had to walk out through the waiting area this is embarrassing for them and very scary for those walking up to you. Another exit or a private room would be made available."

"Southport isn't clean and seems a bit of a mismatch - I had to see Dr Hyatt and needed to walk through patient treatment areas - not good for privacy."

"to have all units wheelchair accessible"

"Would like bright waiting areas and refreshments and magazines."

Personalised support and issues relating to translation, gender and sexuality

Over 30 replies asked for a comprehensive provision of services, including psychological support, with consideration being given to translation services, the needs of single sex relationships and the requirements of the transgender community.

"Emotional support - need someone to talk to. Difficulties using the telephone. Surgeons - abrupt; could improve bed-side manner (Southport)."

"Health records do not reflect transgender information causing embarrassment and inappropriate breast screening invitations, or no invite for screening. Some individuals fall out of the system. Unsupportive and uneducated GP's and health professionals – have no understanding or

knowledge of transgender issues. Tailored support throughout treatment and after treatment especially as this group more likely to be vulnerable and isolated to have all units wheelchair accessible."

"I want a local service. Public transport is difficult to Aintree. I would also like a translator."

"From a lesbian and gay perspective, lesbians are more likely to suffer from or be at risk of breast cancer as there is a correlation with having children. Lesbians are still less likely to have children. I think this is a need which is hidden or not promoted and there needs to be some specific awareness raising." [Further info provided]

Transport

Accessing services was seen as a key element of the service where transport, particularly public transport availability, and car parking needed to be improved to enhance the patient experience. Here some responses asked for more services in Southport rather than having to travel to the Ormskirk site.

"I am fortunate in having family locally in Liverpool with whom I stayed the night before chemo treatment and a couple of days after to recover from sickness etc, otherwise would have found it difficult travelling to and from appointments."

"Perhaps not having to go to another hospital for other things like Isotope injection."

"Transport - not the wait, but the discomfort."

"Attending Clatterbridge for chemo/radiotherapy - if you don't drive it's a long day especially when feeling unwell."

"I had all my treatment at the Royal & Clatterbridge. I would say transport could be a problem for quite a few people. I had to travel by train and public transport, which when you are feeling not too good is not very satisfactory."

"Having to keep answering the same questions when booking Patient Transport Service."

"Would have been good if oncologist could have clinics in Southport instead of just Ormskirk."

"Have mammograms at Southport again rather than just at Ormskirk"

"Should be available in Southport."

Treatments

Respondents made the following suggestions for improvement to treatments:

"Increase number of breast care nurses (with training in helping/ counselling skills)"

"Use of dressings post op that less people are allergic to."

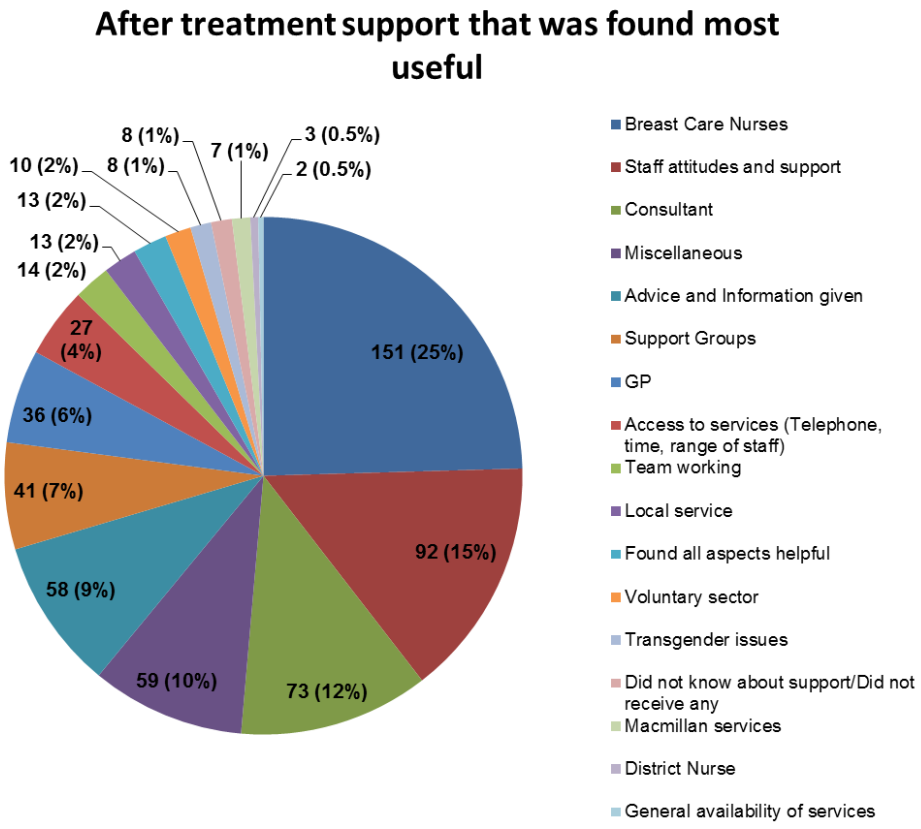
"More urgent care in A&E at Southport when neutropenic. Someone in A&E who can use a picc line. Separate ward in hospital for cancer patients. 24hr 7 days specialist cancer nurse."

"Mammogram process is painful wish there was a different way of doing the test."

4.1.5. If you are, or have been, a patient of the service what aspects of after treatment support have you found most helpful e.g. consultant advice, breast nurse support/advice, support groups, GP support?

There were 246 responses to this question generating almost 600 comments. The main themes are as follows

Diagram 3



The most popular response for what after treatment support people had found most useful was "Consultant advice, breast nurse support" with 151 of the responses mentioning the service provided by the breast care nurses and 73 mentioning their consultant. Respondents valued the staff attitude and support, and advice and information provided by these two staff groups.

Breast care nurses

The value of the support and advice provided by the breast care team was strongly recognised by respondents, and they appreciated the relatively easy access to this:

"Breast care nurse - you know they are always at the end of the phone and if you leave a message they always get back to you ASAP. It's having a point of contact rather than a vague department."

"Breast care nurse was excellent I was given leaflets and books that were useful. The breast care nurse even came to my house to see me this gave me reassurance and confidence"

"The breast nurses provided an invaluable role, always available to reply to queries if they were unable to help they knew which direction to point me for appropriate advice."

"To know I only need to ring the breast care nurse about a concern rather than possibly having to ring the GP and start at point 1 is very valuable."

"Consultant advice; breast nurses fantastic e.g. lymphoedema spotted by a breast care nurse - referral to lymphoedema nurse - also excellent."

Team working

Respondents recognised the benefits from the health care staff working as a team, and also valued seeing the same team/individuals on a regular basis:

"Follow up services are excellent, Even though I have my MRI and Mammogram every year it's still really worrying to go for the results."

"The breast care nurses and Clatterbridge radiotherapists - the way they speak to you and allay your fears - the teams are second to none. And they work as a team. Seeing the same surgeon for check-ups means a lot too."

"I found the consultant advice, breast nurse support/ advice and GP support most reassuring. All these work well together at Ormskirk and makes attending clinics less daunting."

"Continuity of Consultant care - maintaining a direct line with my healthcare team."

"A week after completing my radiotherapy I was concerned that my skin may have become infected. Having called the number I was given to discuss my concerns I was then contacted by Clatterbridge Centre, Aintree and given an appointment on the same day to have my wound looked at, which was reassuring."

Support groups

The benefits of a support group were acknowledged by 41 of the respondents, including the therapies and courses they offer:

"Support group Sarah's Stars".

"Complimentary services were good I attended a session at the Linda McCartney unit about makeup and how to tie a scarf your self-image really suffers when you have treatment like this but these sessions really helped."

"Occasional telephone calls from BCN. Attending hospital support group. Attending 'pamper sessions' weekly at Marina Dalglish in Aintree for on-going support."

"Support groups - I found the retreat at Aintree unit very helpful.
did not find much formal support after treatment finished. No real support by my own GP?"

"Even after 12 years I still greatly value the support of lift up to help quell fears that still arise."

"Starting Over course at Halton Hospital.GP support"

"Breast care support group including therapies such as rekei/reflexology - really helpful."

GP

The GP was mentioned as being a helpful resource following treatment by 36 respondents:

"It's all been good. GP been excellent."

"GP support from my local GP practice."

"The consultants have been most reassuring, as my GP."

Other and miscellaneous

Other helpful resources for after treatment support were district nurses and Macmillan services, oncologists, radiology team and volunteer drivers:

"District nurse made regular visits and checked on drains. Macmillan nurse community centre - Scarisbrick Avenue was helpful to go and talk about experience."

Volunteer drivers for transport to Clatterbridge/radiotherapy invaluable."

Members of the In-Trust transgender support group commented:

"GPs supportive of transgender population makes all the difference to mental and physical health and wellbeing. Less traditional typed of aftercare such as art therapy sessions provided by Big Sista Love which are held in the community."

Just 8 respondents (1%) did not know about the availability of or how to access after treatment support.

4.1.6. Do you have any other comments about local breast care services?

The main themes emerging in the responses to this question were:
- to keep the service local for emotional and practical reasons
- the need for other supporting, complementary services
- the importance of continuity
- concerns around the lack of information
- suggestions for improvement

Specific examples of the above themes are as follows:

A local service

"Keep it local for patients who are unable to travel, breast care is an important service for women which is better closer to home."

"Don't want to go to Liverpool, getting there is a problem especially when you're unwell. It is difficult enough time, but if you've faith and know the people who are treating you it helps."

"Appreciate not having some specialist staff is a problem and therefore the acute elements of the service may have to be provided elsewhere, but as breast cancer is such a common condition, it's a shame not to have the 'outpatient' elements kept locally. Especially as numerous visits to clinic are required, some people do not have access to cars for easy transport to other non-local hospitals at such a stressful time."

"Patients have enough worry and anxiety when attending the breast service and moving it further afield just puts added stress and anxiety that is not needed when there is a perfect local service."

"I am concerned at how far any patients will have to travel for treatment given that Ormskirk & Southport won't have a service. My experience was one of ten months filled with appts across three hospitals, I was incredibly tired, so weary, I used hospital transport and sometimes friends took me, despite a generally excellent service, the parts that let it down to me seemed so avoidable, down to poor admin, breakdown in communication, depts out of touch with each other etc."

"I have been extremely impressed with all the local services provided by Southport and Ormskirk hospital. The access to local hospitals means that there is not the added stress of a long journey at what is a very difficult time. I would like to see this local service retained. I travelled to Aintree for radiotherapy but this was a short term, time-limited activity and I prefer to have a local continuity of care."

"It's atrocious that the service could be going as far afield as Aintree. This would be very difficult. I have a young family, if you are going to be introducing extra travel it will make it very difficult. I've still got to meet my

family's needs. It will be harder for my mum who is going to be moving into this area - the train from Burscough to Ormskirk and then onto wherever. The train from Burscough to Ormskirk is only every hour and 45 minutes. The hospital destinations are not near. Southport and Ormskirk Hospital Trust is friendlier and more personal. If you are transferred into a massive service are you going to have the same personal experience, especially for something that is so life changing for the patient and their family? It's difficult to make a choice when local provision is not available. If people start to use more Patient Transport Service to get further away, The Patient Transport Service are already in demand but this will increase demand."

"If you've got a long way to travel and then get bad news, it will be very difficult to get back home."

"People will need more time off work with increased travel, not all employers would allow this, so they could postpone their appointments or it could lead to Did Not Attends."

"It's wrong what has happened with the breast care services and its move to Preston, Liverpool, Wigan, Whiston etc. It's detrimental to patients. Vascular services have been consolidated so that major surgery takes place at a Liverpool hospital but all your investigations, specialist nurses, consultations etc. take place locally, this model makes services more accessible."

"We've been told the service is closing 31st March - I can't understand why they are closing it. Cancer is not uncommon. 1 in 3 women are affected by breast cancer therefore there should be full services in all local hospitals. As I have a physical disability I needed the Patient Transport Service to get to radiotherapy - the Patient Transport Service have rickety old vehicles which cause a lot of pain due to my muscle problem. The Patient Transport Service is a good service and amazing if you just needed to use it once a month but every day for three months was horrendous. At one point during radiotherapy I was thinking of giving up due to the additional pain. Requesting a car via the Patient Transport Service was very stressful. I had a reoccurrence of cancer and I've just had a scare, I found a lump. If I had to go to Wigan or Liverpool this would be too much of a trek for me. I have no family in the area. Transport is a problem. The care from the breast service is faultless. It's disgraceful that it is being closed down. I've petitioned my MP John Pugh. We've got to have local services. It really upsets me that if I have another scare I might have to go to Wigan, I can't bear the thought of Patient Transport Service due to the discomfort and the follow up as well. The follow up can be for five years."

"Elderly people, amongst others, will not be able to travel easily. This could result in an increase in the number of Patient Transport Service bookings and a corresponding increase in cost. Also a lot won't go if services are moved. People may decide not to come thinking "that's my lot". It's very off putting the thought of more travel. If you are an inpatient you need visitors, but extra travel and fuel may reduce the number of visitors. Will the so called "super centres" be able to cope with the extra numbers? Will people get the time and attention that is needed? They may have to take time off work too to accommodate the extra travel time."

"Why do people have to travel to Liverpool - this incurs cost and time at a time when you are vulnerable?"

"My niece has just had to travel to Liverpool at age 18 to be seen for breast screening. This was very traumatic for her as again she felt communication was poor. Staff need to be reminded that not everyone is able to ask the correct questions or are even aware of questions to ask. The need for kindness is paramount."

"I am saddened and disgusted by the closure of this excellent service in my local community. I could understand if the service was deemed "not fit for purpose" but I have not heard a bad word about the breast care services in either Southport or Ormskirk. I worry about the travelling distance for new patients, in particular elderly women, having to go to Aintree, The Royal Liverpool, Wigan or St Helens if they do not drive or have somebody to drive them there. I am not aware if there is a direct public transport facility to these hospitals. Also, I am amazed that in this day and age of high technology why was digital x-rays with another local hospital not put in place in the interim period until a consultant radiologist had been appointed? Another point that concerns me, should a public consultation period on the closure of this service, been put in place?"

"Initially I was receiving appointments for different clinics at different hospitals on the same day, meaning that some would have to be rearranged. A local service, "one stop shop" would have been far easier to deal with and I am sure would result in less wasted appointments where people do not attend due to clashes with appointments at other hospitals which are some distance away."

"The population of West Lancs is big enough to have its own breast care service."

"Follow up clinics must still be offered at Ormskirk Hospital. Breast care nurses must still be based at Ormskirk. Diagnosis clinics could still be offered at Ormskirk with support from another local unit eg Whiston Hospital."

"To be kept in Southport- difficult to fit appointments in around work commitments. (Family History Patient)"

"I've attended Aintree and find the treatment at Ormskirk a lot more personal. At Aintree I felt like a number on a conveyor belt. It was also more difficult to get there I don't drive and had to get someone to take me and parking is difficult. Even the consultant didn't seem to have enough time for you."

"People who don't drive will have difficulties there are limited bus services in most of the rural areas and it is even worse if you're feeling poorly"

"It would be most helpful to patients to have the breast services "local" no excuses about difficulty recruiting specialist/Radiographer. A lot of people find that excuse hard to believe. The NHS is said to be for patients, not bonuses. It has been decided that other hospitals will be used for diagnosis, i.e. Aintree hospital, if some form of transport were available it would soften the blow, especially for those without private transport."

Other supporting/complementary services:

"I have concerns about the future of the bra service. Now, I go to Southport Hospital. I knock on the breast care nurses' room, don't need an appointment, say I've brought my bras to have a pocket sewn in and leave my details. The altered bras are posted back to me. What's going to happen with this service in the future? This service isn't available at Wigan. My friend is given pockets to sew herself. Now the safety net has gone if the service is not running anymore."

"If the breast-care nurses are not going to be here after March where do we get a prosthesis from when they burst? Who will be the point of contact for patients?"

"I'm concerned about the Prosthesis service were will this be I would have difficulty traveling to Aintree and am concerned about possible waiting times there"

"Regular screening is important, especially when you have had experience of breast cancer. Southport calls us for mammogram and X-ray in between appointments. That will stop. It's now self-referral. I was discharged today so advised to ring Houghton St regarding screening, the next appointment is 2018 - I would prefer annual screening for peace of mind."

"Hopefully aftercare will be able to be local and that the service of the complementary massage therapies will be continued. To have help to reduce stress and tension is in this way is most important. The breast care nurse role is vital, as she knows her patients very well. Breast cancer is very emotive and it is important not to feel on a treadmill as a number rather than an individual. Please don't lose the knowledge and skills of the local breast care nurse, one has already left."

"The small local caring setting at Ormskirk and Southport is vital to BC Services. The range of support services provided, groups and particularly 'pink pamper days' at Hurleston Hall (arranged by BC Nurses, Sarah, Trish and Janet) provided a unique sharing and support experience. This involved a social gathering of about 100 bodies who were treated free of charge to a lovely buffet, manicures, foot massages, Reiki treatment, etc. A very personal touch. Just a measure of the extra mile this BC service has provided."

"I think there is a need for support for families this could be through voluntary organisations it would also be good if we could have complimentary therapies at Southport."

"The vital support of a local breast cancer nurse is being removed. In the community she can quickly answer questions/give advice over the phone/direct who you need to see/provide new prosthesis etc. I think this is a HUGE loss. Also communication from different hospitals to district nurses about new patients and differences in care need thinking about."

The importance of continuity

"How many times can you flash your boobs to new people? Part of my breast is missing. I feel very uncomfortable when there are new people there in clinic. It's the psychological effect as well as the physical ones, for years after the surgery I felt uncomfortable about going out and did people know? The radiotherapy alters the appearance of the breast too. If you go to one of these super centres will you see the same surgeon for all appointments?"

"It's a good service. I want it to be kept here. I've received really good care. I don't want to go anywhere else. I worry about longer waiting times if using Trusts in another area as they've already got their patients, there will be more people on the waiting list and things could get missed due to the increase in volume of patients."

"As a patient at the end of my treatment (5yrs) I was told that I would now go onto routine checks every 3 years I feel this is too long to go and am concerned something would be missed. Feel it would be better if we had a phone number we could ring or a drop in surgery"

"I am worried that I will not get good after care. I am on tamoxifen for possibly 10 years but if staff are made redundant due to no new patients, I will not get the support that I might need. I am not in favour of phoning a number for anything or discussing personal information with a stranger so the one to one support and discussions from all staff (consultant and nurse) is important."

Concerns around the lack of information:

"Today I have been to see my Oncologist at S/port Hosp; and to my horror I have been told by my Oncologist that he will NOT be seeing me again. He was unsure whether I would be seeing ANY OTHER ONCOLOGIST in the future. Now that is, for me and I suggest many other Cancer sufferers, very, very bad news. Having undergone a full Mastectomy and subsequently diagnosed with secondary cancer of the Femur I was lead to believe that I would be seeing an Oncologist at regular six monthly intervals. Knowing this has been very important to me mentally as I battle with this dreadful disease. To have this service taken away is almost as deflating as being diagnosed with the disease. Not only is it the knowledge that you will be seeing a Specialist that helps you to be positive it is the help and medication that goes with each consultation."

"Having brought my concerns to the meeting with trust CEO and co, I was advised that J Parry would write to me regarding prosthetics, his reply said I would be put in touch with the breast care nurses. I spoke to my breast care nurse who wasn't able to shine any light on the problem. I feel that the CEO has not considered the effect this closure is having on patients, past and present. I feel that those of us who are just completing our treatment and follow up are being left out of the information loop."

"I will be extremely sorry to lose this wonderful service, after re-assurances at a public meeting in December by Jonathan Parry that he would do his best to ensure follow-ups etc. stay in Southport and yet only a month later I hear we are to lose these at the end of March too. Once again this appears to have

been decided behind closed doors, as there is no mention of it in the last Trust Board Minutes for December I accessed on line! I spoke to my Breast care nurse last week, who confirmed that we would lose the rest of the service at end of March 2015! She has not been informed what provision will be made for follow up appointments etc. so I am now unclear where or when I shall be followed up. My next appointment with the Oncologist is due in mid-March, I hope this will take place at Ormskirk Hospital as planned."

"Concerned that if any patient should have concerns reoccurrence etc who do we go to? I feel we've been abandoned."

"I believe that the support I get from the breast care nurse is to be discontinued from the end of March ?? Firstly this is disgusting as I will no longer have any support person to turn to. Secondly were am I to get my prosthesis from I didn't ask for cancer to strike me & to have my breast removed so why should I & many other people suffer , so answers would be grateful or are we to find out about another service to be lost via the newspaper!!!!"

"Would like to know where I am likely to be sent now to see the doctors."

"This confusion about Ormskirk hospital we the patients are in the dark and don't know how things are going to be. Please keep me informed. Don't Desert Ormskirk. Very confused about what future holds. Appointment etc. April appointment at Ormskirk with regular consultant, I will still go and hope to be seen."

"I have been a patient since 2008, lately I have found things quite distressing as first my breast nurse left, now I have been told my oncologist is going these are people who have cared for me for seven years, however when I ask what the future holds no one seems to be able to answer the question. I feel the trust is waiting for all us long term patients to ask for another trust, so it does not reflect badly on them as if they have forced us out. At the moment there is no continuity of care we are seeing different doctors and have no idea how long these will be around for. We trust these oncologists with our lives and I feel it takes time to build this trust which is never going to happen when we are getting passed from person to person."

"It isn't what you had to do it was the way it was done - it was ill-planned and ill-judged. You treated the medical staff shamefully. Why has no-one's head rolled? You had a great service and now the patients undergoing treatment don't know what is going on. You talk about choices - have any of them had a personal letter asking them where they would like to go?"

"The whole process of closing the service to new patients at Ormskirk, has a questionable timescale and communication systems in place to inform the population are flawed. The breast care services leaflet is full of incorrect and misleading information, this must be addressed and an apology and correct information published in the Ormskirk Advertiser and local Champion newspaper. Only then can it be stated that local consultation taken place."

"They need to be retained at Southport & Ormskirk however this does not appear to be the case and without any consultation with the public."

Suggestions for improvement:

"There may be a national shortage of specialist radiographers but the laws of supply and demand would say that if you offer an excellent remuneration package you will attract high calibre, suitable applicants. I have raised £2000 this year for Clatterbridge Cancer care. I am one individual who isn't even firing on all cylinders due to my own Cancer treatment. If I had been given the chance I could have easily raised this amount towards the cost of a specialist radiographer and I am sure there are plenty more current or past patients who feel the same."

"How do the travelling clinics work? Is that not an option?"

"Needs to be more disabled friendly, particularly Learning Disabilities."

"Would like more advice on healthy lifestyle, fitness."

"If you would like some training on Lesbian, Gay, Bisexual and Transgender issues, please get in touch. There are quite a lot of available resources."

"Transgender education programme required for all NHS employees, particularly GPs and Clinicians."

"Should investigate more about alternative medicines I used Chinese medicine to help me with the side effects of the Chemo it really helped."

"We need a satellite breast clinic run from the centre of excellence with experienced up to date breast nurses , this is a paramount need."

"It's a vital service, especially to those over the age of 50, which MUST be kept local, even if this is only by providing Satellite clinics!!"

"Would prefer local diagnostics on site adopting a 1 stop shop approach with service coordinated via one organisation."

"I believe that the mobile breast scanning unit should be made accessible to women less mobile."

"Improvements are required to the Ambulance travel service which is essential to elderly patients and to anyone with other health or painful problems."

"District nurses could be more helpful after discharge, the hospital nurse said the district nurse would remove my drains when they were ready to come out, but they refused, so I had to go back to hospital to have them removed."

"We need LESS managers and executives and MORE clinical staff."

4.2 Profile of survey respondents

A detailed demographic breakdown of the survey respondents is found in Appendix C.

The data is reflective of the reach of the engagement and also the targeted engagement as recommended by the initial equality analysis.

4.3 Meeting and event feedback

During the course of the engagement, the CCGs attended 26 meetings/events and engaged with 627 people. They also attended 9 breast care clinics and spoke to 69 follow-up and family history patients.

Overall, the feedback reflected the themes as outlined in Section 3.1 of this report (Survey Response), but as with the survey responses, these differed across stakeholder groups. Examples of these differences are as follows:

- Breast Care Support Groups included a high number of current follow-up patients who praised the care they had received at Southport and Ormskirk Hospital, expressed concerns about the future of their individual care and the lack of communication they had received in this regard, the importance of continuity of care and clinicians, and the support provided by the breast care nurses.
- Family history patient clinics praised the convenience and accessibility of the local service as especially as this enabled them to fit appointments in around work and family commitments.
- Older People Forums were concerned with travel and transport, ease of access, support/advocacy at appointments and valued the friendliness of a smaller hospital setting.
- Disability groups/migrant worker groups also were very concerned about travel and public transport, the availability of information in various formats and interpreters.
- Lesbian, Gay, Bisexual and Transgender groups expressed concerns about the accuracy of medical records and patient history and the impact on appropriate/inappropriate screening referrals; lack of education and the need for more innovative forms of aftercare support (one size does not fit all).

A full list of the engagement events and their related themes are included in Appendix A.

4.4 Patient Experience Team

The Patient Experience Team received 87 enquiries ranging from people booking onto public meetings, callers wishing to log their comments on the service changes, people wanting to complete surveys over the telephone and general enquiries regarding the engagement. This feedback has been captured in the overall analysis.

4.5 Website comments

NHS Southport and Formby CCG's website received 5 extensive comments from patients of the service expressing the excellent treatment they had received at Southport and Ormskirk Hospital and their upset at the sudden change to the service and impact on the continuity of their care. All comments

praised the professionalism and support of the staff, particularly the breast care nurses.

4.6 Petition

Initiated by the West Lancashire Councilor, Elizabeth Savage over a thousand people signed an online petition to Southport and Ormskirk Hospital asking that the trust: *"continues to recruit a radiologist for the Breast Care Services to prevent closure to this important unit at the Trust".*

Each person signing the publically available online petition was asked if they wished to give their reasons for signing. Below is a resume of the main themes, which also reflect the engagement outcomes:

- **Travel and Transport:** concerns were expressed that the stress and tiredness of patients having to travel longer distances when feeling unwell was unacceptable, causing greater psychological impact. Cost implications were a concern, especially for those on low incomes and with no family support. A forty mile round trip to alternative providers was seen as an issue, particularly for those in more rural parts of the borough and for those using what was termed a "difficult" public transport system. Juggling work and caring commitments was also mentioned by patients and carers when travelling increased distances.
- **Local Service:** people said this was a vital, much needed service that they didn't want to lose. Many commented on the excellent quality of the service that they had received at Southport and Ormskirk. There were concerns that services in Southport across the board were being reduced and that this closure was linked to cost savings.
- **Lack of consultation**: complaints were voiced that there was a lack of consultation when the hospital knew it was having difficulty recruiting and that patient choice had been removed. Concerns were expressed that the changes would put a strain on other hospitals.
- **Breast care nurses:** the level of support provided by the nurses was greatly appreciated and valued, particularly in helping patients to cope during a difficult time. Concerns were raised that support groups would fold if breast nurses were re-deployed.

4.7 Equality Analysis

Following the completion of the engagement, a full Equality Analysis was undertaken by the Equality and Diversity lead and can be found in Appendix 2.

The key issues and recommendations of the analysis are as follows:

- **Travel and transport**: consider the views and experiences of patients in relation to travel, as identified in the Equality Assessment and which responds to the report's recommendations
- **Provision of local service**: provide access to elements of the breast care service in the Southport and West Lancashire areas

- **Accessibility**: ensure access to treatments for new patients are cognisant of patient need and develop reasonable adjustments, particularly for the frail elderly and disabled
- **Continuity of care**: to be addressed for existing patients as soon as possible and details/arrangements fully communicated to patients and providers
- **Communication and engagement:** a comprehensive engagement feedback and communications plan is required to ensure that all stakeholders are fully briefed on decisions and changes; target minority groups as listed and consider providing information in different formats and languages; engage with local CVS and minority group networks in communications.
- **Support services/groups:** ensure that these continue to be available in local community and are suitably resourced
- **Public Sector Equality Duty (PSED) requirements:** ensure staff are fully trained to deal with different ethnicity, sexuality and transgendered patients and that providers can demonstrate their compliance with PSED. As part of their Public Sector Equality Duties, the CCGs are required to address the key analysis recommendations.

4.8 Other considerations

The following issues arose during the course of the engagement, presenting some challenges and barriers to the progress and aims of the engagement:

- **Communication with patients** – follow-up patients expressed concerns about the lack of communication from Southport and Ormskirk Hospital around the initial closure of the service to new patients, and many were anxious about the trust's ongoing lack of communication regarding the future of their care.
- **Reasons for closure of the service** – scepticism was expressed regarding the reason for the sudden changes to the service with some people believing that it was a cost-saving exercise and/or that a specialist radiologist was a temporary problem which could be addressed.
- **Patient perception of service** – since the closure of the service to new patients, some patients perceived the service remaining at Southport and Ormskirk Hospital as second rate.
- **Engagement information and materials** – some people felt that the engagement materials implied that the quality of the original breast care service at Southport and Ormskirk Hospital was questionable; a few people commented on the complexity of the information leaflet and pathway diagrams and that, in part, these were difficult to understand.

  These issues were expressed by individuals and groups and were captured in meeting feedback, survey responses, petition comments etc. The majority of these issues were addressed with the individuals and groups throughout our engagement activities and where appropriate, feedback to service providers

5. CONCLUSION

The aims of this engagement programme were to inform local patients, carers and the wider local community of the changes to local breast care services, explain why these have come about and to hear people's views and experiences of breast care services to help inform how these services might be provided in the future.

A variety of communication and engagement methods were used in order to reach as many people and be as inclusive as possible.

The aim of the engagement was to help the CCGs understand what matters most to patients about breast care services and to help shape future services. However, respondents also used the opportunity to share their disappointment and frustration around the sudden closure of the service at Southport and Ormskirk Hospital NHS Trust to new patients. They were also felt there was a lack of certainty about their future care - who it would be delivered by and where it would be provided from.

The vast majority of people who gave their views as part of this exercise had very positive experiences, no matter which hospital they had received care from. There was an overwhelming sense of gratitude, importance and passion when views were shared by both former and current patients of all breast care services and their carers.

The themes that emerged from the findings are that people want local service provision in the Southport, Formby and West Lancashire areas that offers at least follow up support and care, and ideally a complete service. There was some acceptance that certain services could not be delivered from the Southport and Ormskirk hospital sites but participants would certainly like to access the breast care nurses, prosthesis service, bra fitting service, support groups, review appointments, family history clinics, and mammography appointments locally.

Associated with the need for a local service were the perceived travel problems if services were to be provided out of the local area. This was from both a practical point of view in terms of the cost, extra time it would take, time needed off work and experiencing difficulties with public transport, and also from an emotional aspect in terms of having further to travel when already feeling tired, unwell or if receiving bad news, and having to also factor in carers'/family responsibilities. The Equality Analysis report makes recommendations for consideration around transport issues to mitigate the difficulties experienced. See Appendix 2.

The majority of responses – a high number of which were Southport and Ormskirk patients - spoke very highly of the support of their breast care nurses. In particular, they highlighted the personal nature of the service, the level of support and information that is provided and the accessibility of the service. People really valued being able to phone the breast care nurses and have a single point of contact. Participants also identified continuity of care and team working as being a real positive when undergoing treatment. They valued their relationships with the team and the relationships the team had with other health professionals/departments.

Speed of referral into the service and then to access to diagnostics and treatment was important to participants, and participants highlighted the "one stop shop" model to minimise the wait for results.

Participants requested better communication and information. Consistent messages are needed across the healthcare economy. From the survey responses 200 people

provided their contact details to be kept informed of future developments of local breast services. This resource will be an additional way to communicate plans going forward. Suggestions for ways to be more involved have also been received from LGBT and migrant groups.

This extensive communications and engagement programme has resulted in over 3,750 contacts and generated thousands of comments relating to the local population's thoughts on and experiences of local breast care services. It is recommended that this insight is considered and used to shape future breast care services. A further piece of communications and engagement work will be needed to inform people of how the future models of care will look and how their feedback has been used to arrive and these, and to also explain where it has not been possible to incorporate suggestions and why.

6. APPENDICES

Appendix A

Timetable of public meetings/events/clinics and feedback

(**Those meetings highlighted in yellow were open to the public and places on these events were bookable via the CSU Patient Experience Team**)

Event details (for both CCG areas in date order)	**Feedback: main themes**
Wednesday 19 Nov – Southport and Formby CCG Big Chat, Royal Clifton Hotel, Southport	• Service update • Plans for engagement
Wednesday 14 Jan – Aintree staff briefing 12 noon Aintree Hospital	• Increase in number of new patient referrals • Distance and travel for patients from Southport and Formby/West Lancashire CCG areas
Thursday 15 Jan – staff briefing 4.30pm onwards Ormskirk Hospital	• Unhappy with the wording of the leaflet, feel it reads as if there are no current benefits to the services at SOHT. • Felt that by removing service from SOHT working relationships would be lost - trying to keep cohesiveness of teams across different sites could be problematic and could result in communication problems. • Suggested the following services could be kept on site: pre-op teaching and information, ongoing support, prosthetic clinic, local support groups, post op wound checks, seroma management, post treatment holistic needs assessment. • Patients very worried due to not knowing when and where they will be seen next. • Lack of consultation with staff around the future of the service.
Tuesday 27 Jan – SPAC forum (Maghull) 1.30 - 3.30pm St Andrew's Church Hall, 22 Damfield Lane, L31 6DD	• Value of screening service and accessibility • Access to screening for over 70s • Importance of support attending hospital appts
Tuesday 27 Jan – Migrant worker group 6pm – 8pm Parenting 2000, Mornington Road, Southport PR9 0TS	• Transport and distance • Understanding the changes to service/clinical benefits • Availability of information in other languages • Availability of interpreters during

	treatment
Wednesday 28 Jan - SPAC Forum (Southport) 1.30 – 3.30pm Lord Street West Church, PR8 2BH	• Availability of screening • Access to alternative hospitals by public transport • Continuing role of breast care nurses.
Wednesday 28 Jan - Aintree Breast Cancer Support group 6pm – 8pm Marina Dalglish Centre, Aintree hospital	• Future of Southport and Ormskirk services • Lack of co-ordination and information sharing between different aspects of service
Thursday 29 Jan – In Stitch 10 – 12noon Macmillan Cancer Support Centre, 23-35 Scarisbrick Avenue (off Lord Street), Southport PR8 1NW	• Communication with f/up patients • Service now perceived by patients as 2nd rate and fragmented • Importance of relationship with/support provided by breast care nurses • Travel issues for older patients • Some patients prepared to travel for a 'better' service • Importance of environment in helping to relieve anxiety (Aintree does this very well)
Friday 30 Jan – Firm Roots 1.30pm – 3pm St John's Church Hall, School Lance, Burscough	• Questions around future provision of services and issues around lack of communication concerning the changes only information most participants had was hearsay. • If follow up clinics were held on other sites it may lead to more non attendances because of the difficulty getting there. It's a lot easier to get to Ormskirk so patients are more likely to turn up. • Unhappy when having to travel between sites as part of treatment process e.g. patient was injected with a dye at the hospital she attended and then told she had to get herself to Wigan Hospital for the next part of her treatment.
Wednesday 4 Feb – Migrant worker support group 3pm – 4.30pm Holy Trinity School, Southport	• Attendees unsure of women's health services in the area - a leaflet outlining these or something on line would be useful. • One attendee described how in Poland ladies are routinely called for health checks even if there are no known symptoms or family history. There was a delay in this lady's referral reaching the hospital. The lady had been unsure though how long these things normally took.

	• Surveys and information taken away by attendees and left at the school too.
Thursday 5 Feb – Health and Social Care Forum, 10 – 12 noon, Netherton Feelgood Factory	• Information on engagement and how to get involved
Thursday 5 Feb - Ormskirk Support Group 7pm – 9pm Ormskirk Hospital Out Patients department	• Uncertainty of their future follow up appointments • Emotional distress • Conflicting messages from trust and consultants themselves e.g. oncology • Not all patients had received letter from trust announcing engagement • Concerns over patients managing to cope change of teams/service • Value locally based team even if have to travel further for some treatment • Liked consistency of getting to know local nurses who support throughout journey • Concerns over transport • Overwhelming support for existing service at S&O • Lack of understanding why trust not engaged
Saturday 7 Feb – In Trust transgender group 3pm – 5pm Waterloo Community Centre, St Georges Road Waterloo	• Health records that do not record background and transition • Transgender individuals being incorrectly called for screening or falling out of the system • Unsupportive and uninformed clinicians – training requirement • Tailored /innovative aftercare and support groups required
Monday 9 Feb – Sefton Cancer Support Group 10.30 – 12.30 1 Duke Street, Formby, Merseyside L37 4AL	• Continuity of care for current follow up patients • Poor communication with current patients and related anxiety • Importance of other cancer care consultations to inform development of service • Importance of empowerment to make decisions on care choices. • Scepticism re. inability to recruit radiologist • Importance of support groups in "recovery package"
Tuesday 10 Feb Big Sista Love, 3 - 5pm	• Support offered to patients should be varied and less "traditional",

Hanover Street, Liverpool	particularly valued by LGTBI community.
Tuesday 10 Feb SAFE event (Sexual Awareness For Everyone), Edge Hill University	• Information and surveys taken to event
Thursday 12 Feb – Sefton Equalities Partnership 5 – 6pm, CVS, Burlington House, Crosby	• Satisfied that engagement was inclusive • Further support offered with engagement
Thursday 12 Feb –Lift-up Cancer Support Group, 7 – 9pm Lakeside Christian Centre, Fairway, Southport, PR9 0LA	• Continuity of care for follow up patients • Improved communications for follow up patients • Transport - cost / difficulty of getting to alternative providers • Scepticism re. inability to recruit a radiologist • Importance of communication for joined up after care • Importance of relationship with/support provided by breast care nurses • Accountability of Southport and Ormskirk Trust and lack of representation at meeting
Tuesday 17 Feb – SPAC Forum (Formby) 1.30 – 3pm Formby Methodist Church, Elbow Lane, L37 4AF	• Positive comments about quality of service at Southport and Ormskirk and other hospitals • Importance of support at appointments, either family, friends or advocate – providers should welcome and encourage • Transport • Poor communication between hospital and patients
Tuesday 17 Feb – West Lancs Pensioners Forum community centre at The Galleries, St Helen's Road, Ormskirk	• Changes to the breast care services were discussed as part of a wider presentation to the group • Surveys and information were given to the group to complete
Wednesday 18 Feb - West Lancs CVS Health Network Event	• Information and surveys taken to event
Friday 20 Feb – Skelmersdale library 10am – 12pm	• Issues with mobile screening - turned away from scheduled appointment twice due to machine not working due to a replacement part being needed - not contacted beforehand. • Parking at Wrightington not good, neither is public transport to get there. • Positives of current service: speed, manner, one stop shop, work as a

	team. Quality of support extended to relatives too e.g. support for husband • Marina Dalglish centre - radiotherapy - marvelous • Volunteer driver - amazing service • Suggested improvement: can be waiting too long between surgery and radiotherapy • Leaflet could be misleading in that it may imply that one stop clinics do not happen at Ormskirk and that SOHT do not have modern up to date services
24 Feb - Sarah's Stars Breast Cancer Support Group, 7 – 9pm, The Olive Tree, Community Centre, Penketh	Feedback recorded on surveys
25 Feb – Ability Group (disabilities network) 10-12noon Sing Plus Litherland	• Travel and transport - difficulties using public transport and distance from bus/train to hospitals • Communications between hospitals • Accessibility - some old buildings have poor access • Confusing signage and information - needs to be in accessible formats e.g; audio appointment letters for the visually impaired • Health passports are good • Allowing support dogs to attend appointments • Advocacy • Continuity/joined up care for those with multiple conditions.
25 Feb – Southport Rest Home (for Jewish community) 3-4pm Albert Road Southport	• Travel and transport - residents unable to use public transport and travel time/distance magnified for those with long term conditions • Costs - most would require the support of a paid care to attend appointments • Preference for smaller, friendlier hospitals • Difficulties in hearing and understanding what is being said by clinicians
28 Feb - NHS West Lancashire CCG's Burscough Listening Event	• Information and surveys taken to event

Timetable of clinics and feedback (existing patients only)

Clinics (for both CCGs in date order)	**Feedback: main themes**
Friday 23 Jan – Ormskirk Hospital Outpatients AM Ormskirk Hospital	Comments recorded on surveys but main themes were • Concerns around the future of the existing service bra fitting, prosthesis service, breast care nurses etc • Increased travel if service moved
Friday 23 Jan –Family History Outpatients PM Ormskirk Hospital	Comments recorded on surveys • People may FTA if service moved further away
Monday 26 Jan – Ormskirk Hospital Outpatients AM Ormskirk Hospital	Comments recorded on surveys but main themes were: • Putting more stress on families/workers by increasing travel at an already very stressful time • A local service is needed
Monday, 2 Feb – Ormskirk Hospital Outpatients AM Ormskirk Hospital	• Limited feedback • Comments re. late running of clinic and increased waiting times • Information requested in Romanian
Tuesday, 10 Feb – Ormskirk Hospital Outpatients AM Ormskirk Hospital	• Lack of continuity/poor communication in transition to a new service - unsettling • Lack of choice of alternative provider • Importance of a named breast care nurse for support • Like the intimacy of a small service/hospital
Wednesday 11 Feb – Mammography clinic, Ormskirk hospital	• Need for a local service that offers a variety of support
Thursday 12 Feb – Mammography clinic, Ormskirk Hospital	• Receiving a holistic service – not treating just the breast cancer but taking into account long term conditions too.
Friday, 13 Feb – Family History Outpatients PM Southport Hospital	• Positive comments on the efficiency, friendliness, supportive and discreet nature of the service • Local and easy to access for those with work and family commitments
Wednesday 18 Feb – Mammography clinic, Ormskirk Hospital	• Concerns over increased travel if services moved • Need for local service

Appendix B

Breast care services engagement stakeholders

West Lancashire

West Lancashire Age UK
Age UK's Older and Out
Aughton Community Together
Boiler Room
Burscough Older People's Club
Central and West Lancashire Carers
Corum (Supporting Young parents)
Families and babies team
Firm Roots
Homestart Lancashire
Lancashire LGBT
Liverpool Road Hall Community Centre
"My View" – NHS West Lancashire CCG's membership scheme
North West Breast Cancer Telephone Buddies
Ormskirk Community Partnership
Ormskirk Support Group
Parent Carer Network West Lancashire
Parkinson's Disease Society
Quarry Bank Community Association
SAFE,(Sexual Awareness for Everyone) Edge Hill University
Skelmersdale Writers Group
South Lancashire Disability Partnership
Southport Mums in the know
Aughton & Ormskirk U3A
Burscough & District U3A
Parbold, Newburgh & District U3A
Southport Alzheimer's team
West Lancashire Borough Council
West Lancashire CVS
West Lancashire CVS Health MNetwork
West Lancashire Disability Helpline
West Lancashire Multiple Sclerosis Society
West Lancashire Pensioners Forum

Southport and Formby

Ability Group
Age Concern
Aintree Breast Cancer Support Group
Aintree University Hospital NHS Foundation Trust
Big Sista Love
Chinese Carers Network
Embrace (Sefton)
EPEG
Health and Social Care Forum
HealthWatch Sefton
In Stitch Support group
In Trust
Jewish Community Care
Lift Up Cancer Support group
Macmillan Cancer Support
Migrant Worker Group
Migrant Worker Group (ESOL)
Public Health Sefton
Sarahs Stars Breast Cancer Support group
Sefton Cancer Support
Sefton Carers Centre
Sefton Consultation and Engagement Panel
Sefton Council
Sefton CVS
Sefton Disability Network
Sefton Equalities Partnership
Sefton Pensioners Advocacy Centre
Southport and Ormskirk Hospital NHS trust
Southport Rest Home

Appendix C

Breast Care Services engagement feedback report

Diversity and Equality monitoring data

What is your age?

	Response Percent	Response Count
16 or under	0%	0
17 - 25	2%	5
26 - 35	3%	9
36 - 45	13%	44
46 - 55	27%	88
56 - 65	22%	72
66 - 75	19%	64
Over 75	14%	46
Prefer not to say	1%	2
answered question	330	330

How would you describe your gender?

	Response Percent	Response Count
Male	5%	17
Female	95%	309
answered question	326	326

Is this the same gender you were born with?

	Response Percent	Response Count
Yes	96%	315
No	2%	6
Prefer not to say	2%	6
answered question	327	327

Which area do you live in?

	Response Percent	Response Count
Southport and Formby	46%	154
West Lancashire	41%	136
Somewhere else, please state	13%	43

Of the 43 respondents who answered that they lived somewhere else, the breakdown of locations is as follows:

Maghull	9
Sefton	3
Lancs	3
Wigan	2
Liverpool	2
Berkshire	1
Blackburn	1
Bootle	1
Chorley	1
Halton	1
Knowsley	1
Lydiate	1
Manchester	1
Netherton	1
St. Helens	1
Wigan	1
Wirral	1
Warrington	0
Not stated	12
Total	43

Are you a carer?

	Response Percent	Response Count
Yes	11%	34
No	89%	284
answered question	318	318

Do you have a long term condition that affects your day to day activity?

	Response Percent	Response Count
Yes	26%	80
No	74%	228
answered question	308	308

What is your ethnic group/background?

	Response Percent	Response Count
White British	92.9%	302
White East European	2.5%	8
White Other	2.5%	8
White Irish	0.6%	2
White/Black African	0.3%	1
Other ethnicity	0.3%	1
Gypsy/Roma/Traveller	0.0%	0
White/Black Caribbean	0.0%	0
White/Asian	0.0%	0
Mixed other	0.0%	0
Indian	0.0%	0
Pakistani	0.0%	0
Bangladeshi	0.0%	0
Black Caribbean	0.0%	0
Black African	0.0%	0
Chinese	0.0%	0
Prefer not to say	0.9%	3
Total		325

Please choose a category that best describes your level of disability

	Response Percent	Response Count
No disability	68%	182
Physical impairment	14%	38
Multiple impairments	6%	15
Hearing impairment	5%	12
Mental health	2%	5
Learning disability	1%	2
Wheelchair user	1%	2

Visual impairment	1%	2
Prefer not to say	3%	8
answered question	266	266

What is your religion/faith?

	Response Percent	Response Count
Christian (C Of E, Catholic, Protestant and all denominations)	80%	256
No religion/belief	13%	41
Other	3%	8
Sikh	0%	1
Hindu	0%	0
Jewish	0%	0
Muslim	0%	0
Prefer not to say	4%	13
answered question	319	319

What is your sexual orientation?

	Response Percent	Response Count
Heterosexual /straight (attracted to the opposite sex)	92.7%	292
Gay/Lesbian (attracted to the same sex)	1.6%	5
Bisexual (attracted to both sexes)	0.6%	2
Prefer not to say	5.1%	16
answered question	315	315

Equality Analysis Report
Breast Care Services, Southport and Ormskirk Hospital

Date: Opened EA (pre-assessment to aid engagement and communication activity) 25/11/14
Date: updated with commissioner and communication / engagement lead input-10/12/14
Date: EA amended to incorporate engagement activity – survey –3/3/15
Date: EA amended to incorporate equality target groups and meetings – 9/3/15
Date: Amended after discussion with Engagement and Patient Experience Group -12/3/15

Locality Development Manager (North Southport)

NHS Southport and Formby Clinical Commissioning Group (CCG)

Details of service / function

Change in location: Southport & Ormskirk Hospital has historically provided a range of breast care services to the local population (across Southport and Formby and West Lancashire CCGs areas). Due to the reasons outlined below the service was closed to new patients on 1 September 2014. Patients have always been able to choose the hospital where they receive breast care. Since the closure of Southport & Ormskirk Hospital's service the majority of new patients have chosen treatment at Aintree, Wigan the Royal Liverpool and Whiston hospitals.

Legitimate aim: The service at Southport & Ormskirk closed to new patients as it was unable to recruit a specialist breast radiologist in order to provide a safe service. The closure of Southport & Ormskirk's service does however present opportunities to improve the quality and consistency of the range of breast care services that local patients can choose from – by carrying out a clinical review of these services and ensuring that more effective services can be planned for the longer term, which are also informed by patient's views and experiences.

Evidence

Current data - Regarding age, sex and ethnicity was taken from the service annual report for 2012/14

Of the 174 patients diagnosed between April 2012 and March 2013,

171 were female and 3 (<2%) were male.

The breakdown of patient ages is as follows;

- 35-40 years old 5 patients 3 %

- 41-50 years old 31 patients 18%

- 51-60 years old 28 patients 16%

- 61-70 years old 30 patients 17%

- 71-80 years old 48 patients 27%

- 81-90 years old 27 patients 16%

- 91-99 years old 5 patients 3%

Ethnicity - 2 patients ethnic group 'A' - white British. There was 1 C (any other white) a 1 L (any other

Asian).

In order for Public Sector Equality Duty (PSED) to be met we will need to ensure that in the coming stages of developing the programme:

a) Identify in the proposal any inherent indirect discrimination

b) Identify any barriers or detriments connected to protected characteristics in transferring services

c) Ensure that all patients are suitably communicated with and that they understand what is being asked of them

What is changing?

New breast care patients can no longer choose to receive their treatment at Southport & Ormskirk Hospital. They must now choose from one of the other local breast care providers – such as Aintree, Wigan, Royal Liverpool or Whiston hospitals. All patients who previously chose to be referred to Southport & Ormskirk Hospital up until 1 September 2014 remain in the care of that hospital. The issues in relation to these changes and which the communication and engagement work looked at are as follows:

1. Patients and relevant communities knowing about the changes and providing their views on what future services should look like (survey and engagement with equality target groups and other interested parties, including interim providers)

2. Being able to comment on the change and these comments being taken in to consideration and linked to protected characteristics. (survey and engagement with equality target groups and other interested parties, including interim providers)

Several major issues have been identified by desk research and feedback from service users, interested parties and support groups feedback.

i) Existing S&O patients

- Potential extra travel for patients who need to continue on the breast services pathway
- anxiety about continuity of treatments
- timescales and clarity of message

ii) New patients from the Southport Formby and West Lancashire area

- Travel and transport
- Anxiety about the continuation of support available locally

- Timescales of review and clarity of message

iii)) wider public

Timescales of review and clarity of message:

Issue	Protected Characteristic particularly affected	Recommendations for CCGs to consider
Travel and transport: A clear message came from the engagement process that additional travel and the difficult public transport arrangements across the geography are significant worries for new patients.	(Female) Elder people; disability/carers, BME Southport has a significant elder population and data shows a high rate of older people using services – especially those in their late 60s, 70s & 80s. Any additional transport would be burdensome. However given that many express concern as they use public transport, then the lack of a location in Southport / Ormskirk may become a barrier. Disability: People with learning disability and physical disability would mean that the additional travel may be overly burdensome. For most disabilities cost is a concern as the extra travel would incur extra cost. Given that many disabled people are on a low fixed income this has a greater impact. Patients would have to use scant resources to pay for extra travel, which is more likely to be by taxi than public transport.	Consider: **a) A continuation of some elements of the service locally in Southport and West Lancashire areas.** b) Identify best travel routes from local area to alternate service provision - work with patients and patient support groups to determine support needs for transfer of patients. c) Give information to patients on travel arrangements as early as possible. d) Ensure information is given to different communities, consider providing information in different languages and formats. e) Targeted communications and engagement due to high proportion of Eastern Europeans and migrant workers and extended families When working with communities (c, d, e, above) ensure that local CVS and minority groups /

		partnerships are part of the process **Disease Prevalence** Commissioners to refer and consider Macmillan research and recommendations entitled Cancer Services Coming of Age: Learning from the Improving Cancer Treatment Assessment and Support for Older People Project
Continuity of service and anxiety about local provision :	Sex (female), age, disability, race, religious & belief, sexuality, transgender.	A) Ensure existing S&O patients and new patients are fully briefed on the new arrangements so they understand arrangements and key personnel and have key contact details. B) Ensure information is given to different communities, consider information in different languages and formats C) Ensure all provider staff are fully trained to deal with needs associated with different ethnicity and language, sexual orientation and transgendered patients and men. D) Information, advice and support services – such as those from Macmillan and other voluntary, community and faith groups - should be included in new pathways development.

		Evidence needs to be sought by service provider to demonstrate how they comply with these requirements.
Local support Services based in locality, including support services and support charities /community groups may lose coherence and support	Female/ age / disability (including carers)	Points listed in 'Travel' also apply. a) Incorporating information, advice and support services – such as Macmillan and other voluntary, community and faith groups – in any new pathways b) Devise strategy for positive aspects of the S &O service to inform the new pathway
Time scales and clarity of message: Concern was expressed as to 'when things will happen and who will do what'	Female	All service users need to understand exactly what is going to happen and have a clear voice on the process. a) Continue to engage service users to ensure their needs are understood and met. b) Ensure that they understand reasons: • Why current S&O unit is changing • What advantages this may present • How future service will meet their needs

Is this service specific to a protected characteristic?

Yes – high risk change. Public Sector Equality Duty is engaged and must be applied.

Public Sector Equality Duty:

Objective 1: Eliminate discrimination.

The changes to the service from Southport & Ormskirk Hospital does have an impact on all users from this area, but particularly elder women and people with a significant disability. Southport as a community has one of the highest female 'elder 'population (65+). West Lancashire has a growing elderly female population in line with nationally trends. Breast cancer services can reasonably be seen as treating a majority of female patients and as such the changes and reduction to such a service, from a community with a high rate of elder females, may be deemed to be in breach of **Section 19**[1] of the Equality Act 2010, in particular sections (1)&(2)(b)(C). However, the CCGs have a case for (2)(d) '***proportionate means of achieving a legitimate aim'***, if and only if they accept the following recommendations:

- Consider a continued service in Southport and the West Lancashire area in the very near future.
- Develop a full support package to counter any transport & travel issues for those already undergoing treatment.

Objective 2: Advance Equality of Opportunity

In developing the revised services, attention has to be given to informing and engaging with people as to and when change is likely to happen. Ensuring that the process is a smooth and supportive one and that all key parties understand exactly what is happening. The switch to a new team can be daunting for patients; all staff need to ensure that they can support individuals from different life styles, religions, ethnicity, sex and disability.

The service providers need to provide evidence that their staff are competent and can understand and can work with these equality dynamics.

Objective 3: Foster good relations

As part of the change programme, patients' needs to be fully informed. This may need to be in different formats and languages. CCGs need to work with key community groups to enable this to happen in a timely and appropriate manner.

[1] **Section 19: Indirect discrimination**

(1) A person (A) discriminates against another (B) if A applies to B a *provision, criterion or practice* which is discriminatory in relation to a relevant protected characteristic of B's.
(2) This statement is to be understood in conjunction with (2)(b)(c)(d) below
(b) it puts, or would put, persons with whom B shares the characteristic *at a particular disadvantage when compared with persons with whom B does not share it,*
(c) *it puts, or would put, B at that disadvantage*, and
(d) A cannot show it *to be a proportionate means* of achieving a legitimate aim.

Recommendation moving forward:

If the following recommendations are approved then the Public Sector Equality Duty is met. The development of a SMART action plan will be developed against the recommendations to ensure equality issues are mitigated

Consider some breast service footprint in Southport and the West Lancashire areas as a priority **Reasonable adjustments for disabled people (frail elderly) need to be developed and support** **Continuity of care in short term for existing patients** **Access to treatments for new patients from the Southport and Ormskirk areas to be cognisant of patient needs**	**Earliest as programme starts**
Develop a travel strategy addressing the issues and recommendations of a,b,c,d,e above	**Earliest as programme take shape**
Develop knowledge bank of advice, information and support services to maintain community cohesion	**Ongoing**
Develop an enveloping patient case transfer system to ensure all parties understand transfer. Have clear access points of support during this process. **Ensure information, advice and support services such as Macmillan are part of the new pathway**	**Earliest as programme takes shape**
Ensure service users continually engaged in development of services.	**Urgent**
Ensure wider community engage in debate and understand future changes and proposals why such a change is taking place (medium to longer term)	**Urgent**
Ensure service provider (terms within contract)	**As programme takes shape**

understands their duties under PSED and can demonstrate compliance.	

N.B. Consultation with staff and consideration of staff morale is an issue that will need to be addressed.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/54	**Author of the Paper:**
Report date: March 2015	Karl McCluskey Chief Strategy & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7006

Title: 2015/16 Planning Submission

Summary/Key Issues:

The CCG has revisited its current two year Operational Plan and five year Strategic Plan as part of the 2015/16 planning round informed by the new NHSE Planning Guidance issued on 24th December 2014.

These plans have considered the revision to existing plans in light of national and local pressures on A&E and admissions and reflect the discussions and agreement with the Governing Body as part of the Development Session in February 2014 and Senior Leadership Team on 10th March 2014.

The plans reflect a realistic flat 0% attribution to Non-elective activity for 2015/16. In addition activity plans related to RTT, HCAI, Cancer, Mental Health, A&E and Primary Care are set out, with descriptive supporting rationale. A full schedule of activity against the prescribed performance measures is also set out, aimed at meeting the national targets.

Recommendation

Receive	
Approve	x
Ratify	

The Governing Body is asked to

Note the detail contained in the national planning guidance and the implications for the review of existing two year operational and five year operational plans.

Approve the submission of 2015/16 plans in relation to NEL activity at 0% and the re-profiled plan for future years.

Approve the submission of plans to achieve the various national performance measures including RTT, A&E, Mental Health, HCAI, Cancer and Primary Care.

Enable the necessary delegated authority via the CCG Chair, Accountable Officer, Chief Financial Officer and Chief Strategy & Outcomes Officer to progress the necessary work to enable national return requirements to me met in line with the revised planning timetable.

Links to Corporate Objectives	
x	Improve quality of commissioned services, whilst achieving financial balance.
x	Sustain reduction in non-elective admissions in 2014/15.
x	Implementation of 2014/15 phase of Virtual Ward plan.
x	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
x	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
x	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
x	Review the population health needs for all mental health services to inform enhanced delivery.

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

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

Report to the Governing Body
March 2015

1. Introduction

1.1 This paper provides the Governing Body with an update on the progress, plans submissions, together with the rationale that have been used to develop the plans for 2015/2016 as part of the annual planning requirements. This builds on the paper that was presented to the Governing Body in January 2015, where an outline of the intended approach by the CCG was described.

1.2 The paper describes the plans for both South Sefton CCG and Southport and Formby CCG as part of the Sefton footprint. As such it contains and reflects the plans for both CCGs.

1.3 The approach taken by the CCG is in line with the existing two year operational and five year strategic plan and conforms to the planning guidance that was issued on the 24 December 2014 in support of the five year forward view.

1.4 In the January 2015 paper that was presented to the Governing Body, the National timetable was set out and referred to. This timetable has been revised nationally, in large part due to the negotiations on developing a National tariff. A revised timetable was issued to the CCG on 10 March 2015 and is contained within this paper.

1.5 Previously the Governing Body supported the request for delegated authority to enable the various timetable milestones and submission requirements to be made. The need for this remains with the publication of the new timetable.

2. Background

2.1 The January update to the Governing Body described the work that the CCG has undertaken over the last 12 – 18 months in developing its strategic plan across Sefton. In considering planned submissions for 2015/2016, the CCG has affirmed and endorsed its strategic vision together with the three identified priority areas:-

1) Frail Elderly;
2) Unplanned Care;
3) Primary Care.

2.2 The CCG is now embarking upon the next stage of its strategic plan, implementation and delivery with the establishment of our “locality model” to meet the needs of the local population. The CCG commitment to the above stated priorities, now requires consideration on how best to develop and invest in key essential areas to enable service transformation and a shift in activity and resource from traditional secondary care settings to primary care, community care, intermediate care and mental health care to support;

- Self-Care;
- Avoidance of unnecessary hospital admission;
- Facilitated discharge from hospital;
- Integrated locality care through joined up local services.

2.3 It should be noted that the planning requirements for the 2015/2016 submission have changed considerably from those that were in place when the CCG developed its original two year operational and five year strategic plan twelve months ago. This is a decision that has been taken nationally, against which the CCG is expected to conform.

2.4 The most significant change to the planning requirements from 2014/2015 to 2015/2016 relates to data sources and the counting of activity. Specifically, the previous two year operational plan and five year strategic plan was based on and arrived from MAR (monthly activity returns). MAR data is produced by providers and as such remains un-validated by commissioners and only relates to episode activity. In addition, the MAR data only referenced general and acute specialities, as such representing an incomplete subset of overall activity. The 2015/2016 plans are to be based on SUS (Secondary User Service). This SUS data has enabled the CCG to review activity in greater detail including, spells and across all specialities. In addition the SUS data is based upon spells and the dominant HRG, upon which contractual payment is ultimately made. It represents a data set that the CCG is able to validate from providers.

2.5 The change in data requirements and format has meant that it is virtually impossible to compare the previous CCG activity plan submissions as part of the 2014/2015 two year operation and five year strategic plan and the 2015/2016 plan now required by NHS England.

2.6 The CCG was asked to for its views at the end of the 2014/2015 planning round on the use of different data sets and their appropriateness and application. The feedback provided highlighted the level of dissatisfaction in using MAR based activity and advocated a shift to the use of SUS based activity. CCG feedback nationally supported this view, which has now been reflected in the 2015/2016 planning approach. However, it does pose challenges for both the CCG and in particular NHS England in their efforts to track and relate the 2015/2016 plan to the previous years.

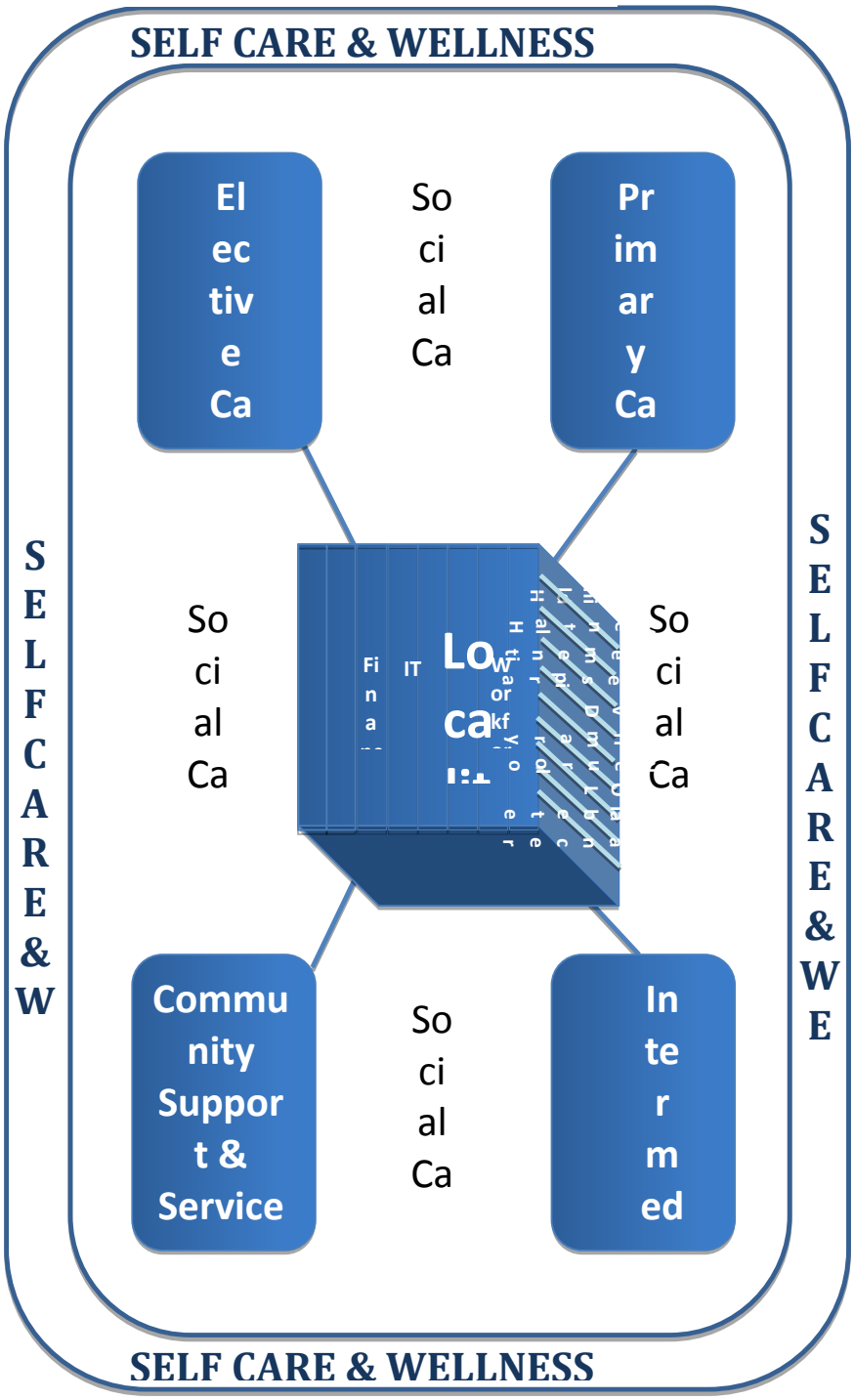
2.7 It should also be noted that at the time of developing the two year operational and five year strategic activity plans that CCG level activity was only available for the previous 12 months, with assumptions in the attribution of PCT level activity being made to the newly formed CCG footprint. This year, however a much more detailed historical picture of CCG activity is available. This has been used to inform the 2015/2016 planning submissions.

3. The Five Year Forward View

3.1 NHS England published its up-dated planning strategy in October 2014 (Five Year Forward View). This places an increasing emphasis on the prevention of ill-health and the role of public health in tackling major causes of disease. This emphasis is consistent with the CCG Strategic Plan and is in keeping with the Better Care Fund plan that has been jointly developed with Sefton Metropolitan Borough Council.

3.2 In addition, the Five Year Forward View places a resounding emphasis on self-care and local support for self-care. This is very much in keeping with the CCG locality model and adds strength to the major transformation schemes (Virtual Ward, Care Closer to Home) within the CCG strategic plan.

3.3 A focus on developing a health care system that supports individuals with multiple conditions, not just single diseases is at the heart of national policy. This is reflected in the way that the CCG is now bringing together the strategic programmes (Primary Care, Cancer, CVD, Diabetes, Children's Health, Neurology, Liver Disease, Mental Health & Dementia) in an integrated way as part of the locality model of care. This is aimed at bringing together the multiplicity of conditions that individuals may have and shaping the way in which healthcare is provided in the settings of unplanned care, elective care, community care and intermediate care. This is reflected in the diagram below.



3.4 The Five Year Forward View will present the CCG with a range of potential delivery options:

- **Multidisciplinary Community Provider:** Permitting groups of GP's to combine with Nurses and other community health services, hospital specialists, mental health and social care to create out-of-hospital integrated care;
- **Primary & Acute Care Systems:** An integrated hospital and primary care provider;
- **Urgent & Emergency Care:** Integration between A&E departments, GP out of hours services, urgent care centres, NHS 111 and ambulance services.

3.5 In keeping with the CCG priority of Primary Care, The Five Year Forward View signals a sustained commitment to list based primary care. It recognises the pressures on primary care and the need to address and stabilise core funding. The CCG has endeavoured to support this, in the first year of its strategic plan through the primary care quality contract. Future national policy aims to support the CCG in shifting investment from acute to primary and community services. This fits well with the current review of the CCG plans on activity and resources to build a sustainable approach to shifting and investment in resources.

3.6 Finally, the forward view recognises the challenging need to balance demand, efficiency and funding. Thus a review of the existing CCG strategic and financial plans is necessary to support optimum service provision, transformation in support of patient needs, within agreed funding levels and supporting QIPP delivery.

4. Planning For 2015/16

4.1 The national guidance to support CCG's in revising existing plans and strategy was published on 24th December 2014. This has prescribed a number of significant changes that the CCG has now to consider in the review of existing plans. The detail on these changes including the alterations to the business rules was described in the January 2015 paper that the Governing Body considered.

5. 2015/16 Plans

Activity plans as part of financial return

5.1 A high level activity plan formed part of the first submission on 13/01/15. As described previously, the planning requirements changed significantly in terms of data sources from MAR to SUS

5.2 For both the January and the February planning returns the data used to inform the plans was SUS except the outpatient data which used MAR because the SUS figures do not relate to the equivalent MAR figures. The official planning guidance has confirmed that the SUS definitions are yet to be defined for out patients. Referrals are also based on MAR as per the guidance.

5.3 As there is no definitive MAR measure for first outpatient all referrals all specialties a proxy has been calculated between GP first outpatient all specialties and General and Acute to gain this figure.

Overview of Planning Rationale Employed in 2014/2015 for the Two Year Operational and Five Strategic Plans

5.4 **A&E attendances -** Due to historic volatility it was originally proposed that a 0% change in 14/15 followed by -2% annually until end of 2018/19. As at the February submission, this rationale still remains until further agreement was reached on the direction of travel by the Governing Bodies.

5.5 **Unplanned admissions -** (i.e. all non-elective admissions not just those considered avoidable). As at the February submission, the rationale submitted in the original 5 year strategic plan had not been applied; the activity data was simply a roll forward of 14/15 FOT into 15/16. The same data used in the original 5 year plan was also used to plan the overarching BCF measure against which a -3.5% reduction in non-elective admissions expected during the period Q4 2014/15 – Q1 2014/15 to Q3 2015/16.

Table 1.0 Original 5 year plan trajectory (Apr 2014)

	2013/14 (based on month 8 forecast)	2014/15	2015/16	2016/17	2017/18	2018/19
South Sefton	-10.5% (-1,865 admissions from 12/13 baseline)	0%	-1.0%	-1.0%	-1.5%	-2.0%
Southport & Formby	-5.8% (-862 admissions from 12/13 baseline)	0.00%	-2.00%	-4.00%	-2.50%	-2.00%

BCF Plan trajectory (Nov 2014):

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	Quarterly rate	3,090	2,977	2,978	2,848	2,958	2,885	2,885	2,739	2,920
	Num erator	8,455	8,145	8,148	7,793	8,100	7,900	7,900	7,500	8,000
	Denom inator	273,624	273,624	273,624	273,624	273,796	273,796	273,796	273,796	274,012

P4P annual change in admissions -1141
P4P annual change in admissions (%) -3.5%
P4P annual saving £1,808,485
Please enter the average cost of a non elective admission £1,585
Rationale for change from £1,490

5.6 The activity plans submitted as part of the Non Elective element of the Better Care Fund was based as per the national guidance on Non Elective (General and Acute) Finished First Consultant Episodes (FFCEs) on which the MAR is also calculated. The Better Care Fund measures activity across two financial years, but one calendar year: January-December 2015 (i.e. Q4 2014/15 – Q3 2015/16). The 'payment for performance' period is adjudged to have been successful if a 3.5% reduction on a baseline period has been achieved in the number of admissions. The original planned 3.5% reduction was equal to a reduction of 1,141 admissions. The baseline period is January-December 2014 (i.e. Q4 2013/14 – Q3 2014/15). At the time the BCF plans were submitted the baseline period was incomplete therefore national guidance was to submit a baseline based on MAR plans. Actual MAR data is now available for the baseline period which is higher than planned. This has had the effect of increasing the baseline period which means to achieve a 3.5% reduction would require a heightened level of admissions avoided (1,218 instead of the 1,141 originally submitted).

5.7 It is proposed that the target reduction for non-electives in the BCF remains as 1,141. This equates to a 3.3% reduction as opposed to 3.5% reduction.

5.8 **Avoidable admissions.** A planned level of avoidable admissions at CCG level mirrored the Quality Premium guidance in the original 5 year plan submission. This was also a supporting measure of the BCF at Sefton level. This measure is not planned for as part of the activity and finance planning submission for 2015/16 but is simply described here as additional context.

5.9 Against the original 5 year plan which intended a 0% change in emergency admissions in 2014/15, month 8 admissions forecast to year end are projected for both CCGs to be in the region of 9% higher than the previous financial year (2013/14).

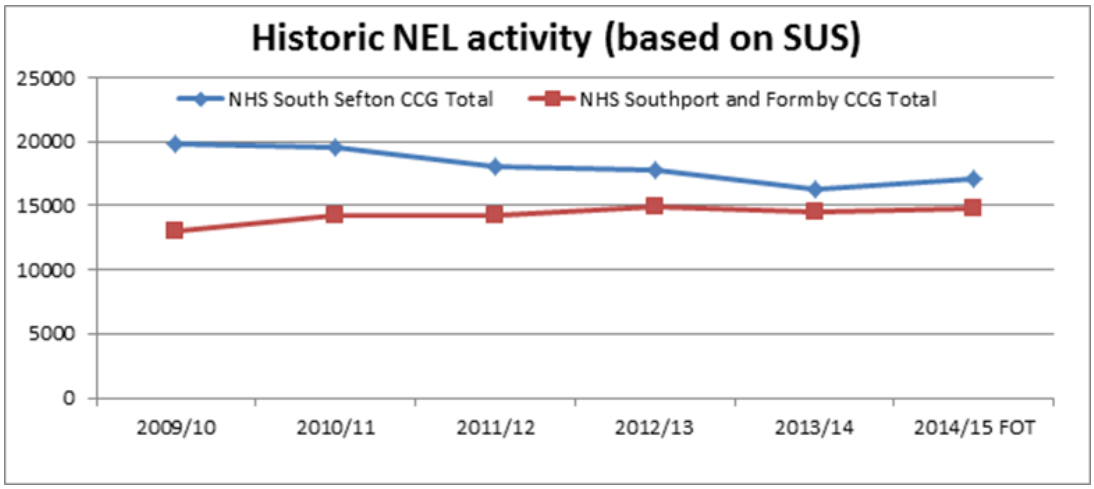
Table 2.0 Comparison of MAR Activity Changes

	2013/14 (based on month 8 forecast)	2014/15 plan	**2014/15 Actual (m8 FOT) compared to 2013/14**	2015/16 plan	2016/17 plan	2017/18 plan	2018/19 plan
South Sefton	-10.5% (-1,865 admissions from 12/13 baseline)	0%	**+9.14%**	-1.0%	-1.0%	-1.5%	-2.0%
Southport & Formby	-5.8% (-862 admissions from 12/13 baseline)	0.00%	**+9.07%**	-2.00%	-4.00%	-2.50%	-2.00%

5.10 At both CCGs Governing Body Development Sessions in February 2015, together with further consideration at the CCGs Senior Leadership Team meeting which took place on 10 March 2015, the CCGs revisited the existing strategic plan activity profile and reductions described in the table above. This analysis, based on MAR data, for comparative purposes illustrated a swing in non-elective activity from -10.5% in 2013/2014 compared to 2012/2013 baseline, to +9.14% as evidence in 2014/2015 for South Sefton CCG. Similarly for Southport and Formby CCG a swing from -.5.8% in 2013/2014 compared to 2012/2013 baseline has shifted to +9.07% in 2014/2015.

5.11 The diagram on the next page represents the trends in non-elective activity from 2009/2010. This illustrates a reduction in South Sefton related activity from 2009/2010 to 2013/2014, with an increase evident in 2014/2015. Southport and Formby illustrates an increase in non-elective activity from 2009/2010 with a further increase apparent in 2014/2015.

Table 3.0 Historic NEL Activity (based on SUS)



5.12 This volatility can be partially explained by the respective changes to the emergency pathways that have taken place at both Aintree University Hospital and Southport and Ormskirk Hospital, however it is in no way accounts for the significance. The view of the Governing Body was that, given the changes in counting activity, through pathway changes together with the changes in National requirements for planning submissions, that no robust forecast could be extrapolated at this stage. In view of this the consensus was that the existing planned profile for non-elective activity should remain flat at 0% for 2015/2016. The revised planning profile for the respective CCGs is set out in the table below.

Table 4.0 Revised 5 year CCG plan for NEL

	2015/2016 Plan	2016/2017 Plan	2017/18 plan	2018/19 plan	2019/2020 plan
South Sefton	0%	-1.0%	-1.0%	-1.5%	-2.0%
Southport & Formby	0%	-2.00%	-4.00%	-2.50%	-2.00%

5.13 The table below represents a comparative analysis between the previous CCG plans for 2015/2016, using the previously prescribed MAR dataset and the new requirement for the SUS data set. It is clearly evident that in changing the datasets that an increase is evident between the original 2015/2016 plan and the revised version (as per this year's guidance). For South Sefton this represents an increase in 2437 non elective (G&A) spells. For Southport and Formby this equates to an additional 1324 non elective spells (G&A). An analysis of current utilisation based on different Points of Delivery (PODs): Non Elective, Elective (Ordinary & Day Case), Outpatients (First and Follow Up), and A&E is set out in the tables on the next page.

5.14 The rationale for January and February submissions was 2014/15 month 8 forecast to year end then replicated for 2015/16 i.e. no change. This has had the effect of 'increasing' the numbers submitted in the 2014/15 five year plan as follows:

Table 5.0 Overall CCG Plan Comparison between 2015/16 planning submission and that reflected in 2014/15, as part of the 5 year Strategic Plan

South Sefton

	Spells	Spells	Spells	Spells	Spells	Outpatients					A&E
	Non-elective spells - all specialties E.C.23	Non-elective spells - G&A E.C.4	Daycase Elective Spells - G&A E.C.2	Elective Spells - all specialties E.C.21	Ordinary Elective Spells - G&A E.C.1	All First Outpatient Attendances - all specialties E.C.24	All First Outpatient Attendances - G&A E.C.24	First Attendance following GP Referrals - all specialties E.C.25	First Attendance following GP Referrals -G&A E.C.12	All subsequent outpatient attendances - all specialties E.C.6	A&E attendances all types E.C.8
14/15 original MAR plan	-	16,177	17,920	-	3,813	-	49,327	-	27,133	-	233,521
15/16 original MAR plan	-	16,016	17,921	-	3,814	-	49,325	-	27,134	-	228,851
FOT 14/15 (m8 SUS)	21,294	18,453	18,371	22,239	3,869	54,549	48,417	26,469	23,537	134,400	54,320
NEW 15/16 SUS plan (1415 M8 FOT rolled over)	21,294	18,453	18,371	22,239	3,869	54,549	48,417	26,469	23,537	134,400	54,320
Effect of counting change: original - new 15/16 plan	-	2,437	449	-	55	-	-908	-	-3,598	-	-174,532
ACTUAL 13/14 OT (SUS)	21,772	17,417	18,663		3,934						53,566
ACTUAL 14/15 M8 FOT (MAR)	-	17,889	18,179	-	3,962	-	53,336	-	29,678	-	54,320
ACTUAL 13/14 OT (MAR)	-	16,408	18,112	-	3,845	-	49,987	-	27,553	-	53,566
% change 13/14 - 14/15 (MAR)		9.03%	0.4%		3.0%		6.7%		7.7%		1.4%
% change 13/14 - 14/15 (SUS)	-2.20%	5.95%	-1.57%		-1.66%		#DIV/0!		#DIV/0!		1.41%
Original planned % change 13/14 - 14/15 (MAR)		0%	0%		0%		0%		0%		0%

Southport & Formby **2015/16 planning requirements excludes Walk In Centre Activity hence lower number**

	Spells	Spells	Spells	Spells	Spells	Outpatients					A&E
	Non-elective spells - all specialties E.C.23	Non-elective spells - G&A E.C.4	Daycase Elective Spells - G&A E.C.2	Elective Spells - all specialties E.C.21	Ordinary Elective Spells - G&A E.C.1	All First Outpatient Attendances - all specialties E.C.24	All First Outpatient Attendances - G&A E.C.24	First Attendance following GP Referrals - all specialties E.C.25	First Attendance following GP Referrals -G&A E.C.12	All subsequent outpatient attendances - all specialties E.C.6	A&E attendances all types E.C.8
14/15 original MAR plan	-	15,611	17,168	-	3,267	-	36,993	-	23,002	-	41,342
15/16 original MAR plan	-	15,299	17,174	-	3,267	-	36,963	-	23,001	-	40,515
FOT 14/15 (m8 SUS)	17,282	16,623	17,055	20,117	3,062	48,783	43,515	25,364	22,313	115,380	39,716
NEW 15/16 SUS plan (1415 M8 FOT rolled over)	17,282	16,623	17,055	20,117	3,062	48,783	43,515	25,364	22,313	115,380	39,716
Effect of counting change: original - new 15/16 plan		1,324	-119		-206		6,552		-689		-800
ACTUAL 13/14 OT (SUS)	16,942	15,740	17,531		3,363						36,772
ACTUAL 14/15 M8 FOT (MAR)		16,766	17,588		3,075		39,519		24,621		39,716
ACTUAL 13/14 OT (MAR)		15,371	17,827		3,247		37,580		23,471		36,772
% change 13/14 - 14/15 (MAR)		9.07%	-1.3%		-5.3%		5.2%		4.9%		8.0%
% change 13/14 - 14/15 (SUS)	2.00%	5.61%	-2.72%		-8.97%		#DIV/0!		#DIV/0!		8.00%
Original planned % change 13/14 - 14/15		0%	0%		0%		0%		0%		0%

The increase above is entirely accounted for by the change in the way of counting.

Demographic Changes

5.15 In line with the previous development of CCG plans, the CCG recognised the importance of demographic changes in planning activity for the future.

5.16 Future population projections from ONS were applied to current trends to understand the impact of demography. Modest population changes are forecast over the next 5 years. The biggest percentage increase is in the over 85 age group of circa 3% per year, however in terms of the entire population of over 85s the numbers are low; circa 4,500 for South Sefton and 5,000 for Southport and Formby. Smaller percentage increases forecast in the other age groups may mean a higher number of additional people in those age groups.

Table 6.0 CCG Demographic Changes

South Sefton:

	15/16 change	16/17 change	17/18 change	18/19 change
0-19	0.00%	-0.17%	0.50%	0.32%
20-64	0.07%	-0.17%	-0.19%	-0.32%
65-74	1.28%	1.60%	0.95%	0.62%
75-84	0.46%	-0.02%	0.92%	1.85%
85+	3.50%	3.38%	3.16%	3.17%
TOTAL	0.29%	0.11%	0.25%	0.17%

Southport & Formby:

	15/16 change	16/17 change	17/18 change	18/19 change
0-19	0.08%	-0.08%	0.57%	0.34%
20-64	0.08%	-0.15%	-0.09%	-0.25%
65-74	1.27%	1.49%	0.88%	0.61%
75-84	0.48%	0.05%	0.95%	1.83%
85+	3.48%	3.36%	3.33%	3.15%
TOTAL	0.41%	0.24%	0.41%	0.32%

5.17 When applied to current utilisation the changes to activity are small. This is evident in the diagrams on the next page.

Diagram 1.0 South Sefton Demographic Changes applied to Points of Delivery

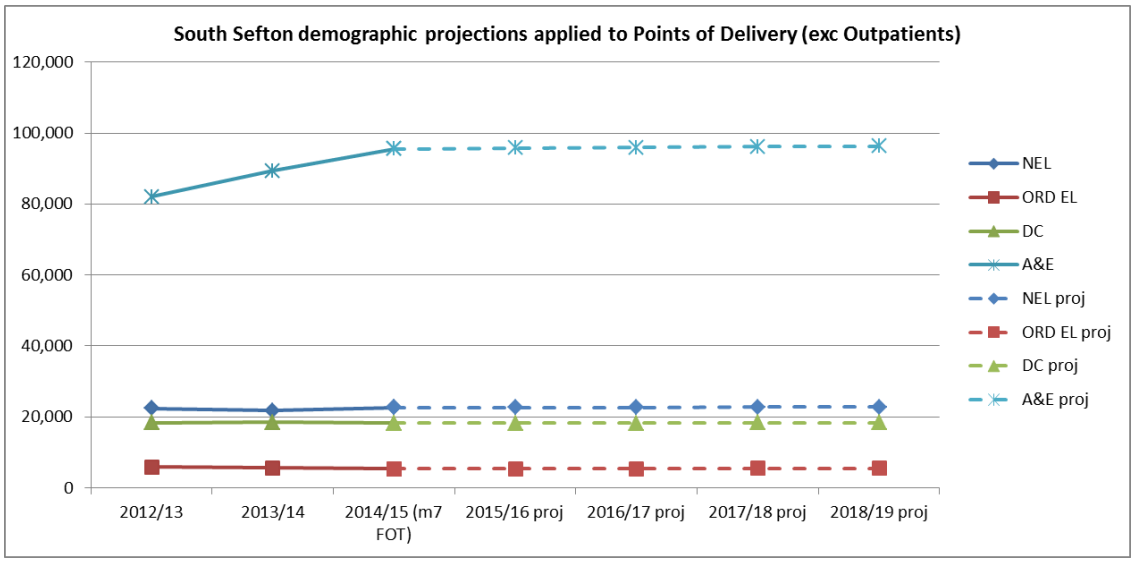


Diagram 2.0 South Sefton Demographic Changes applied to Out Patients

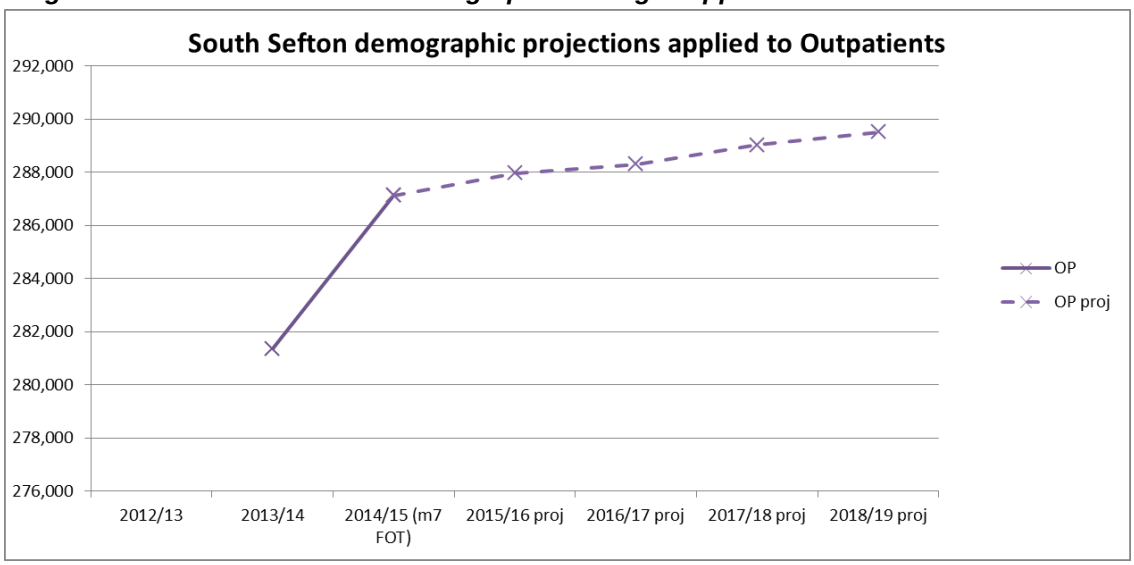


Diagram 3.0 Southport & Formby CCG Demographic Changes applied to Points of Delivery

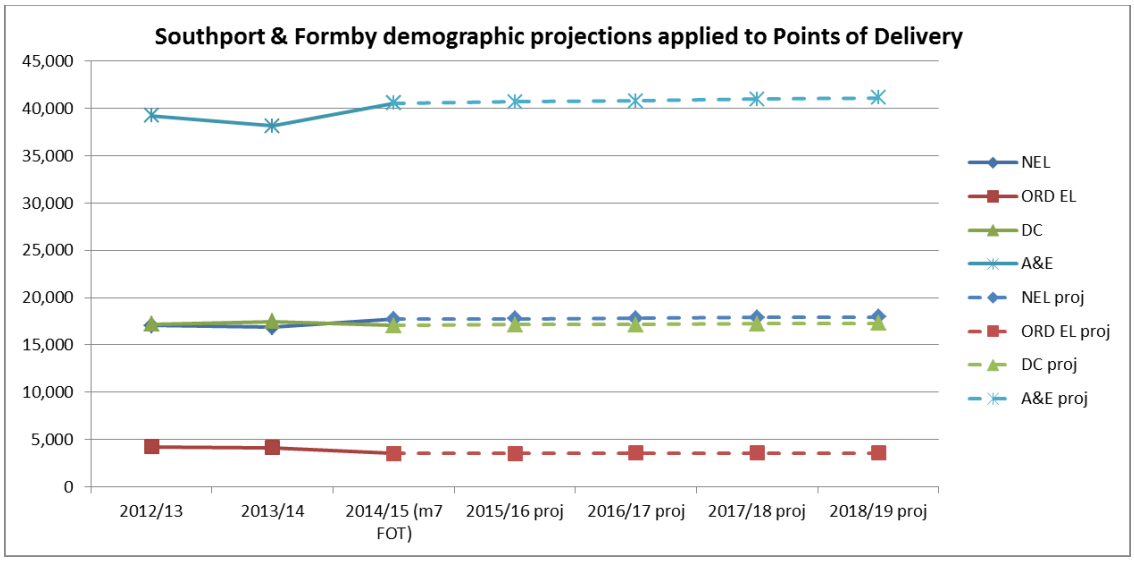
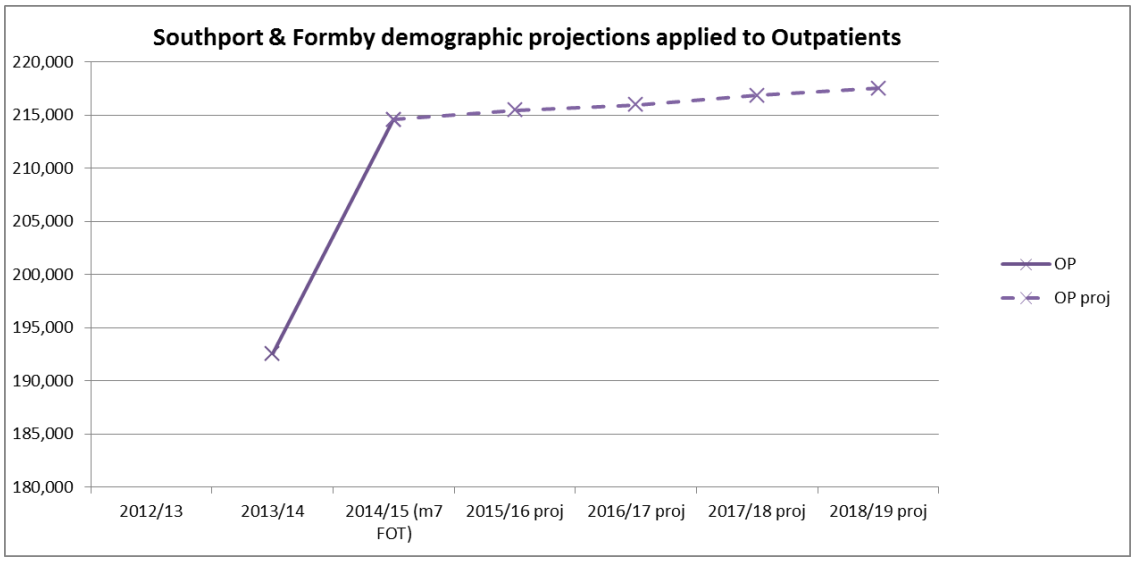


Diagram 4.0 Southport & Formby Demographic Changes applied to Outpatients



5.18 The demographic changes have been reflected in the 2015/2016 plan.

5.19 **Managing elective activity**: The CCG considered an approach to inform changes to elective plans. This included the management of follow up outpatient ratios to either current agreed contract values or to the national average, for particular specialties at specific providers. If this approach were to be adopted it would also have a prospective influence on future elective activity. Applying a specified level of first OP

attendances (based on Better Care Better Value), and managing the contract activity planning assumptions to this, the current OP:EL conversion rates could be applied to elective activity.

5.20 Clinical board members felt the peer group CCGs proposed for Southport & Formby CCG were not similar enough therefore further work is being undertaken to look at different peers as proposed by the vice chair.

5.21 Further work is being undertaken in relation to South Sefton CCG with Clinical Governing Body Members to consider a clinical approach to outpatients that maybe adopted going forward.

6. Performance Measures

6.1 A further planning submission was made on January 28th outlining plans and trajectories for a number of measures relating to the NHS Constitution, Primary Care and Other Measures.

Referral to Treatment (RTT)

6.2 The following ***Referral to Treatment*** measures are contained within the 2015/16 planning submission;

- ***EB1 RTT*** *– The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis.*
- ***EB2 RTT*** *- The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.*
- ***EB3 RTT*** *- The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.*
- ***EB4*** *- Diagnostics Test Waiting Times*

6.3 The Tables on the next page describe the planned performance and trajectories for the respective CCG's.

Table 7.0 Southport & Formby Plans

8.8.1			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis	2013-14	Completed pathways < 18 weeks	632	626	643	667	518	656	612	641	555	694	666	726
		Total Completed Pathways	686	679	714	740	566	734	726	756	652	765	756	770
		%	92.1%	92.2%	90.1%	92.8%	91.5%	91.9%	84.3%	84.8%	84.8%	88.1%	90.5%	94.3%
	2014-15	Completed pathways < 18 weeks	680	686	626	656	550	656	-	-	-	-	-	-
		Total Completed Pathways	719	726	663	704	591	697	-	-	-	-	-	-
		%	94.6%	95.8%	94.7%	93.2%	93.1%	94.1%	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	671	677	620	647	543	647	645	672	579	700	677	716
		Total Completed Pathways	709	706	654	695	553	688	716	746	645	777	745	760
		%	94.6%	95.9%	94.8%	93.1%	93.1%	94.0%	90.1%	90.1%	90.0%	90.1%	90.5%	94.2%

8.8.2			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.	2013-14	Completed pathways < 18 weeks	2407	2352	2200	2375	2126	2495	2677	2525	2097	2776	2445	2546
		Total Completed Pathways	2481	2403	2250	2453	2200	2581	2765	2606	2178	2847	2515	2596
		%	97.0%	97.9%	97.8%	96.8%	96.7%	96.6%	96.8%	96.8%	96.3%	97.5%	97.3%	98.1%
	2014-15	Completed pathways < 18 weeks	2366	2345	2715	2821	2338	2721	-	-	-	-	-	-
		Total Completed Pathways	2414	2391	2765	2875	2386	2782	-	-	-	-	-	-
		%	98.0%	98.1%	98.2%	98.1%	98.0%	97.8%	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	2306	2265	2646	2749	2276	2652	2609	2459	2043	2705	2385	2451
		Total Completed Pathways	2352	2310	2694	2802	2325	2711	2684	2539	2122	2774	2451	2510
		%	98.0%	98.1%	98.2%	98.1%	98.0%	97.8%	96.8%	96.8%	96.3%	97.5%	97.3%	98.1%

8.8.3			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	2013-14	Incomplete Pathways < 18 weeks	6054	6197	6130	6429	6467	6205	6566	6113	5964	5716	5670	5639
		Total Incomplete Pathways	6434	6559	6458	6763	6835	6525	6931	6427	6250	5915	5822	5790
		%	94.1%	94.8%	94.5%	94.8%	94.6%	95.1%	95.3%	95.1%	95.7%	96.6%	97.4%	97.4%
	2014-15	Incomplete Pathways < 18 weeks	5797	6154	6176	6265	6195	6239	-	-	-	-	-	-
		Total Incomplete Pathways	5950	6312	6309	6397	6359	6432	-	-	-	-	-	-
		%	97.4%	97.5%	97.9%	97.9%	97.4%	97.0%	-	-	-	-	-	-
	2015/16 Plan	Incomplete Pathways < 18 weeks	5915	6280	6302	6393	6521	6366	6495	6236	6106	5655	5706	5754
		Total Incomplete Pathways	6071	6441	6435	6528	6689	6565	6917	6335	6378	6036	5941	5908
		%	97.4%	97.5%	97.9%	97.9%	97.4%	97.0%	93.9%	93.1%	95.7%	96.6%	97.4%	97.4%

8.8.4			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
Diagnostics Test Waiting Times	2013-14	Number waiting > 6 weeks	5	5	5	5	7	11	20	23	9	7	6	6
		Total Number waiting	1517	1587	1646	1565	1536	1682	1579	1639	1525	1286	1767	1764
		%	0.2%	0.2%	0.3%	0.2%	0.5%	0.7%	1.3%	1.4%	0.6%	0.5%	0.3%	0.3%
	2014-15	Number waiting > 6 weeks	6	7	2	5	17	8	-	-	-	-	-	-
		Total Number waiting	1914	1961	1816	2061	2629	2154	-	-	-	-	-	-
		%	0.3%	0.4%	0.1%	0.2%	0.6%	0.4%	-	-	-	-	-	-
	2015/16 Plan	Number waiting > 6 weeks	5	7	2	5	11	7	17	18	10	5	7	7
		Total Number waiting	1695	1545	1637	1772	1714	1677	1762	1619	1705	1435	1872	1868
		%	0.3%	0.3%	0.1%	0.2%	0.6%	0.4%	1.0%	1.0%	0.6%	0.6%	0.4%	0.4%

Table 8.0 South Sefton RTT Plans

8.8.1			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis	2013-14	Completed pathways < 18 weeks	719	746	722	765	612	721	761	751	591	795	711	747
		Total Completed Pathways	765	794	756	815	641	766	817	792	627	861	773	801
		%	91.6%	94.0%	95.5%	93.6%	95.5%	93.9%	93.1%	92.3%	94.3%	92.3%	92.0%	93.3%
	2014-15	Completed pathways < 18 weeks	664	629	665	605	636	736	-	-	-	-	-	-
		Total Completed Pathways	715	665	716	660	662	796	-	-	-	-	-	-
		%	93.1%	94.9%	95.8%	93.6%	93.3%	92.7%	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	664	629	665	606	636	739	761	752	591	796	711	748
		Total Completed Pathways	715	665	716	661	662	797	816	795	627	862	774	802
		%	93.1%	94.9%	95.8%	93.6%	93.3%	92.7%	93.2%	92.3%	94.3%	92.3%	91.9%	93.3%

8.8.2			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.	2013-14	Completed pathways < 18 weeks	5415	5344	2956	3535	2735	3214	3575	3450	2779	3394	3250	3345
		Total Completed Pathways	5459	5201	3015	3615	2796	3300	3655	3336	2852	3466	3315	3424
		%	97.9%	98.2%	98.2%	97.8%	97.7%	97.4%	97.8%	97.5%	98.1%	97.9%	98.0%	97.6%
	2014-15	Completed pathways < 18 weeks	5165	5152	5444	3660	2744	3601	-	-	-	-	-	-
		Total Completed Pathways	5245	5220	5519	3951	2829	3737	-	-	-	-	-	-
		%	98.2%	97.9%	97.9%	97.7%	97.0%	96.4%	-	-	-	-	-	-
	2015/16 Plan	Completed pathways < 18 weeks	5135	5103	5390	3600	2701	3548	3517	3396	2756	3341	3199	3291
		Total Completed Pathways	5194	5170	5464	3689	2765	3679	3598	3463	2768	3434	3263	3371
		%	98.2%	97.9%	97.9%	97.7%	97.0%	96.4%	97.7%	97.5%	98.1%	97.9%	98.0%	97.6%

8.8.3			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
RTT - The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	2013-14	Incomplete Pathways < 18 weeks	8077	7169	7451	7639	8306	7985	7604	7635	7462	7705	7257	7628
		Total Incomplete Pathways	8306	7376	7626	8047	8562	8206	7840	7915	7752	7945	7500	7697
		%	97.2%	97.2%	97.7%	97.4%	97.0%	97.0%	97.0%	96.5%	96.3%	97.0%	96.8%	96.6%
	2014-15	Incomplete Pathways < 18 weeks	7456	7758	7973	7682	8126	8339	-	-	-	-	-	-
		Total Incomplete Pathways	7719	8062	8267	8013	8491	8735	-	-	-	-	-	-
		%	96.2%	96.0%	96.4%	95.9%	95.7%	95.5%	-	-	-	-	-	-
	2015/16 Plan	Incomplete Pathways < 18 weeks	7456	7760	7975	7684	8128	8341	7606	7640	7464	7707	7259	7626
		Total Incomplete Pathways	7751	8064	8269	8015	8494	8738	7842	7917	7734	7945	7502	7699
		%	96.2%	96.0%	96.4%	95.9%	95.7%	95.5%	97.0%	96.5%	96.5%	97.0%	96.8%	96.6%

8.8.4			APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
Diagnostics Test Waiting Times	2013-14	Number waiting > 6 weeks	16	14	17	22	13	7	17	10	22	29	23	16
		Total Number waiting	2256	2345	2252	2276	2060	1427	2050	1671	2065	2014	2122	2066
		%	0.7%	0.6%	0.8%	1.0%	0.6%	0.5%	0.8%	0.5%	1.1%	1.4%	1.1%	0.9%
	2014-15	Number waiting > 6 weeks	16	11	15	9	23	15	-	-	-	-	-	-
		Total Number waiting	1965	1994	1966	1952	1904	2183	-	-	-	-	-	-
		%	0.8%	0.6%	0.9%	0.5%	1.2%	0.7%	-	-	-	-	-	-
	2015/16 Plan	Number waiting > 6 weeks	16	12	15	10	19	15	17	9	21	20	21	19
		Total Number waiting	2012	2021	1995	1976	1950	2215	2076	1696	2111	2041	2151	2134
		%	0.8%	0.6%	0.9%	0.5%	1.0%	0.7%	0.8%	0.5%	1.0%	1.0%	1.0%	0.9%

6.4 The plans for the measures above are based on an average month of total patients on pathway, of the total April 13 - Sept 14 worked up to full year effect. This was then split by month which has been worked out using a % split from the months Oct 13 through to Sept 14 (latest 12 month's data). The numerator will either equal the latest data target we have if above the target or be made to equal the target where below.

6.5 **A&E 4 Hour Target:** In addition to the above, the 2015/16 plans require the CCG to submit ***A&E Waiting*** times (*EB5: A&E Waiting Time).* These are set out in the tables below.

Table 9.0 Southport & Formby A&E Plans

			Quarter 1	Quarter 2	Quarter 3	Quarter 4
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	2013-14	Number waiting > 4 hours	1579	723	648	1040
		Total Attendances	23877	24986	27844	27984
		% < 4 hours	**93.4%**	**97.1%**	**97.7%**	**96.3%**
	2014-15	Number waiting > 4 hours	873	758	-	-
		Total Attendances	29746	29680	-	-
RVY		% < 4 hours	**97.1%**	**97.4%**	-	-
	2015/16 Plan	Number waiting > 4 hours	1487	1484	1392	1399
		Total Attendances	29746	29680	27844	27984
		% < 4 hours	**95.0%**	**95.0%**	**95.0%**	**95.0%**

Table 10.0 South Sefton A&E Plans

			Quarter 1	Quarter 2	Quarter 3	Quarter 4
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	2013-14	Number waiting > 4 hours	1232	517	1069	1258
		Total Attendances	20769	19683	23932	27008
		% < 4 hours	**94.1%**	**97.4%**	**95.5%**	**95.3%**
	2014-15	Number waiting > 4 hours	2208	2117	-	-
		Total Attendances	28096	27625	-	-
REM		% < 4 hours	**92.1%**	**92.3%**	-	-
	2015/16 Plan	Number waiting > 4 hours	1452	1428	1237	1396
		Total Attendances	29056	28569	24750	27931
		% < 4 hours	**95.0%**	**95.0%**	**95.0%**	**95.0%**

6.6 Plans for the measure above are based on an average quarter of total patients attending A&E, of the total April 13 - Sept 14 worked up to full year effect. This was then split by quarter which has been worked out using a % split from the months Oct 13 through to Sept 14 (latest 12 months' data). The numerator will either equal the latest data target we have if above the target or be made to equal the target where below.

6.7 An adjustment was made to South Sefton's submission which is at Trust level (i.e. Aintree) to account for the effect of St Chads Walk In Centre late on 2013. This involved taking Q4 13/14, Q1 14/15 and Q2 14/15 and averaging the total attendances to a single quarter. Then multiplying by 4 to create a full year effect and then split by the percentage usage between Q3 13/14 and Q2 14/15.

6.8 An adjustment was also made to Southport & Formby's submission (i.e. Southport & Ormskirk) due to increases in activity throughout the year from Q1 13/14 to Q3 14/15. The total attendances between Q1 13/14 to Q2 14/15 were summed then divide by 6 to get a monthly average, then multiplied by 4 to create full year effect and then use % split between Q3 13/14 - Q2 14/15 to create the quarterly trajectory.

Cancer Targets

6.9 The following Cancer Performance measures are also included within the 2015/16 planning submission.

- *EB6 Cancer: All cancers 2 week wait*
- *EB7 Cancer: Two week wait for breast symptoms (where cancer not initially suspected)*
- *EB8 Cancer: Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis.*
- *EB9 Cancer: 31 Day standard for subsequent cancer treatments –surgery*
- *EB10 Cancer: 31 Day standard for subsequent cancer treatments -anti cancer drug regimens*
- *EB11 Cancer: 31 Day standard for subsequent cancer treatments - radiotherapy*
- *EB12 Cancer: All cancer 62 day urgent referral to first treatment wait*
- *EB13 Cancer: 62 day wait for first treatment following referral from an NHS cancer screening service*
- *EB14 Cancer: 62 day wait for first treatment for cancer following a consultant's decision to upgrade the patients priority*

6.10 The planned performance for the respective CCG's is set out in the tables on the next page.