NHS
South Sefton
Clinical Commissioning Group

AGENDA

Governing Body Meeting in Public
Agenda

Date: Thursday, 27th November 2014 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.

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

The Governing Body		
Dr Clive Shaw	Chair and Clinical Director	CS
Graham Morris	Vice Chair and Lay Member - Governance	GM
Dr Craig Gillespie	Clinical Vice-Chair and GP Governing Body Member	CG
Lin Bennett	Practice Manager and Governing Body Member	LB
Fiona Clark	Chief Officer	FLC
Michelle Creed	Chief Nurse, NHSE (Merseyside) *(co-opted member on behalf of Clare Duggan)*	MC
Roger Driver	Lay Member, Engagement & Patient Experience	RD
Debbie Fagan	Chief Nurse	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 and Governing Body Member	SMcG
Dr Andrew Mimnagh	Clinical Director and Governing Body Member	AM
Peter Morgan	Deputy Chief Executive, Sefton MBC *(co-opted member on behalf of M Carney)*	PM
Dr Paul Thomas	Clinical Director and Governing Body Member	PT
Dr John Wray	GP and Clinical Director	JW
In Attendance		
Paul Horwood	Insight, Engagement and Research Team Leader, SMBC	PH
Tracy Jeffes	Chief Delivery and Integration Officer	TJ
Dwayne Johnson	Director of Older People, SMBC	DJ
Jan Leonard	Chief Redesign and Commissioning Officer	JL
Karl McCluskey	Chief Strategy and Outcomes Officer	KMcC

The meeting will be preceded by a presentation by Dr Craig Gradden of Liverpool Community Health NHS Trust on Integrated Clinical and Quality Strategy

No	Item	Lead	Report	Receive/ Approve	Time
Governance					
GB14/142	Apologies for Absence	Chair	Verbal	R	5 mins
GB14/143	Declarations of Interest regarding agenda items	All	Verbal	R	5 mins
GB14/144	Hospitality Register	Chair	✔	R	5 mins
GB14/145	Minutes of the Previous Meeting	Chair	✔	A	5 mins
GB14/146	Action Points from Previous Meeting	Chair	✔	R	5 mins
GB14/147	Business Update	Chair	Verbal	R	5 mins

AGENDA

No	Item	Lead	Report	Receive/ Approve	Time
GB14/148	Chief Officer Report - including verbal update re Care Makers in CCGs	FLC DF	✔	R	10 mins
GB14/149	Safeguarding Annual Report	DF	✔	A	5 mins
GB14/150	Remuneration Committee Terms of Reference	TJ	✔	A	5 mins
GB14/151	Risk Management Strategy	TJ	✔	A	10 mins
GB14/152	Emergency Preparedness and Resilience and Response Statement of Compliance	FLC	✔	A	5 mins
Finance and Quality Performance					
GB14/153	Integrated Performance Report	KMcC/ MMcD/ DF	✔	R	10 mins
Service Improvement/Strategic Delivery					
GB14/154	Update on CCG Strategy	KMcC	✔	R	10 mins
GB14/155	Care Act 2014	DJ	✔	R	10 mins
GB14/156	Commissioning Policy Review	JL	✔	A	10 mins
GB14/157	Sefton Strategic Needs Assessment	PH	✔	A	10 mins
GB14/158	Better Care Fund Update	TJ	✔	R	10 mins
For Information					
GB14/159	Emerging Issues	ALL	Verbal	R	5 mins
GB14/160	Key Issues reports from committees of Governing Body: a) Quality Committee b) Finance & Resource Committee c) Service Improvement Redesign Committee d) CCG Network		 ✔ ✔ ✔ ✔	 R R R R	
GB14/161	Quality Committee Minutes	-	✔	R	
GB14/162	Finance & Resource Committee Minutes	-	✔	R	
GB14/163	Merseyside CCG Network Minutes	-	✔	R	
GB14/164	Service Improvement Redesign Committee Minutes	-	✔	R	
GB14/165	Locality Meetings: a) Seaforth & Litherland Locality b) Bootle Locality c) Crosby Locality d) Maghull Locality	 - - - -	 ✔ ✔ ✔ ✔	 R R R R	
Closing Business					
GB14/166	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting.*				5 mins
GB14/167	Date, Time and Venue of Next Meeting *Thursday 29th January 2015 at 13.00 at Boardroom, Merton House, Bootle*				-
Estimated meeting close					15.00

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
November 2014

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

No hospitality received

NHS
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Clinical Commissioning Group

Governing Body Meeting in Public Minutes

Date: Thursday, 25th September 2014 at 14.00 – 16.00
Venue: L20 Hotel School, Opposite Hugh Baird College, Bootle, L20

Present		
Dr Clive Shaw	Chair and Clinical Director	CS
Graham Morris	Vice Chair and Lay Member - Governance	GM
Dr Craig Gillespie	Clinical Vice-Chair, GP Governing Body Member	CG
Lin Bennett	Practice Manager and Governing Body Member	LB
Fiona Clark	Chief Officer	FLC
Canon Roger Driver	Lay Member, Engagement and Patient Experience	RD
Debbie Fagan	Chief Nurse	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	SMcG
Dr Andrew Mimnagh	Clinical Director	AM
Peter Morgan	Deputy Chief Executive, Sefton MBC *(co-opted member on behalf of M Carney)*	PM
Dr Paul Thomas	Clinical Director	PT
In Attendance		
Mark Graham	Liverpool Community Health NHS Trust	MG
Karl McCluskey	Chief Strategy and Outcomes Officer	KMcC
Sue Page	Acting Chief Executive, Liverpool Community Health NHS Trust	SP
Ian Senior	Liverpool Community Health NHS Trust	IS
Katherine Sheerin	Chief Officer, Liverpool CCG	KS
Minutes	Bronagh Slater	

Sue Page, Interim Chief Executive at Liverpool Community Health Services NHS Trust, made a presentation updating the Governing Body on the LCH improvement plan.

Action: Mr Astles and Mr Senior to provide details of nursing posts within the community and supply information to Mrs Bennett.

Ms Clark acknowledged the progress made by LCH. Canon Driver reiterated these comments, providing positive feedback from a patient engagement perspective.

No	Item	Action
GB14/119	**Apologies for Absence** were noted from Dr John Wray	
GB14/120	**Declarations of Interest** regarding agenda items – there were no additional declarations to report.	

No	Item	Action
GB14/121	**Minutes of the Previous Meeting**	
	The minutes of the previous meeting were accepted as an accurate record of the previous meeting.	
GB14/122	**Action Points from Previous Meeting** 14/101 Ms Fagan referenced a national IT system issue, which has subsequently been corrected.	
GB14/123	**Business Update** Dr Shaw suggested increased focus was required in relation to the CCG localities. The recent NHS England assurance meeting was a success. The Chair wished to thank staff in the CCG, acknowledging recent challenges.	
GB14/124	**Chief Officer Report** Ms Clark presented her Chief Officer report to the Governing Body. In particular members were advised that in respect of the ongoing issues associated with CHC, the Chief Finance Officer and Chief Nurse are working together to lead on the necessary improvements locally which includes the integration agenda of CHC across Sefton and restitution cases. Good progress continues to be made in respect of the follow up actions arising from the CQC visit to Aintree and there is a continued focus on ensuring that the improvement plan is implemented. Members noted that over the past six weeks work had been undertaken at pace to meet 19th September deadline for the Better Care Fund submission and supported same.	
	The Governing Body noted the content of the report.	
GB14/125	**South Sefton CCG – New Case for Change Process** Mr McCluskey presented the report to Governing Body which outlined the process by which cases for change or investment proposals, under an estimated value of £50,000 will be assessed. The model documentation requires individuals and teams to provide a sufficient amount of information to enable robust decision making in respect of investment opportunities. This will ensure that there is a clear rationale and framework by which such decisions are made and will ensure that investment matches CCG strategic priorities. Ms Bennett noted recent challenges to the process, however, Mr McCluskey assured the Governing Body as to the availability of support to clinicians. Following the discussion at Seaforth & Litherland locality, the consensus was that they were satisfied with this solution. Dr Mimnagh queried what would happen in the event of system failure; Ms Clark advised that a service redesign would be put in place.	
	The Governing Body approved the documentation and associated processes contained within the report, subject to the minor changes proposed.	KMcC

No	Item	Action
GB14/126	**Healthy Liverpool Programme – Committee in Common** Ms Sheerin gave an overview of the Healthy Liverpool Programme which is supported by the Mayor of Liverpool. The CCG is considering the optimum model of care for hospital and out of hospital services. Formal consultation will ultimately be required with NHS England and neighbouring CCGs, for which a Committee in Common is sought. Engagement with the community is ongoing and connection with Liverpool Community Health Services NHS Trust and other providers was highlighted. There is engagement with the Liverpool Health and Wellbeing Board, which is chaired by the Mayor of Liverpool.	
	The Governing Body approved in principle the establishment of a Committee in Common with Liverpool CCG and Knowsley CCG, upon the proviso that the paper will be circulated to the Governing Body after the meeting and email confirmation obtained.	FLC
GB14/127	**Integrated Performance Report** Mr McCluskey highlighted specifics within the Performance report; areas of challenge included Ambulance Performance times, A&E performance and healthcare acquired infections. It was noted that Dr Halstead had clinically-led the C.Diff appeals process and that the CCG Deputy Chief Nurse had chaired the appeals panel, which had been successful in ensuring that decision making was not delayed. In relation to MRSA, Dr Halstead has met with the Medical Director of Aintree University Hospital NHS Foundation Trust, where there is a post infection review process in place. Feedback is sought in relation to the case which was attributed to the Trust by NHS England. In any event, the provider has an appropriate action plan in place. Mr McCluskey referred to the Cancer performance and advised that it has achieved a strong performance across all areas. The NHS screening service achieved a figure of 84.6% against a target of 90% in July to give some context in terms of statistics. As a separate point, Mr McCluskey advised that the schedule of the data run for this report makes it challenging to produce in time for the Governing Body and sought agreement from the Governing Body for this paper to follow the main body of papers, but in advance of the meeting.	
	The Governing Body noted and received the content of the Integrated Performance Report.	
GB14/128	**Month 5 Finance Report** Mr McDowell provided an overview of the financial position of the CCG and went through the figures in detail. There are enough funds reserved in place to cover the forecast overspend and with implementation of its management plan, the CCG remains on track to meet all the business rules required by the NHS.	
	The Governing Body members noted and received this report by way of assurance.	

No	Item	Action
GB14/129	**Management of Allegations Policy** The policy had previously been reviewed by the Corporate Support Governance Group and recommended for approval by the Quality Committee. The Governing Body ratified the Management of Allegations Policy.	
GB14/130	**South Sefton Transformation Programme** Mr McCluskey provided an overview of the report and asked that the Governing Body support the approach to locality development, as well as the development of a project structure to assist in terms of progress. Mrs Jones suggested the need to involve NHS England. The Governing Body approved the recommendations contained within the report.	
GB14/131	**Better Care Fund (Third Iteration)** Ms Clark formally thanked Sam Tunney for her work on this paper and the Better Care Fund in general. Mr Morgan advised that there is still a significant amount of work ahead. The assurance process is now under way. The Governing Body noted that the Health and Wellbeing Board had been asked to sign off the BCF Plan and supporting metrics to enable the submission to be made to the Department of Health within the deadline of 19th September. Ms Clark advised members that the sign off of the BCF submission was achieved on 19th September 2014 by Chair and Chief Officer. The Governing Body received and approved the content of the report.	
GB14/132	**Breast Services at Southport & Ormskirk NHS Trust** Mrs Leonard gave an overview of the paper to the audience and advised that it may affect patients from the Maghull and Crosby area who choose to access services at Southport and Ormskirk NHS Trust. The CCG is not aware of any patients that have had any issues. Working with Aintree in the interim to get some services closer to home so that we have a more sustainable solution. Ms Clark made it clear to the Governing Body that this service has been suspended due to patient safety and the quality Ms Clark also advised that if there are any ladies or families who need support or advice they should please contact the CCG. Dr Thomas expressed some concern over the handover arrangements. Ms Clark advised that the CCG were informed on 8 August when they were advised that the two radiologists were not able to take up their appointments. Dr Thomas sought clarity over services available at Aintree Hospital and the Royal Liverpool. Ms Clark suggested that JL contact Dr Thomas with more information. (a) The GB received the report and noted progress; (b) JL to contact PT with more information.	JL
GB14/133	**Emerging Issues** None to report	

No	Item	Action
GB14/134	**Key Issues Logs** • **Corporate Governance Support Group** *Liverpool Clinical Laboratories* - Dr Gillespie noted the undue pressure placed on staff due to the absence of reporting information. A review is to be conducted and all risks recorded on the risk register with mitigating actions. • **CCG Network** Ms Clark gave an overview of the four key issues, with particular reference to the Home Oxygen Service. (a) The Governing Body received the key issues reports; (b) Mr Astles to review absence of reporting information.	SA
GB14/135	Quality Committee Minutes were received by the Governing Body	-
GB14/136	Finance & Resource Committee Minutes were received by the Governing Body	-
GB14/137	Merseyside CCG Network Minutes were received by the Governing Body	-
GB14/138	Health & Wellbeing Board Minutes were received by the Governing Body	-
GB14/139	Locality Meetings: were received by the Governing Body • Seaforth & Litherland Locality • Bootle Locality • Crosby Locality • Maghull Locality	-
GB14/140	**Any other Business** There was no other business.	
GB14/141	**Date, Time and Venue of Next Meeting** *Thursday 27th November 2014 at 13.00 – Boardroom, 3rd Floor, Merton House*	

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Governing Body Meeting in Public
Actions following meeting in September 2014

No	Action	Action
14/125	**New Case for Change Process** The model documentation requires individuals and teams to provide a sufficient amount of information to enable robust decision making in respect of investment opportunities. This will ensure that there is a clear rationale and framework by which such decisions are made and will ensure that investment matches CCG strategic priorities.	KMcC
14/126	**Healthy Liverpool Programme – Committee in Common** The Governing Body approved the establishment of a Committee in Common with Liverpool CCG and Knowsley CCG, upon the proviso that the paper will be circulated to the Governing Body after the meeting	FLC
14/132	**Breast Services at Southport & Ormskirk NHS Trust** Dr Thomas sought clarity over services available at Aintree Hospital and the Royal Liverpool. Ms Clark suggested that JL contact Dr Thomas with more information.	JL
14/134	**Key Issues Log – Corporate Governance Support Group - Aug 14** *Liverpool Clinical Laboratories* - Dr Gillespie noted the undue pressure placed on staff due to the absence of reporting information. A review is to be conducted and all risks recorded on the risk register with mitigating actions.	SA

NHS
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MEETING OF THE GOVERNING BODY
November 2014

Agenda Item: 14/148	**Author of the Paper:** Fiona Clark Chief Officer Email: fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7069
Report date: November 2014	
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 this report by way of assurance.

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.

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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		x	Various

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

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Report to Governing Body
November 2014

1. NHS Five Year Forward View

The NHS Five Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS. It has been developed by the partner organisations that deliver and oversee health and care services including NHS England, Public Health England, Monitor, Health Education England, the Care Quality Commission and the NHS Trust Development Authority. Patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

The purpose of the Five Year Forward View is to articulate why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery. Everyone will need to play their part – system leaders, NHS staff, patients and the public – to realise the potential benefits for us all. It covers areas such as disease prevention; new, flexible models of service delivery tailored to local populations and needs; integration between services; and consistent leadership across the health and care system.

The Five Year Forward View starts the move towards a different NHS, recognising the challenges and outlining potential solutions to the big questions facing health and care services in England. It defines the framework for further detailed planning about how the NHS needs to evolve over the next five years.

Much of the document resonates with the direction of travel of the CCG, the full document can be found at http://www.england.nhs.uk/ourwork/futurenhs/

2. Co-Commissioning Guidance

On the 10th November 2014 NHS England published *Next steps towards primary care commissioning*. This gives clinical commissioning groups (CCGs) the opportunity to choose afresh the co-commissioning model they wish to assume. It clarifies the opportunities and parameters of each co-commissioning model and the steps towards implementing arrangements. The document has been developed by the joint CCG and NHS England Primary Care Commissioning Programme Oversight Group in partnership with NHS Clinical Commissioners.

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning is a key enabler in developing seamless, integrated out-of-hospital services based around the diverse needs of local populations. It will also drive the development of new models of care such as multispecialty community providers and primary and acute care systems.

There are three primary care co-commissioning **models** CCGs could take forward:

The scope of primary care co-commissioning in 2015/16 is general practice services only. For delegated arrangements this will include contractual GP performance management, budget management and complaints management. However, co-commissioning excludes all functions relating to individual GP performance management (medical performers' lists for GPs, appraisal and revalidation). Furthermore, the terms of GMS contracts and any nationally determined elements of PMS and APMS contracts will continue to be set out in the respective regulations and directions.

Under joint and delegated arrangements, CCGs will have the opportunity to design a local incentive scheme as an alternative to the Quality and Outcomes Framework (QOF) or Directed Enhanced Services (DES). This is without prejudice to the right of GMS practices to their entitlements, which are negotiated and set nationally. In order to ensure national consistency and delivery of the democratically-set goals for the NHS outlined in the Mandate set for us by the government, NHS England will continue to set national standing rules, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets, equivalent of what is collected under QOF, and IT intra-operability.

In joint and delegated arrangements, NHS England and/or CCGs may vary or renew existing contracts for primary care provision or award new ones, depending on local circumstances. CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest. In delegated arrangements, where a CCG fails to secure an adequate supply of high quality primary medical care, NHS England may direct a CCG to act.

A significant challenge of primary care co-commissioning is finding a way to ensure that CCGs can access the necessary resources as they take on new responsibilities. Pragmatic and flexible local arrangements for 2015/16 will need to be agreed by CCGs and area teams.
Conflicts of interest need to be carefully managed within co-commissioning. Whilst there is already conflicts of interest guidance in place for CCGs, this will be strengthened in recognition that co-commissioning is likely to increase the range and frequency of real and perceived conflicts of interest, especially for delegated arrangements. A national framework for conflicts of interest in primary care co-commissioning will be published as statutory guidance in December 2014.

The approvals process for co-commissioning arrangements will be straightforward. The aim is to support as many CCGs as possible to implement co-commissioning arrangements by 1 April 2015. Unless a CCG has serious governance issues or is in a state akin to "special measures", NHS England will support CCGs to move towards implementing co-commissioning arrangements. CCGs who wish to implement joint or delegated arrangements will be required to complete a short proforma and request a constitution amendment. The approvals process will be led by regional moderation panels with the new NHS England commissioning committee providing final sign off for delegated arrangements.

NHS England intend to make it as simple as possible for CCGs to change their co-commissioning model, should they so wish.

On-going assurance of co-commissioning arrangements will form part of the wider CCG assurance process. NHS England intends to work with CCGs to co-develop a revised approach to the current CCG assurance framework. NHS England will also ensure it continually evaluates the implementation of co-commissioning arrangements to share best practice and lessons learned with CCGs and area teams. CCGs and NHS England must comply with public procurement regulations and with statutory guidance on conflicts of interest.

http://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf

3. South Sefton CCG Assurance Quarter 1

The CCG received written confirmation of the outcome of quarter 1 assurance, following the meeting on the 11th September 2014. NHSE (Merseyside) acknowledged the overall progress South Sefton CCG has made to date. Below is a summary of assurance for each domain:-

Domain 1 – Are patients receiving clinically commissioned high quality services?
Assurance level: Assured

Domain 2 – Are patients and public actively engaged?
Assurance level: Assured

Domain 3 – Are CCG plans delivering better outcomes for patients?
Specific challenges were highlighted by the CCG in relation to Cancer, 4 Hour Standard Aintree University Hospitals NHS Foundation Trust, and North West Ambulance Service (NWAS) with other areas for future monitoring to ensure continued performance such as Referral to Treatment (RTT).
Assurance level Domain 3: Assured with support.

Domain 4 – Does the CCG have robust governance arrangements?
Assurance level: Assured

Domain 5 – Is the CCG working in partnership with others?
Assurance level: Assured

Domain 6 – Does the CCG have strong and robust leadership?
Assurance level: Assured

In summary NHS England (Merseyside) have confirmed that South Sefton CCG is assured for Quarter 1, with Domain 3 (Are CCG plans delivering better outcomes for patients) being the only domain which is assured with support, this is consistent across Merseyside.

4. Aintree University Hospital NHS Foundation Trust - Emergency Pathway

The CCG has been leading on a piece of work to assess and understand the changes in the pathway that have occurred over the year in terms of activity and patient flow, working together with the CSU and supported by Liverpool CCG. The key findings have been prior to June 2013; GP referrals have been attending A&E, with onward admission being made to the MAB where clinically appropriate. CDU activity has been diminishing over the year, to June and indeed ceased with the revised pathway changes made from June.

This CDU activity previously supported the 4 hour performance in A&E, however with its discontinuation; these patients are now being admitted rather than attended. The new pathway has demonstrated a significant increase in admissions from June. To date A&E 4 hour performance continues to be challenged and remains below 95%. There is no evident increase in length of stay related to the changes made to the pathway.

The CCG has detailed the findings to the Aintree Collaborative Commissioning Forum and with their agreement has issued a contract query in relation to the changes.

5. Cheshire/Mersey Neuro/Acquired Brain Injury (ABI) Rehab Pathway

This pilot scheme was established by Merseyside PCT Cluster in the last year of its existence and initially set up to run for 2 years. The CCG's are responsible for the commissioning of "spoke beds" with units housed in St Helens and Broadgreen Hospitals, along with local Community services.

The initial review conducted by the Cheshire and Mersey Rehabilitation Network reported that the impact of the pilot has been positive. In discussions at the CCG network, members noted the review but suggested that further independent evidence would be helpful in terms of supporting a decision to permanently commission the service.

On this basis, it is recommended that the pilot is extended for a further 12 months and the Governing Body is asked to approve this recommendation. The funding associated with this pilot has been included within the CCG's strategic financial plan for 2015/16.

6. Integrated Personal Commissioning

The CCG, in partnership with Southport & Formby CCG, Sefton Council, Sefton Council for Voluntary Services and Mersey Care NHS Trust, submitted an application earlier this month to participate in a nationally-led programme to facilitate Integrated Personalised Commissioning (IPC).

The programme supports Health and Wellbeing Board areas that wish to move towards developing person-centred approaches for those with complex needs, to deliver better outcomes by tailoring support to better meet their needs.

It also aims to promote integrated working across health and social care and the voluntary sector and is focused on those who may be most at risk of a crisis or unplanned admissions which, through more tailored support, could be avoided.

Our proposal builds on plans to develop pooled and personal budgets and in the first instance focuses on possible cohorts with complex learning disabilities, complex mental health and Chronic Obstructive Pulmonary Disease. If successful the plans would begin implementation from April 2015.

7. North West Commissioning Support Unit (NWCSU)

As of 1st October 2014, the formal coming together of Cheshire and Merseyside Commissioning Support Unit (CSU) with Greater Manchester CSU was completed which saw the creation of the North West Commissioning Support Unit (NWCSU).

The CCG and the CSU have now agreed to extend the current Service Level Agreement (SLA), at current prices, until the end of March 2015. This has enabled the senior team to undertake an internal review of CSU service areas in order to inform CSU commissioning intentions for 2015/16. This review will be completed by the end of November, when it is expected that we will be in a position to inform the CSU of proposed changes to the SLA, including the possibility of bringing a number of service lines in-house.

This will allow for a sensible transition period, in which we can to assess the impact of potential changes and agree implementation plans for April 2015.

8. Health and Wellbeing Board (HWBB)

The Health and Wellbeing Board continues to progress work on integration through its Programme and Integration Group and Provider Forum.

We have now received the outcome of the national assurance process for the Better Care Fund, which is a separate report on this agenda. With regards the outcome, the Sefton Plan has been approved with conditions.

In order to progress with pace and move further from planning to delivery of our integration ambition, discussions have been held with both the Better Care Fund Advisor for Sefton to seek support to take forward 'economic modelling' of the wider health, care and wellbeing economy in Sefton and specifically, the impact of the BCF, the Care Act and other legislation which is challenging the overall system in which we operate.

Work will now continue at pace on the engagement of all our Providers through the HWBB Provider Forum. This should ensure that the system locally is able to step up to the challenges. Discussions have commenced with the Kings Fund with the aim of them facilitating a series of sessions to engage with partners across the health, care and wellbeing economy system.

9. Merseyside Quality Surveillance Process - Single Item Quality Surveillance Group Meetings with the Provider Present

There have been three Single Item Quality Surveillance Group Meetings (SIQSG) at which the providers were present. These were chaired by NHS England (Merseyside) in October 2014.

These meetings involved Aintree University Hospital NHS Foundation Trust, SSP and the Royal Liverpool & Broadgreen University Hospitals NHS Trust.

The SIQSG regarding Aintree University Hospital NHS Foundation Trust was a single topic meeting to discuss A&E performance.

The single item Quality Surveillance Group Meeting was held with NHS England and SSP Health Ltd on October 9th 2014. The purpose of the meeting was to establish if there was evidence of any problems with the quality of primary care medical services delivered by SSP Health Ltd which impacted upon patient safety, clinical effectiveness, or patient experience. The QSG examined issues relating to a number of areas, considered evidence presented and heard from a number of

stakeholders including CCG representatives. As a result, the QSG felt assured that there were no significant concerns relating to the provision of general practice services by SSP Health. On this basis, the QSG partners unanimously agreed that the QSG process in relation to SSP Health should be concluded.

In the case of all three providers, NHS England (Merseyside) concluded that the necessary level of assurance had been received at this time. Provider quality will continue to be monitored via the existing mechanisms that are currently in place.

10. 0-5 Years Child Health Transition

From 1st October 2015, the Government intends that Local Authorities take over responsibility from NHS England for commissioning public health services for children aged 0-5. This includes Health Visiting and Family Nurse Partnership (a targeted service for teenage mothers).

The commissioning of Child Health Information Systems and the 6-8 week GP check (also known as Child Health Surveillance) will not transfer. Health Visiting and Family Nurse Partnership (FNP) contribute to the national, universal Healthy Child Programme (HCP). The Government intends to mandate certain elements of this programme : Antenatal health promoting visits, new baby review, 6-8 week assessment, 1 year assessment and 2-2 ½ year assessment.

In Merseyside, NHS England chairs a Health Visiting assurance board which aims to ensure a collaborative approach to oversight, management and governance of both health visiting and FNP during the transition. Another group chaired by Sefton Council Chief Executive provides strategic assurance that councils across Merseyside are prepared to receive the commissioning responsibility. Local authority public health and early years' leads as well as the two Sefton CCGs are represented on these groups.

The Chief Nurse attended the first Sefton Transition Meeting Chaired co-ordinated by Sefton Public Health commissioners in October 2014 to represent the CCG. Progress will be reported to the Early Life Forum as part of the local HWBB governance arrangements as well as within the CCG.

NHS England and Sefton Council have submitted an initial budget template outlining the budget and staffing trajectory for both Health Visiting and FNP to the Department of Health. The final allocations are expected in December 1014. Liverpool Community Health is expected to meet their staffing trajectory.

FNP will also be rolled out across Sefton prior to October 2015. Sefton council has indicated to both NHS England and the provider that it does not intend to commission a new service to be in place by October 2015. The council intends to review these services as part of an integrated 0-19 Health Child Offer along with school health and early years' interventions.

The Sefton operational group, chaired by public health, will work with NHS England to ensure stakeholder engagement events planned for early 2015 provide relevant updates and opportunities to discuss future priorities. This work is on-going across the Merseyside area to ensure the successful transition for commissioning Health Visiting Services from NHS England to Public Health Teams within Local Authorities in time for October 2015.

11. CCG Student Placement Audit

To support the CCG ambition to become a Teaching CCG, a student placement audit was undertaken in October 2014 by the North West Placement Team and Edge Hill University. A successful audit was undertaken to enable the CCG to be both a hub and spoke placement and the Chief Nurse or Deputy Chief Nurse will formally sign-off the audit in late November 2014.

Mentorship updates have been arranged for the Chief Nurse, Deputy Chief Nurse and Practice Nurse Facilitators in order to take students from January 2015. The North West Placements Team has stated that the two CCGs in Sefton will be the first CCGs nationally to be recognised as a hub and spoke placement site.

12. CCG Safeguarding Peer Review

Following the presentation of the CCG Safeguarding Peer Review to the Governing Body meeting which was held in public in July 2014, the Chief Nurse delivered the findings of the review and progress to date to the Sefton Safeguarding Adult Board in October 2014. A date has been confirmed for December 2014 for the Chief Nurse to repeat this to the Sefton Local Safeguarding Adult Board.

13. Court of Protection

Since September 2014, the CCG has been required to attend Court on two occasions due to being named as a Third Party to Court of Protection proceedings. With regard to the second case, the CCG was named as a witness for the Local Authority and was required to give evidence under oath in Court.

14. Southport & Ormskirk Hospitals NHS Trust Chief Inspector of Hospitals Inspection Visit

The CQC have undertaken a Chief Inspector of Hospitals Inspection Visit to Southport & Ormskirk Hospitals NHS Trust which commenced on 10 November 2014. The purpose of such a visit has been previously reported to the Governing Body in the Chief Officer Report. The outcome of the visit will be reported to both the Quality Committee and the Governing Body once known.

15. Francis Inquiry - Sefton Overview & Scrutiny Committee

The Chief Officer delivered a presentation to the Overview and Scrutiny Committee in October 2014 regarding the Francis Inquiry. The presentation also included information on subsequent reports and the Chief Nursing Officer national Care Strategy as well as CCG compliance with the recommendations.

16. IM&T Update

Informatics Merseyside continue to rollout a portfolio of IM&T projects to the CCG and to constituent GP practices. Current highlights include:

- The initial rollout of Mobile Computing has been completed and as a result, 27 GP practices and 46 users are now live with the ability to access their clinical system ‘on the move’ for home visits via ERICOM software. A pilot of the EMIS Mobile application is also about to commence;

- The initial phase of EMIS Web rollout is complete with 32 GP practices now on Web. A further site currently on INPS Vision has booked a system demo with EMIS;

- EMIS Web has been installed and configured for the Virtual Ward and Managed Referrals (electronic) is now live and operational in 1 practice and will be rolled out to all sites shortly;

- All GP practices are now live with the ability to receive electronic discharge summaries with Trusts. All Trusts in the local area are working towards 100% of documents being sent in this manner and ultimately, safely switching off paper discharges;

- 15 GP practices across South Sefton are now live with Summary Care Record with a further 10 booked in prior to the end of March 2015;

- An initial site will be live with Electronic Prescription Service (EPSR2) by the end of November with further sites scheduled in after this. EPS gives the ability to send electronic prescriptions to dispensers;

- Clinical data sharing is well established across South Sefton with GP practices sharing appropriate clinical data with numerous services within Liverpool Community Health and Aintree. As most LCH services are on EMIS Web Community, GP practices are also able to view community data from within their own system;

- GP practices will shortly receive a communique with details on how to go live with Patient Access to Medical Records. Access can be customised by each practice and builds on online patient services already in place; online appointment booking and online repeat medications.

17. NHS England Reconfiguration

The process for reconfiguring NHS England is underway following the required period of consultation.

Interviews are being held this week for the Area team Directors, there are 12 vacancies. It is a national process.

Further work will then occur to recruit to the Area team structures. It is expected that the Cheshire & Merseyside team will be completed for January 2015.

18. Confirmation of External Auditors

On 9th September 2014, the Chief Officer received confirmation that KPMG LLP has been appointed to audit the accounts of South Sefton CCG from 2015/16 for two years. The appointment will start on the 1st April 2015.

Originally the proposed appointment was EY LLP and due to the nature of the shared management arrangements with Southport and Formby CCG and therefore the practicalities of the shared finance team having to liaise with two separate audit firms, it was agreed by both Audit Committee Chairs in liaison with the Chief Finance Officer to request alignment.

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19. Healthy Liverpool/Committee in Common (CIC)

On 3rd November 2014, the Healthy Liverpool-Prospectus for Change was launched. This is a culmination of work commenced by the Mayor of Liverpool Joe Anderson in 2012. Liverpool CCG set up the Healthy Liverpool programme in response to this challenge. The programme sets out a clear vision for health improvement from the people of Liverpool, the outcomes expected and the plan for delivery of the vision. Members of SSCCG have been engaged in the relevant steering groups which have been supporting the programme. This has been recently strengthened by Dr Dan McDowell attending the Realigned Hospital Services group.

In order to support the Governance of Healthy Liverpool, due to its geographical boundaries and potential impact and commonalities, the Governing Body received a paper at its September 2014 meeting to establish a Committee in Common (CIC). This was approved and the CIC established.

The first meeting of the newly formed (CIC) met on 5th November 2014. South Sefton CCG is represented by Chair - Dr Clive Shaw, Deputy Chair - Graham Morris and Chief Officer - Fiona Clark, with the rest of the membership being made up of Liverpool CCG, Knowsley CCG and NHS England.

The draft terms of reference were reviewed and slight amendments made following discussion and clarity re governance arrangements. It was agreed that scrutiny arrangements for each LA to be described and shared and the 'live' work by NHSE re specialised services in Liverpool and the relationship / impact on HLP to be shared.

Future meetings are to be held on the 1st Wednesday of the month, the next meeting is January 7th 2015. The governing body will receive ongoing updates.

20. Recommendation

The Governing Body is asked to receive this report.

Fiona Clark
Chief Officer
November 2014

NHS
South Sefton
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MEETING OF THE GOVERNING BODY
November 2014

Agenda Item: 14/149	**Author of the Paper:** Ann Dunne Designated Nurse, CCG Safeguarding Service Email: des.nurses@nhs.et Tel: 0151 495 5469
Report date: November 2014	

Title: Safeguarding Annual Report

Summary/Key Issues:

This annual safeguarding report is to provide assurance to the Governing Body that the organisation is effectively responding to the safeguarding needs of children, adults and their families across the constituency.

Recommendation

The Governing Body is asked to approve the Safeguarding Annual Report 2013/14.

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 Care Closer to Home.
	Review and re-specification of community nursing services ready for re-commissioning from April 2015 in conjunction with membership, partners and public.
	Implementation of 2014/15 phase of Primary Care quality strategy/transformation.
	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
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		To be presented at Quality Committee in December 2014 due to timelines for submission of papers.

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
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South Sefton CCG Safeguarding Annual Report 2013/14

November 2014

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1. Purpose of the Report

The purpose of this annual safeguarding report is to provide assurance to NHS South Sefton Clinical Commissioning Group (CCG) Governing Body that the Organisation is effectively responding to the safeguarding needs of children and their families across the Merseyside and Halton area. The report reviews the work completed across the 2013 / 14 financial year, giving assurance that the CCG has discharged its statutory responsibility to safeguard the welfare of children and adults both as an Organisation and across the health services it commissions.

This is the first full year report for safeguarding children and adults and builds on the strengths which have transferred from the Primary Care Trust Cluster arrangements pre 2013. The report provides information about national changes and influences, local developments and activity about how statutory requirements are being managed.

2. The NHS Reforms and Merseyside.

The Health and Social Care Act 2012 has radically transformed how health services are now delivered. Since April 2013, Clinical Commissioning Groups (CCGs) have been responsible for the majority of health service commissioning.

CCGs are statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. This includes specific responsibilities for looked after children and for supporting the Child Death Overview Process, to include sudden unexpected death in childhood. Local authorities have the same responsibilities in relation to the public health services that they commission.

The CCG safeguarding resource to support safe discharge of these responsibilities has been created and further developed from the resource inherited from the PCT Cluster arrangements pre April 2103.

3. National context

3.1 National Health Service (England)

In March 2013, the NHS Commissioning Board (now known as NHS England) published the ‘Accountability and Assurance Framework: Safeguarding Vulnerable People in the Reformed NHS’.
The accountability and assurance framework was commissioned by NHS England in order to set out clearly the responsibilities of each of the key players for safeguarding

in the future NHS. It has been developed in partnership with colleagues from the Department of Health (DH), the Department for Education (DfE) and the wider NHS and social care system.

The Mandate from the Government to the NHS Commissioning Board, now known as NHS England (NHSE), 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 Mandate also sets NHS England a specific objective to continue to improve safeguarding practice in the NHS, reflecting also the commitment to prevent and reduce the risk of abuse and neglect of adults.

Safeguarding accountabilities of CCGs are set out in the Accountability and Assurance Framework: Safeguarding Vulnerable People in the Reformed NHS (NHS England 2013), and include:

- Plans to train staff in recognising and reporting safeguarding issues;
- A clear line of accountability for safeguarding properly reflected in the CCG governance arrangements;
- Appropriate arrangements to co-operate with local authorities in the operation of Local Safeguarding Children Boards (LSCBs) and Safeguarding Adult Boards (SABs)
- Securing the expertise of a designated doctor and nurse for safeguarding children and for looked after children and a designated paediatrician for unexpected deaths in childhood;
- Having a safeguarding adult lead and a lead for the Mental Capacity Act, supported by the relevant policies and training.

3.2 Clinical Commissioning Groups (CCG's)

As part of the assurance and accountability framework there is a clear directive as to the role and responsibilities of the CCG's, this includes the establishment of a Governing Body. The role of the Governing Body is to ensure and assure good governance and the critical link between good governance and improvement in outcomes for patients. Specific duties for the Governing Body are outlined in Clinical Commissioning Group Governing Body Members: Role outlines, attributes and skills (October 2012).

4. Local Context

4.1 Merseyside Approach to Safeguarding

To meet the requirements for authorisation with regard to safeguarding, the six CCGs across Merseyside agreed to jointly commission a service approach to the delivery of safeguarding function for both children and adults. This was to promote resilience, reduce variations in provision, ensure consistency in delivery and enable the development of a sustainable and flexible commissioning safeguarding workforce. A Memorandum of Understanding was developed to support this methodology. The Service comprised of ten whole time equivalent posts. The agreed model of operation was that of having a named designated professional for both children and adults facing each of the CCG / Local Authority areas further supported by the use of individual expertise within the Service to lead on work streams across the health economy as a whole. The service is managed by means of a 'hosted' arrangement which has been agreed by the six CCGs through a service level agreement, which is under the management of Halton CCG

The reporting year has been one of great challenge and uncertainty due to staff changes, recruitment issues and long term sickness for example for part of the year the CCG Safeguarding Service Children's team were operating at 40% capacity , the Adult Team has never reached full capacity and it has proved difficult to recruit to vacant posts.

In spite of the concerns with regard to capacity within the service (for both adults and children) the team have maintained a high level of professionalism and integrity to ensure that children and adults are kept safe, and that the CCGs statutory obligations in relation to safeguarding were fulfilled.

It is relevant to make reference to and understand the demographics of the area in order to appreciate the impact on both the CCG and our commissioned services. Across Merseyside, around 25% of the population is aged 19 or under. In all Boroughs the populations aged 0-4 and 5-9 are expected to increase. The biggest increases will be found in Knowsley (approximately +11% by 2015). There will be a decrease in the population aged 10-14 and 15-19 by 2015 in each borough. It is anticipated that the largest decreases in population will occur amongst those aged 15- 19 in Sefton (-22%0 and Liverpool (-21%). This is likely to be attributed to the fluctuating birth rates over the last 20 years across Merseyside, however as a whole, the population across the region is relatively static.

The health and well-being of children in Merseyside is mixed compared with the England average. The infant and child mortality rate is similar to the England

average whereas the level of child poverty is worse than the England average with 35% of children aged under 16 years living in poverty.

Merseyside has amongst the highest rates of Poverty in the country, with Liverpool 4th most deprived, Knowsley 7th, Halton 22, St Helens 47 and Sefton 80th (deprivation indices, 2010). The correlation between poverty and child neglect is well documented (NSPCC, 2008), given that all the Local Authority areas across Merseyside have reported significant increases in children made subject to child protection plans under the category of neglect it is important to acknowledge the impact that this will have on services providing care to children. Poverty and neglect are strongly associated with other health concerns such as alcohol abuse, substance misuse, obesity etc.

Children in Merseyside have higher than average levels of obesity. 12% of children in Reception and 22% of children in Year 6 are classified as obese, the children Halton faring the worst with higher than average levels of obesity: 11.8% of children aged 4-5 years and 23.1% of children aged 10-11 years are classified as obese. (Chi Mat, 2014). 54% of children participate in at least three hours of sport a week which is worse than the England average. The hospital admission rate for alcohol specific conditions is higher than the England average. The percentage of children who say they have been drunk recently is lower than the England average. The hospital admission rate for substance misuse is similar to the England average. The percentage of children who report drug use is lower than the England average (Chi Mat, 2014).

Sefton Children and young people under the age of 20 years make up 21.9% of the population of Sefton. 5.6% of school children are from a minority ethnic group. The health and wellbeing of children in Sefton is generally similar to the England average. The infant mortality rate is similar to and the child mortality rate is better than the England average. The level of child poverty is similar to the England average with 20.9% of children aged under 16 years living in poverty. Children in Sefton have average levels of obesity: 10.2% of children aged 4-5 years and 20.0% of children aged 10-11 years are classified as obese.

All the above have a direct impact on safeguarding and safeguarding services including those services which will be commissioned by the CCGs across Merseyside. Although it is often very difficult to quantify, statistically with a population with a generally poor health profile this will have implications as to how safeguarding services operate and are configured to ensure that the best possible outcomes are achieved for our children.

5. Safeguarding Children

5.1 Statutory Guidance

5.1.1 Working Together to Safeguard Children 2013

This statutory guidance clarifies the responsibilities of professionals towards safeguarding children, and strengthens the focus away from processes and onto the needs of the child. Last published in 2010, Working Together has been revised and came into force on April 15th 2013.

In response to recommendations from Professor Eileen Munro's report, 'A Child Centred System' 2011 *Working Together to Safeguard Children 2013* guidance clarifies the core legal requirements on individuals and organisations to keep children safe. It sets out, in one place, the legal requirements that health services, social workers, police, schools and other organisations that work with children, must follow – and emphasises that safeguarding is the responsibility of all professionals who work with children.

5.1.2 Multi-agency safeguarding arrangements

CCGs have a statutory duty to be members of Local Safeguarding Children Board working in partnership with local authorities to fulfil their safeguarding responsibilities. These statutory duties fall under Section 11 of the Children Act 2004 and apply to a range of organisations as well as the health economy.

5.2 Local Safeguarding Children Boards (LSCB)

LSCBs were established in law by the Children Act 2004 (section 13) and have two main responsibilities:

- To co-ordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in their local community.
- To ensure the effectiveness of what is done by each such person or body for those purposes.

There are five LSCBs serving the six CCG areas across Merseyside and Halton (Liverpool, Knowsley, Halton, St Helens, Sefton).

The five LSCBs across Merseyside and Halton are partnerships, working to safeguard and promote the welfare of children. As individual LSCBs they place a statutory responsibility on all agencies in the Merseyside and Halton area, including

CCGs to provide assurance that they are working to ensure that all children and young people across the area stay safe and are adequately protected. They are responsible for coordinating and ensuring the effectiveness of services across Merseyside and Halton in protecting and promoting the welfare of children and young people and provide the vital link between various statutory and voluntary organisations.

The LSCB has faced many challenges over the year due to significant external factors including the changes to national guidance, the reconfiguration of the health economy and organisational restructuring of member organisations in response to the austerity measures.

In response to the health economy changes and to ensure full and equitable contribution, from all Organisations, to the LSCB agenda a health sub group has been established.

Priorities for the LSCB in 2013/14 have included child neglect, child sexual exploitation and the requirement for thresholds to be redefined and the development of a comprehensive response across partners to early help. Work programmes have been developed to ensure that there is an increased understanding and awareness of these agendas within and between agencies. This work will continue to progress into 2014/15.

The CCG is integral to the LSCB and makes a significant contribution to the work of the LSCB both financially and through the work undertaken by the designated and professional leads for safeguarding. This work includes membership of the Strategic Board, contributing to and or Chairing sub groups of the Board, contributing to and or leading on multi agency audit and contributing to and providing the health perspective on serious case reviews (or any other reviews in line with the learning improvement framework as per Working Together 2013)

5.2.1 Section 11 the Children Act 2004

Section 11 of the Children Act 2004 places a duty on key persons and bodies to make arrangements to ensure that whilst doing their jobs they have regard to the need to safeguard and promote the welfare of children. The CCG is one such key body, This section also states that these key bodies must take any guidance given to them by the Secretary of State and have clear reasons for not doing so. However this duty does not give any other health professional any new functions, nor does it override their existing functions. Simply it requires them to carry out their existing functions in a way that takes into account the need to safeguard and promote the welfare of children.

Working Together 2013 gave Local Safeguarding Children Boards a framework and responsibility to assess whether their local partners are fulfilling their statutory obligations under section 11 of the Children Act 2004 i.e. those Organisations should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children

In response to this guidance the LSCB's have reviewed the Section 11 process and most invested in a regionally agreed on line audit tool. This promotes consistency and quality across the area and specifically aids the health economy where Organisations face one or more Local Authority areas. This method also enables the CCG to better analyse commissioned health services compliance and quality with respect to safeguarding responsibilities.

The CCG are subject to the same scrutiny as the services we commission and has submitted their response to the LSCB in accordance with the process. The analysis and validation of these responses has yet to be progressed and completed

5.3 Child Death Overview Panel (CDOP) arrangements

As per the Working Together guidance 2013, Local Safeguarding Children's Boards are responsible for ensuring that a Child Death Overview Panel (CDOP) undertakes a review of each death of a child under 18, normally resident in the LSCB area. The CCG is an active member of these Panels.

As numbers of deaths are relatively small, to be better able to identify significant themes and trends, the Safeguarding Children Boards of Liverpool, Sefton and St Helens have come together to form the pan Mersey CDOP who have published their first annual report in this year, this has been presented to the LSCB Board. The report provides an analysis of deaths reviewed during 2012/13.

Knowsley were responsible for their own CDOP during the 2013/14 period but reached an agreement to join the Merseyside CDOP from 1st April 2014. The Annual report has not yet been submitted to the LSCB.

Halton is a member of the Pan-Cheshire CDOP and have participated within this panel during 2013/14. The Annual report has not yet been submitted to the LSCB.

Table 3 demonstrates the number of child deaths including modifiable factors by CCG area

Table 3:

CCG	Number of Child Deaths	Modifiable factors	Total Child Population
Liverpool	33	4	105,700
Knowsley	10	4	36,400
Sefton	13	4	60,100
St Helens	11	0	40,600
Halton	5	Not available	31,200
Total	72		274,000

*Figures for 2013 /2014

In reviewing the death of each child, the CDOP considers whether the death was deemed preventable, that is, those deaths in which modifiable factors may have contributed to the death and decide what, if any, actions could be taken to prevent future such deaths. Modifiable factors are defined as those which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths (Chapter 5, para 10 *Working Together to Safeguard Children,* HM Government 2013).

The modifiable factors identified by the Merseyside CDOP included: co-sleeping and substance misuse, smoking and alcohol, IVF exceeding NICE guidelines regarding the number of eggs implanted and appropriate adult supervision. *A copy of the 2013/14 Merseyside CDOP annual report, can be accessed via the LSCB websites*

In response to the themes and learning from the cases heard in Cheshire; Pan Cheshire CDOP have been working to improve the awareness of the signs and symptoms of cardiac conditions and with the Road Traffic Police to improve awareness for young people and issues affecting road safety.

Priorities for 2014/15 include a retrospective six year study of child deaths (within the Mersey region) and a review of the rapid response model currently utilised within both Mersey and Cheshire.

5.4 Safeguarding / Child Protection

Safeguarding children activity is reported quarterly to the Local Safeguarding Children Board but continues to be predominantly social care based. A significant challenge to the Board continues to be about how to expand the data set to encompass and be aware of member agencies performance / activity data.

Activity is tracked from early intervention through to children in care. The child's journey is followed through services. The following information provides a brief overview of children with child protection plans in the Merseyside and Halton local authority areas at 31st March 2014:

Child Protection Plans – Children are placed on child protection plans when they are considered to be in need of protection from either physical, sexual or emotional abuse, or neglect. The plan outlines the main risks to the child, what action is required (and by whom) to reduce those risks and make the child safe. At the end of March 2014 there were a total of 1198 children on plans in across Merseyside and Halton (breakdown by area as Table 1). It is becoming increasingly evident that domestic abuse within the home is a feature in the majority of cases where children are being made subject to a child protection plan, as a consequence domestic abuse is a key focus of the Local Safeguarding Children Board in addition to being identified as an area for development within our safeguarding strategy 2014- 2016.

Table 1:

LA Area	Liverpool	Knowsley	Halton	St Helens	Sefton
Total under 19 years	105,700	36,400	31,200	40,600	60,100
Total CP Plan	391	192	162	239	214

*Figures as of 31March 2014

There are four categories to which a child may become subject of a child protection plan: emotional, neglect, physical or sexual abuse. A child may be subject to more than one type of abuse but will be categorised under the most prevalent.

All Local Authority areas have shown a marked increase in the number of children subject to plans from the previous reporting year 2012/2013. This increased activity has impacted on the resources within the commissioned health services in addition to the CCG services. The CCG are monitoring this by the contractual process and

will respond accordingly to ensure that safe services continue to be delivered. Hypothesis as to why these increases are being seen include; potential deficiency in comprehensive early intervention services, increased staff awareness due to comprehensive training strategies on safeguarding and associated risk factors. It has been noted that there has been a parallel rise in the number of notifications for domestic abuse, this will also further impact upon the figures and appears to correlate with the increased numbers of plans where emotional abuse and neglect have been recorded.

5.5 Looked After Children (LAC)

In accordance with the Children Act 1989, a child is defined as being 'looked after' by a local authority if he or she is in their care or is provided with accommodation for a continuous period of more than 24 hours by the authority (this will includes Unaccompanied Asylum Seeking Children).

Children and young people who are looked after are amongst the most socially excluded groups. They have profoundly increased health needs in comparison with children and young people from comparable socio-economic backgrounds who have not needed to be taken into care. Whilst within the care system, there is opportunity for this imbalance to be addressed, these children and young people need to be able to access universal services as well as targeted and specialist services where necessary.

National data shows that there were 68,110 looked after children at 31 March 2013, an increase of 2 per cent compared to 31 March 2012 and an increase of 12 per cent compared to 31 March 2009. Table 4 illustrates the number of looked after children across the Merseyside footprint.

Table 4:
Numbers of LAC children per Local Authority Area

Liverpool	Knowsley	Halton	St Helens	Sefton
990	258	210	432	343

*Figures as of 31st March 2014

Table 5:

Comparable LAC data across the North West benchmarked against England (per 10,000 population)

England	Cheshire East	Cheshire West & Chester	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
60	50	58	51	73	108	78	121	52	99

*Figures as of 31st March 2014

As evidenced in the above Tables, the statistics demonstrate the high levels of children in care of the Local Authorities (LA) within the region, four of our five Local Authorities are significantly higher than the National benchmark.

Hypothesis as to why these increases are being seen include; potential deficiency in comprehensive and successful early intervention services and or lack of understanding about the efficacy of the child protection intervention.

When children are placed in care by local authorities, the responsible health commissioner has a statutory responsibility to commission an initial health assessment and conduct six monthly or yearly reviews. When the child is placed out of area, the originating commissioner retains this responsibility.

The purpose of the health assessment is to enable the child to have his or her health needs assessed holistically and to develop a plan to meet these needs; it should be seen as part of continuous activity to ensure the provision of high quality health care and not just an isolated event.

National guidance published in 2013 directs commissioners of health services for Looked after Children to ensure efficient and effective services to this vulnerable population. CCG's as one such Commissioner will be held to account for the quality of these services.

In recognition of this statutory responsibility the CCG is obligated to ensure that all health assessments are undertaken within agreed timescales in accordance with *Statutory Guidance on Promoting the Health and Well-being of Looked After Children (DCSF, 2009).*

To achieve this, the CCG has the current commissioning arrangements in place: Alder Hey Children's NHS Foundation Trust (AHCFT) community paediatric service is commissioned to co-ordinate and quality assure the delivery of statutory initial health assessments across the Mersey region by the. Borough specific Community Health provider trusts have the on-going responsibility for the provision of all review health assessments. This is commissioned as a Nurse led service.

The CCG has experienced challenges in respect of the current commissioning arrangements. This has been attributed to administrative systems and lack of capacity within community paediatrics hosted at AHCFT. This has resulted in assessments not having been undertaken within agreed timescales (national and local) and drift being introduced into the system. The CCG have agreed interim arrangements be put into place to ensure that these children and young people receive a safe and timely service, whilst longer term solutions are decided upon. To mitigate any risks remaining within the system Liverpool CCG (as coordinating commissioner) have decided to commission a whole service review during 2014/15 involving the Royal Colleges.

Halton CCG commissioning arrangements are via Bridgewater Community Healthcare NHS Trust (Paediatrics and Nursing). Similar experiences have been experienced within this system, mitigation plans have been put in place and significant work has been done to better understand the presenting issues affecting this vulnerable cohort of children and young people.

In the interim and in view of the above, the CCG has strengthened the KPI data set within the quality schedule for the 2014/2015 year which will demonstrate the timeliness of initial and review health assessments undertaken for all LAC and better understand any challenges faced.
The strategic coordination and delivery of service to looked after children was highlighted as an area of risk for the CCGs in the external safeguarding review as the designated function for LAC is clearly described within the Assurance and Accountability framework as a CCG responsibility. This function has historically been invested within the community provider organisations. The CCG is working towards a more comprehensive approach to discharging its responsibilities in relation to looked after children, service delivery however is largely unaffected there are plans in place to mitigate any risk and to enable the CCG to be fully compliant.

Although the new commissioning arrangements create additional complexities in promoting the health and well-being of children looked after, they also provide opportunities as local authorities are now required (through their new public health role) to make services available to children looked after, including those they are hosting in out of area placements, as part of the general population.

As a priority for the coming year; to ensure there is whole systems approach in promoting the health and well-being of children looked after the CCG designated safeguarding leads are supporting the local authority commissioners, including public health to develop one service specification which addresses the statutory requirements of the respective commissioners and improves the outcomes for this most vulnerable group of children and young people

5.6 Serious Case Reviews and Domestic Homicide Reviews

When a child dies and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a serious case review (SCR). The purpose of the review is to identify improvements that are needed and to consolidate good practice with the findings from the reviews being translated into programmes of action with the aim of delivering sustainable improvement and the prevention of death, serious injury or harm to children.

The reporting year has seen the introduction of a 'systems methodology' applied to SCRs as recommended by Professor Eileen Munro (The Munro Review of Child Protection: Final Report *A child-centred system, 2011).* This has been a significant change in the way in which SCRs have been undertaken by the LSCBs and there have been challenges for both the CCG and the commissioned services to ensure that the learning for health is identified and embedded into practice.

In addition to undertaking SCR's, the LSCB also conducts reviews of cases which do not meet the criteria for a SCR, but nonetheless can provide valuable lessons about the way in which organisations are working together to safeguard and promote the welfare of children these are commonly referred to as Management Reviews or targeted learning event.

The designated professionals have worked closely with LSCB members through the Critical Incident Panels / Serious Incident Review Groups to develop an inclusive model of learning from reviews. This is still being embedded into practice but is successfully ensuring that frontline practitioners are at the forefront of the process and better understand and develop their relationship with the LSCB.

Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. Revised guidance has been issued and is applicable from August 2013. A DHR is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect perpetrated by: (a) a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship, or (b) a member of the same household as himself/herself, held with a view to identifying the lessons to be learnt from the death. An 'intimate personal relationship' includes relationships

between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

It is the responsibility of the Local Safeguarding Adult Board (delegated to a serious incident sub group) to make the decision as to whether the criteria for a DHR is met. Where the decision of the group is that the criteria is not met, this will be referred to the Home office who will review and make the definitive decision.

In the reporting year, across the Mersey and Halton footprint, there have been five serious case reviews (SCR) initiated, eight management reviews (MR) , five Domestic Homicide Review (DHR's) and one practical targeted learning event (TLE) The CCG has been fully engaged in and contributed to all the reviews, ensuring that health providers cooperate and participate in the process.
Table 2 demonstrates the areas where the reviews have been undertaken:

Table 2:

CCG	SCR	MR/ TLE	DHR
Liverpool	2	1	3 (with Home Office) 2 on going
Knowsley	1 (adult)	1	1
Sefton	0	2	1
St Helens	2	3	0
Halton	0	1	0

Themes and Learning from the reviews include; substance and alcohol misuse, domestic abuse, adult mental health issues, supervision and professional challenge. There was a lack of early help interventions.

The CCG are sighted on these findings and the learning through the reporting mechanism of the quality committees.

5.7 Child Sexual Exploitation

In accordance with the national agenda, The Safeguarding Children Boards of Cheshire and Merseyside (which includes Halton, Liverpool, Sefton, Knowsley and St Helens) have identified tackling the sexual exploitation of children as a key strategic priority and are committed to combatting the sexual exploitation of children via effective multi-agency and partnership working.

Government guidance on children involved in sexual exploitation notes: 'because of the universal nature of most health provision, health professionals may often be the

first to be aware that a child may be involved, or be at risk of becoming involved, in sexual exploitation. Children involved in sexual exploitation are likely to need a range of services

CSE is a strategic priority for the CCG and as such there is an identified lead for this agenda, this is assumed by a designated professional, who works with the Merseyside LSCB regional CSE co-ordinator, the health economy and is the representative for the LSCB CSE sub groups.

A key area of work has been to review of the 'National Working Group Organisational Risk Tool for CSE', which has been adopted for use by each of the LSCBs, in order that it can be modified to support the collection of data by health organisations.

Other work has included establishing a baseline position statement with providers including:

- the adoption of the Pan Cheshire/Merseyside Child Sexual Exploitation Multi-Agency Strategy (2012/3) & Merseyside Multi-Agency Child Sexual Exploitation Protocol (2014) and reference within organisational safeguarding procedures

- ensuring a Single Point of Contact within each organisation to lead on the CSE agenda

- raising professional awareness within the organisation and key services, through the dissemination of the CSE 'warning signs and vulnerabilities checklist'

- ensuring internal training programmes incorporate Child Sexual Exploitation and the need to development a Training Needs Analysis to identify additional training requirements for those services considered to be key in the identification of potential cases,

- use of the multiagency risk assessment tool and referral documentation (form CSE1) when concerns arise in line with the Merseyside Multi-Agency Child Sexual Exploitation Protocol (2014)

- establishing membership on the LSCB CSE sub groups (strategic) and operational Multiagency Child Sexual Exploitation (MACSE) meetings

- development of a CSE action plan within each organisation in order to address and progress any outstanding requirements

- incorporating high risk CSE cases discussed at MACSE within established supervision processes including Named Nurse/Designated Nurse supervision

This work remains in its infancy and will continue as a priority going forward into 2014/15 for the CCG.

5.8 Multi Agency Safeguarding Hubs (MASH)

Multi Agency Safeguarding Hubs (MASH) co-locate safeguarding agencies and their data into a secure assessment, research and decision making unit that is inclusive of all notifications relating to safeguarding child and adult welfare in a Local Authority area. It is well evidenced that the co-location of agencies builds trust and confidence and speeds up the process of information sharing and decision making, but the added value of MASH is that it provides for a fuller, more informative intelligence product with a risk assessment supported by a clearly recorded rational for operational use at the earliest stage. The objective is, 'early intervention' to prevent the escalation of harm, risk and crime.

The MASH model supports core aspects of safeguarding work:

- Timed, well informed decision making that leads to early help;
- Right intervention, right time with least changes of workers;
- Agencies are co-located e.g. Police, health, EIP, Children's Social Care, probation; this leads to better relationships, improved understanding of each other's professional role and improved information sharing on a need to know basis;
- Relevant agencies collate a multi-agency chronology that forms the basis for decision making; repeat incidents are identified and a problem solving approach is initiated;
- The least intrusive approach is taken by the agency deemed most appropriate (early help).
- Most importantly children should not fall through between agencies without any support services.
- Professionals have a central point for advice and access to information from a range of services.

The LA and LSCB have stated their intention to adopt this model of working. The CCG have supported this and have commissioned services via the local health providers. This has been achieved either by the redesign of services within an existing financial envelope (Sefton, Knowsley) or the commitment by the CCG to further financial investment with the increase of specialist resource (Liverpool , St Helens).Halton remain in the discussion phase and are looking to undertake a feasibility study to ascertain if this model of working is appropriate for the Borough.

At this stage it is too early to evaluate benefit of MASH within the area, however performance frameworks have been established and data should be available in the next reporting year.

5.9 Domestic abuse

Domestic abuse is defined as: any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The NICE guidance (February 2014) “Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively” makes a number of recommendations for CCGs, including developing an integrated commissioning strategy through local strategic partnerships and commissioning integrated care pathways. The CCG will support this work into 2014/15.

The CCG acknowledges and recognises the ‘cross- cutting’ nature of domestic abuse and is working towards integrating a whole system approach to manage how the Service will respond to domestic homicides and other areas of abuse which potentially impacts on adults and children such as Female Genital Mutilation, Forced Marriage and so-called Honour based killing. This is evidenced within the safeguarding strategy 2014- 2016 as a priority area. All the Merseyside LSCBs and SAB’s have influenced and contributed to the development of a pan Merseyside Forced Marriage and Honour Based Violence Strategy and the Safeguarding Service have been fully engaged within the process through the work of the Policy &Performance sub groups. Halton LSCB and SAB, as part of Cheshire have been equally engaged in the development of a Cheshire strategy and Halton CCG has fully endorsed this work.

Domestic abuse affects the entire family and is not only confined to the victim/ target of the abuse, children are particularly affected by abuse involving one or both parents and as such is among one of the most frequently identified reasons for children becoming subject to a Child protection plan. There are a number of predisposing factors to domestic abuse, the most commonly associated features are alcohol misuse, drug misuse and mental health problems and learning from the local SCR’s and DHR’s reflect these themes.

The CCG will continue to work with partner agencies to ensure that services are commissioned in accordance with national and local guidance to improve outcomes for such children and young people.

6. Safeguarding Inspection Programme

Following a decision by Ofsted to defer the start of a new multi-agency inspection regime for safeguarding and children looked after services, the Care Quality Commission (CQC) commenced a two year programme of inspections of safeguarding and children looked after services starting in September 2013. The inspections focus on evaluating the quality and impact of local health arrangements for safeguarding children and improving healthcare for children who are looked after. This includes mapping the child's journey at all stages – from pre-birth through to their transition to adulthood, and from the point of their entering to leaving care.

The CQC focus the inspections on health services within local authority areas in England. Inspections are prioritised based on identified risk within the health services and give just 48 hours' notice of any pending inspection.

The designated professionals have been coordinating and leading on the health preparation for the pending inspections working with NHSE, Public Health and all local providers. The Service has also been fully engaged with local authority partners in preparation for local Ofsted inspections.

Within the reporting year there have been two Merseyside Internal Agency Audits (MIAA) conducted and two externally commissioned safeguarding reviews undertaken by Edge Hill University. The findings from the reviews have been shared as appropriate and the recommendations identified as areas for development and action plans are in place and being progressed accordingly. Additionally the current safeguarding strategy 2014- 2016 has been developed to reflect and further support the findings of the reviews.

7. Safeguarding Adults

7.1 Statutory Guidance

Prior to 14th May 2014 there was no single coherent legislative framework in respect of Safeguarding Adults. This has now changed when the Care and Support Act 2014 gained Royal Assent. Prior to this there was only a duty for NHS organisations to comply with a range of legislation including the Equality Act 2010, Human Rights Act 1998, Health and Social Care Act 2008, Mental Capacity Act 2005 and the Safeguarding Vulnerable Groups Act 2006. Providers of health and social care services are also required to comply with the Care Quality Commission Essential Standards for Quality and Safety to ensure that people who receive services are protected and receive the expected level of care and support that they need.

The Care and Support Act 2014 creates the legal framework for how local authorities and other parts of the health and care system should protect adults at risk of abuse or neglect.
The Care Act and Support 2014 revises the definition of vulnerable adult to that of 'adult at risk' who has needs for care and support (whether or not the authority is meeting any of those needs), is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The government has reaffirmed the principles of adult safeguarding which are:

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

The widespread publicity of recent high profile cases, such as the failings within Winterbourne View Hospital, and those within Mid Staffordshire NHS Foundation Trust, have refocused the NHS on its safeguarding adult responsibilities and highlighted the particular vulnerability of patients with learning disabilities/autistic spectrum disorder who challenge services.

7.2 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) were introduced in 2007, as an amendment to the Mental Capacity Act 2005. The Mental Capacity Act had allowed restraint and restrictions to be used in the best interests of a person lacking capacity to prevent them being harmed. Following the European Court Judgement, further safeguards were required to ensure that restrictions and restraints amounting to deprivation of liberty are lawful. These are DoLS.

From April 2013 the Department of Health has taken the Deprivation of Liberty Safeguards element out of the resources allocated to the NHS, leaving only the element for the Mental Capacity Act.
The Department of Health added the NHS Deprivation of Liberty safeguards element to the Local Authority allocation. Local Authorities have therefore received an increase in line with their new responsibilities. The Law Commission have proposed

a legal framework around access to care and support services for older people and those with mental health problems and carers.

The DoLS process can be used if the person who will be deprived of their liberty is in a care home or hospital. In other settings, only a Court of Protection judgement can determine whether a person can be deprived of their liberty. Care homes and hospitals only have to obtain authorisation from the local authority to deprive a person of their liberty. Court judgements are only required in complex or disputed cases.

The Cheshire West Supreme Court judgement on 19th March 2014 provided guidance on what is regarded as a deprivation of liberty. The judgement states:

A person may be deprived of their liberty if:

- They do not have the **capacity** to consent to their care or treatment

AND

- They are under **continuous supervision and control**

AND

- The person is **not free to leave**

The Supreme Court has provided what has become known as the "acid test", a person is deprived of their liberty if they are under continuous supervision and control, they are not free to leave and they have not consented to these arrangements (e.g. because they lack capacity). This significantly widens the range of settings in which people can be living where deprivation of liberty may be occurring.

By widening the definition of deprivation of liberty, more people in care homes and hospitals will now be subject to DoLS than previous case law had indicated. These additional people must now be assessed against DoLS criteria.

The DoLS procedure includes assessment by specially trained Best Interest Assessors (BIA) and Doctors. The local authority has a statutory duty to ensure that DoLS procedures are followed within specified timeframes. Failure to complete the DoLS process within these timeframes will lead to unauthorised deprivation of liberty and possible legal action. The CCGs have duty to ensure that commissioned health providers are compliant with the DoLS framework.

The Supreme Court judgement has also clarified that Deprivation of Liberty can occur in a domestic setting. It is now clear that a person can be deprived of their

liberty in their own home, or in supported living setting. This can only be authorised by the Court of Protection.

In summary, assessment for possible deprivation of liberty may now be required for service users in:

- Registered care homes
- Hospitals
- Respite care
- Supported living
- Adult placements
- Family settings with packages of care
- Service user's own homes

The Safeguarding Service continues to work with its partners in order to raise awareness and improve the understanding of the impact of the Supreme Court Judgement.

In February 2014, NHS England Area Teams allocated £45,000 to each CCG, ring fenced for health, for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) developments. Specific training requirements in relation to the MCA and DoLs have been included in the safeguarding Key Performance Indicators for commissioned health providers.

7.3 Local Safeguarding Adults Boards (LSAB)

The Care Act places Safeguarding Adult Boards (SAB) on a statutory footing whilst maintaining their freedom to operate in locally flexible ways; adult reviews are now mandatory when certain triggering situations have occurred and the parties believe that safeguarding failures have had a part to play; councils have a corporate duty to make safeguarding enquiries; it places a duty to co-operate over the supply of information on relevant agencies; and places a duty of candour on providers about failings in hospital and care settings.

There are five Safeguarding Adults Boards serving the six CCG areas across Merseyside and Halton (Liverpool, Knowsley, Halton, St Helens, Sefton).

The Safeguarding Adults Boards are the bodies that ensure that all agencies work together to minimise the risk of abuse to adults at risk and to protect those subject to abuse. The CCGs are proactive partners of the SABs and significantly contribute to the work of the Board. The LSABs monitor outcomes and trends and ensures best practice is disseminated to all agencies.

LSABs now have a statutory footing with the enactment of the Care Bill 2014 and work is on-going in each of the LSABs ensure there are robust arrangements in place to support the Board sub groups and reporting arrangements back to the Board.

7.4 Adult Safeguarding Activity.

Safeguarding alerts to the local authorities in St Helens, Liverpool, Knowsley and Sefton show an overall increase for 2013/14. Not all alerts raised progress as safeguarding. The increase in alerts may be attributed to a greater awareness of safeguarding and training compliance across service providers. Each of the local authorities have undertaken work to define safeguarding referral thresholds.
Sefton

Local Authority Area	Number of alerts 2013/14
Liverpool	1135
St Helens	1241
Halton	Not yet published
Knowsley	977
Sefton	1116

7.5 Care Homes and Safeguarding

The adult safeguarding team has developed a system to receive and process all safeguarding alerts from the local authorities. Alerts via the Single point of Access are triaged by the team for allocation. The Safeguarding Adults team continues to work closely with the local authorities and to support the adult protection investigation process for care homes. The Safeguarding Adults team provides clinical expertise in relation to the Mental Capacity Act and safeguarding advice and guidance for complex cases. The team co-works with the local authority safeguarding leads to progress investigations, produces specialist reports, attend strategy meetings and support and monitor actions plans for quality improvements.

8. Governance and Assurance arrangements

Clinical Commissioning Groups (CCG's) have statutory responsibilities to safeguarding children, young people and adults at risk of harm. These responsibilities are outlined in the authorisation document.

To fulfil this statutory requirement Clinical Commissioning Groups (CCG's) must have in place an executive lead for safeguarding children and adults. Safeguarding functions must be explicit and embedded within the duties of CCG boards and the executive lead is responsible for ensuring that safeguarding remains a high priority area within the business of CCGs. The role is supported by the clinical specialists who hold the statutory posts of designated doctor and nurse.

The Chief Officer is ultimately responsible for ensuring that the statutory duties to safeguard children and adults across the health economy are effectively discharged. This is a delegated responsibility and 'sits' within the portfolio of the Chief Nurse, who provides strategic direction on child and adult safeguarding, including Looked After Children and is a member of the local Safeguarding Children's Board and the Adult Safeguarding Boards.

Governance is achieved via the CCG Quality Committee which is established in accordance with the CCG Constitution. The CCG Quality Committee receives regular reports (quarterly) from the safeguarding service which is designed to ensure that the CCGs are assured about their own and their commissioned provider safeguarding accountabilities, understand safeguarding processes and systems and performance. The report details safeguarding issues within the CCG area in order to ensure any known risks or failures are highlighted and the mitigations where possible and remedial agreed actions are implemented.

A key responsibility for the CCG is to ensure that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. In seeking this assurance the CCG monitors health care providers against a set of regionally agreed safeguarding standards.

The CCG monitors areas of safeguarding activity undertaken by providers with whom the commissioners have a Standard NHS Contract. All provider services are required to comply with the Care Quality Commission Essential Standards for Quality and Safety that include safeguarding standards (standard 7). Safeguarding children activity is monitored by the Designated professionals / Safeguarding Service via both the standard safeguarding audit tool and a number of specific Key Performance Indicators (KPIs) which includes contacts/ referrals to Children's Social Care, CAFs initiated, attendance at child protection case conferences etc. this process enables the service to provide assurances to the CCGs as to our provider compliance and

engagement with the safeguarding agenda. The KPIs are mapped against the LSCB priorities, Inspection findings, performance data and outcomes of reviews (SCRs, MRs, DHRs etc).

The NHS North West (NHS NW) safeguarding policy and standards for delivery documentation is used across the NW region to provide assurance on safeguarding standards and regulatory requirements. This has been part of the healthcare provider contract since April 2010. The self-assessment audit tool and embedded evidence is then assessed and validated by the safeguarding service working in collaboration with commissioners/contract managers. Feedback regarding compliance is shared with providers via the quality monitoring process.

A priority for 2014 will be to further develop the assurance process ensuring that it is proportionate and appropriate for the services being commissioned and to focus on the safeguarding arrangements within care homes with nursing.

It is acknowledged that there is a potential overlap between the Section 11 audit undertaken by the safeguarding board and the NHS NW tool. The designated professionals will ensure that duplication of effort is not a barrier locally.

In addition the following arrangements are in place to strengthen our assurance processes:

- Safeguarding Children Key Performance Indicators (KPI's) form part of the Performance Assessment Framework (as mentioned above) and provide additional assurances on specific areas of risk or particular relevance.

- The Safeguarding Service are invited to attend the provider safeguarding assurance groups (SAG's) where best practice is agreed, safeguarding standards discussed and learning disseminated. This provides the 'soft' intelligence that supports much of the submitted evidence and declarations.

- Single and multiagency safeguarding children audits will be a requirement in the 2014/15 monitoring arrangements the framework for submission is to be developed further with the provider organisations.

- The designated professionals provide a range of support to provider trusts including supervision of the Named professionals (safeguarding and LAC) which assists in gaining a further level of assurance for the CCG. A supervision policy and framework is in place to ensure that this provision is appropriate, timely and structured in accordance with the supervisee's level of competence and experience.

9. Key Achievements:

During the reporting period the CCG has:

- Successfully recruited to 2 Deputy Designated Nurse posts for children and a Deputy Head of Adult Safeguarding and a Lead Nurse for Adults.
- Have maintained full engagement with the LSCBs and SABs ensuring full participation with all Board activities including SCR's/ MRs/DHRs.
- Received Governing Body safeguarding training for both children and adults.
- Supported the delivery of GP training.
- Chairing and active membership of LSCB and SAB sub groups
- Established a robust system of monitoring and overseeing the key provider safeguarding quality and activity.
- Continued to build on and develop relationships within the CCGs ensuring that the Governing Bodies are fully apprised of all safeguarding concerns and/or achievements.
- Developed robust internal reporting systems in relation to safeguarding.

10. Conclusion

This annual report has provided an insight into local developments and initiatives pertaining to safeguarding that have taken place during the last twelve months. In doing so it aims to provide assurance to the Governing Body that the CCG is fully committed to ensuring they meet their statutory duties and responsibilities for safeguarding children and adults at risk of harm.

The CCG is working towards ensuring that robust safeguarding children and adults arrangements are in place. The current safeguarding standards and KPI's are continuously under review and updated in recognition of national guidance and learning outcomes from reviews and inspections.
Resilience and risk management during a time of significant change is essential to ensure that the level of priority is sustained. It has therefore been vital that safeguarding standards have been maintained during this time of change and uncertainty and that accountability remains clear and unambiguous.

The report has also outlined priority areas for the coming year. These include:

1. Securing the voice of the child young, person and adults at risk to inform safeguarding arrangements remains an on-going priority area.

2. Strengthen the connections between child and adult safeguarding in particular around domestic abuse *(including for example so called 'honour based violence,*

female genital mutilation and forced marriage) by identifying some of the organisational developments which can support best practice in this area.

3. Develop and secure a model of safeguarding supervision for the Safeguarding Service.

4. Provide the assurance that the Designated Nurse LAC role and function is being discharged/ delivered within the safeguarding.

5. Develop a programme to deliver the work that will be required under The Care and Support Act, 2015; identify a lead person responsible for coordinating and driving delivery of this and model the likely costs and other impacts of the Act.

6. Contribute to the work of LSCBs and LSABs Safeguarding Strategic Plans. These should be reflected in both the commissioned services KPIs and safeguarding service work plan.

7. Ensure a consistent quality of safeguarding training provision both across the CCG and the health economy as a whole.

8. 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.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2014

Agenda Item: 14/150	**Author of the Paper:** Tracy Jeffes Chief Integration and Delivery Officer Email: tracy.jeffes@southseftonccg.nhs.uk Tel: 0151 247 7049
Report date: November 2014	
Title: Remuneration Committee - Terms of Reference	
Summary/Key Issues: Terms of Reference.	
Recommendation The Governing Body is asked to approve the revised Terms of Reference.	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
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
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	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

Report to the Governing Body
November 2014

1. Authority

1.1. The Remuneration Committee shall be established as a sub-committee of the CCG Governing Body to perform the following functions on behalf of the Governing Body.

1.2. The principal function of the Committee is to make recommendations to the Governing Body on determinations about pay and remuneration for employees of the CCG and people who provide services to the CCG and allowances under any pension scheme it might establish as an alternative to the NHS pensions scheme.

2. Principal Duties

The principal duties of the Committee are as follows:-

2.1. determining the remuneration and conditions of service of the senior team.

2.2. reviewing the performance of the Chief Officer and other senior team and determining salary awards;

2.3. approving the severance payments of the chief officer and other senior staff;

2.4. approve disciplinary arrangements for employees, including the Chief Officer (where he/she is an employee or member of the Group) and for other persons working on behalf of the group;

2.5. approve disciplinary arrangements where the Group has joint appointments with another group and the individuals are employees of that Group;

2.6. to submit an Annual Report of the key areas of work covered by the Committee to a private meeting of the governing body on an annual basis.

3. Membership

3.1. The committee shall be appointed by the CCG from amongst its Governing Body members as follows:-

- Lay Member (with a lead role in governance) as Chair
- Lay Member for Patient and Public Involvement
- 2 GP Governing Body Members
- 1 Nurse Governing Body Member
- 1 Practice Manager Governing Body Member

3.2. Only members of the CCG Governing Body may be members of the remuneration committee.

3.3. The Chair of the CCG's Governing Body shall not be a member of the Committee.

3.4. Only members of the committee have the right to attend the Committee meetings.

3.5. However, other individuals such as the Chief Officer, the HR lead and external advisers may be invited to attend for all or part of any meeting as and when appropriate. They should however not be in attendance for discussions about their own remuneration and terms of service.

4. Chair

The Lay Governing Body Member shall be nominated by the CCG Governing Body to act as Chair of the committee. The Committee shall nominate a Vice Chair from within its membership.

5. Quorum

5.1. The quorum will be the Remuneration Committee Chair or Vice Chair plus 1 other member of the Remuneration Committee membership (all of which must be members of Governing Body as per Section 2 of these Terms of Reference)

5.2. The quorum shall exclude any member affected by a Conflict of Interest. If this has the effect of rendering the meeting inquorate then the Chair shall decide whether to adjourn the meeting to permit the co-option of additional members.

6. Frequency of Meetings and Reporting Arrangements

The Committee will meet at least once a year with clear arrangements for calling meetings at additional times, as and when required, with seven working days' notice. The Committee will submit its minutes to the next available CCG Governing Body. In addition the Committee will report annually to the Governing Body.

7. Secretarial arrangements

7.1. The Business Manager / PA to the Chief Officer shall provide secretarial support to the Committee and support the Chair in the management of remuneration business, drawing the Committee's attention to best practice, national guidance and other relevant documents as appropriate.

7.2. The agenda for the meetings will be drawn up with the Chair of the Committee.

7.3. The agenda and papers for meetings will be distributed one week in advance of the meeting.

7.4. The minutes of the meeting will be produced within 10 working days

8. Policy and Best Practice

8.1. The Committee will apply best practice in the decision making process. When considering individual remuneration, the committee will:-

- comply with current disclosure requirements for remuneration;
- on occasion seek independent advice about remuneration for individuals;
- ensure that decisions are based on clear and transparent criteria.

8.2. The Committee will have full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations.

9. Conduct of the Committee

9.1. The committee will conduct its business in accordance with any national guidance and relevant codes of conduct / good governance practice, such as Nolan's seven principles of public life.

9.2. The Committee will review its own performance, membership and terms of reference on an annual basis and any resulting changes to the terms of reference will be approved by the Governing Body.

9.3. All members are required to maintain accurate statements of their register of interest with the Governing Body. Members of the committee should notify the committee chair of any actual, potential or perceived conflicts in relation to the agenda, in advance of the meeting or at the beginning of each meeting. The Chair shall consider such notices in accordance with NHS South Sefton CCG procedure for the management of Conflicts of Interest as set out in the Constitution.

10. Review

Date:	April 2014
Version	4
Future Review:	November 2013 March 2014 – reviewed on 26th September 2014 September 2015

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2014

Agenda Item: 14/151

Report date: November 2014

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Title: Risk Management Strategy

Summary/Key Issues:

The Governing Body is required to update the Risk Management Strategy on an annual basis.

The strategy was presented to the Corporate Governance Group and the Quality Committee in October 2014 and following a small number of changes recommended by these committees, the strategy is now presented to the Governing Body.

A small number of changes have been made to update the strategy compared to the version presented in 2013 and are summarised below:

- the risk management strategy has been updated to reflect changes in the risk management and governance processes of the CCG. The 2013/14 version was a transitional strategy that was adopted by the CCG as part of the authorisation process. This ensured that there was an appropriate framework in place for the CCG to identity risks and the associated mitigations and controls;

- during the early part of 2014/15, CCG and CSU colleagues reviewed and updated internal Governing Body Assurance Framework processes, the Corporate Risk Register process, accountabilities of senior management and their staff and implemented a new committee structure and supporting sub groups. There changes have now been reflected in the 2014/15 strategy;

- the most significant change is that the Quality Committee is charged by the Governing Body to take an overview of all risk and report directly to the Governing Body by exception, including the escalation of red risks.

Recommendation

The Governing Body is asked to approve this document.

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				
Equality Impact Assessment			x	
Legal Advice Sought			x	
Resource Implications Considered			x	
Locality Engagement				
Presented to other Committees	x			Corporate Governance Support Group – October 2014. Quality Committee – October 2014.

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

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Risk Management Strategy 2014/15

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Clinical Commissioning Group

Title: **Risk Management Strategy**	
Scope: South Sefton CCG	**Classification:** Strategy
Identification No:	**Version No:** 6
Replaces: Risk Management Strategy of July 2013	
Authors/Originators: Lesley Anderson-Hadley. Senior Governance Manager. Northwest Commissioning Support Unit. Tracy Jeffes **,** Chief of Corporate Delivery and Integration	
In consultation with: CCG Corporate Governance Support Group and CCG Quality Committee	
Chief Officer: Fiona Clark, Chief Officer	
Authorised by: CCG Governing Body	**Date:** November 2014
To be read in conjunction with: Governance Policies	
Issue Date: November 2014	**Review Date: November 2015**

In considering the application of this policy, procedure or function the CCG will ensure that members, staff or patients will not be discriminated against or treated differently on account of any subjective bias in relation to the pillars of equality and diversity: race, disability, gender, age, sexual orientation, religion/belief, transgender.

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NHS
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Report to the Governing Body
November 2014

1. Introduction

11 By its very nature the commissioning of healthcare carries risks. The Governing Body accepts the importance of the principles of risk management and recognises the value of taking a strategic, proactive, and comprehensive approach to the assessment and control of risk. Significant benefits can be achieved from this approach, from improving patient care and the safety of the working environment, to reducing levels of financial risk and loss for the CCG as a whole.

1.2 The CCG also recognises that due to a high reliance upon human intervention in the commissioning and provision of care, mistakes and errors can happen. Therefore a strategy and framework is required to deal with the hazards and risks associated with its main functions of commissioning high quality healthcare and improving the health of the local population. The strategy defines the CCGs commitment to developing an open, honest, inclusive and educative 'fair blame' culture which encourages identification, reporting and avoidance of risk. It also brings clinical knowledge, understanding and perspectives to the heart of managing risk within the local health system.

1.3 The Risk Management Strategy therefore represents South Sefton CCG's corporate philosophy towards risk management and aims to provide assurance to the CCG Governing Body that risks are being consistently identified and managed.

2. Purpose, Philosophy & Principles:

2.1 This strategy supersedes the 2013/14 version and is designed to provide a framework for the development of a robust risk management system across the CCG and thereby assisting the CCG in achieving its objectives. Each senior manager or clinical lead is expected to systematically identify and assess the risks associated with their key areas of work and manage them to ensure they do not impede the delivery of team or organisational objectives, and to record this activity on the Corporate Risk Register. Major risks identified as part of the risk assessment process will be integrated into the Governing Body Assurance Framework (GBAF) which the CCG Governing Body recognises as a tool to ensure the delivery of organisational objectives.

2.2 The CCG is committed to ensuring robust systems are in place to ensure high standards of risk management. A proactive structured and systematic approach supports informed management decision making by providing a greater understanding of risks and their potential impact. Effective management of risks has the potential for reducing the frequency and severity of incidents, complaints and claims. The demarcation of risks into clinical, corporate and financial precludes a holistic view so it is proposed that CCG has a unified strategy for managing all risks. This approach should ultimately form an integral part of the business planning process.

3. Scope of the Strategy

This strategy relates to the management of risks faced by the CCG as a commissioner of services and applies from September 2014 – August 2015

4. Risk Management Objectives

The CCG's specific risk management objectives for 2014/15 are to:-

- demonstrate the CCG Governing Body's support and commitment to the risk management agenda;
- be a fundamental part of the CCG's approach to integrated governance;
- continually develop the Risk Management Strategy and ensure communication throughout the CCG;
- clearly define the stages within the risk management process;
- ensure compliance with all the relevant statutory and non-statutory standards relating to the assessment and control of risk;
- manage risks at a corporate and local level;
- develop and maintain risk registers across the CCG by implementing a comprehensive risk assessment and grading system;
- provide an effective system to identify and eliminate or mitigate risk by appropriate means;
- ensure all Governing Body Members and staff attend risk management training/development events to ensure full understanding of their responsibilities;
- develop a risk aware culture throughout the CCG which will embed the consideration and assessment of risk in all work activities;
- encourage a culture of 'fair blame', being transparent when things go wrong;
- ensure lessons are learned from good and deficient practice;
- agree and firmly establish clearly defined roles and responsibilities for the management of risk within the CCG;
- ensure all localities and teams accept their responsibility for managing risk at a local level.

5. Organisation Arrangements and Management of Risk

Annual Governance Statement Governance Arrangements

As a statutory body from 1st April 2013 NHS South Sefton CCG is required to produce an Annual Governance Statement (or an equivalent statement of governance as may be specified by the Department of Health) which acts as a statement of assurance that appropriate strategies and policies and internal control systems are in place and functioning effectively, so that key risks which may threaten the achievement of strategic objectives are identified, recorded and minimised. Any significant issues identified in the Annual Governance Statement will be recorded on the Governing Body Assurance Framework and/or Corporate Risk Register.

6. Governing Body Assurance Framework (GBAF)

6.1 The GBAF is the process by which the CCG can demonstrate that it is doing its reasonable best to manage itself so as to meet its strategic objectives and protect patients, members, staff, visitors and other stakeholders against risk of all kinds.

6.2 The framework records the links between strategic objectives, key risks and key controls. It also indicates the sources of evidence or assurance, which support the controls, and identifies any gaps. The GBAF will be reviewed at internal business meetings of the

Quality Committee following review and recommendation by the Corporate Governance Support Group. The Audit Committee will review the arrangements in place on a 6 monthly basis to provide assurances to the Governing Body that the systems and processes for review and scrutiny are robust. Exceptions and key risks will be reviewed in summary form by the Governing Body at each public meeting with a full review taking place twice a year at a public meeting.

6.3 The Senior Management Team is responsible for regularly reviewing and updating the GBAF and CRR.

6.4 Whilst there are elements of duplication with the Governing Body Assurance Framework and Corporate Risk Register in terms of language and content, the two documents serve different purposes. The GBAF is a summary document which brings together a significant amount of information relating to strategic objectives. Its purpose is to provide the CCG Governing Body with assurance that risks to the delivery of organisational objectives have been identified and are being managed. It provides a list of the key pieces of evidence that the CCG Governing Body should use to gain this assurance. There is also an assessment of the strength of evidence provided. The ideal GBAF will contain a list of significant assurance evidence with no gaps identified in control or assurance, and all assurances provided rated as 'significant'.

7. Corporate Risk Register (CRR)

7.1 The Corporate Risk Register contains high level (red) organisational risks and any risks that have been escalated from the Team Risk Registers where they exist. The CRR also contains operational risks that require active management or review at Governing Body or Quality Committee level. The risks contained in the CRR are more wide-ranging than those in the GBAF. The purpose of the CRR is to provide the Governing Body with a summary of the principal risks facing the organisation with a summary of actions needed and being taken to reduce the risks to an acceptable level. Where risks to achieving organisational objectives are identified within the CRR or directorate risk registers where they exist, they should be added to the GBAF. Likewise where gaps in control are identified in the GBAF these risks should be added to the CRR. The two documents therefore complement each other providing the Governing Body with assurance and action plans on risk management within the CCG.

7.2 The CRR is reviewed on a monthly basis by the CCG Senior Management Team, at the internal business meeting of the Quality Committee, following review and recommendation by the Corporate Governance Support Group. The Audit Committee will review the arrangements in place on a 6 monthly basis to provide assurances to the Governing Body that the systems and processes for review and scrutiny are robust. Exceptions and key risks will be reviewed in summary form by the Governing Body at each public meeting with a full review taking place twice a year at a public meeting. The process for populating and updating the Corporate Risk Register can be found in Appendix G.

8. Locality and Team Risk Management Process/Operational Risks

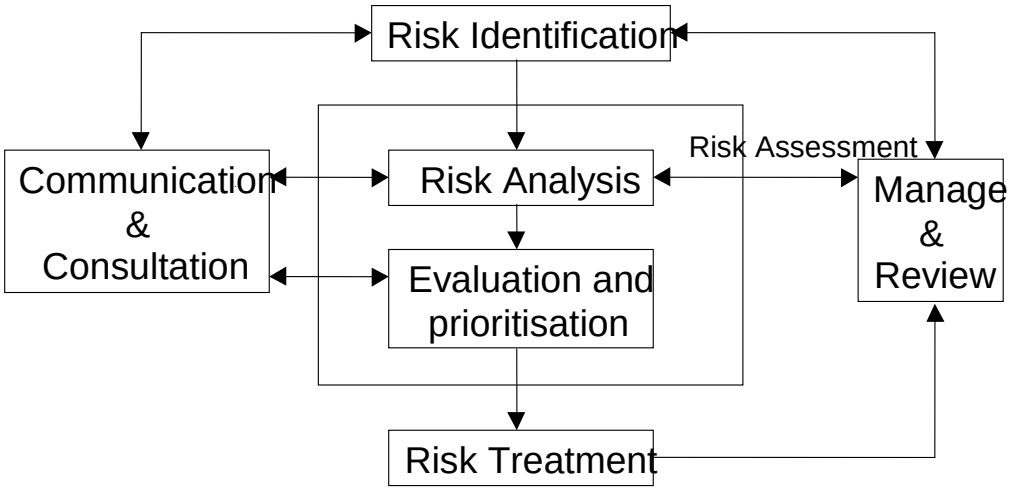
8.1 Operational risks that would prevent the Locality or team from meeting its (or another's) objectives will be recorded on the approved Risk Assessment Form and accompanied by an appropriate action plan. Risks that are well managed, do not require escalation and/or do not need further treatment shall be reviewed regularly until such a time as they can be closed. Major risks arising from local risk assessments will be escalated for inclusion in the CCG Corporate Risk Register for the attention of the Quality Committee and ultimately the CCG Governing Body.

8.2 The Quality Committee has powers to establish sub groups to review risk registers and other integrated governance matters as appropriate and during 2013 established the Corporate Governance Support Group to support the risk management processes.

8.3 Each CCG team will have its own arrangements in place for the monthly review of their operational risks, agreed and overseen by the Senior Management Team.

9. The Risk Management Framework

The CCG has adopted the risk management framework described in the NHS Executives Controls Assurance risk management standard. This draws on the main components of risk strategy, that is risk identification, risk analysis, evaluation and prioritisation and risk treatment.



10. Risk Identification

Incident & Near Miss-Reporting

10.1 The reporting of incidents and near misses by CCG members and staff is an efficient and effective system for identifying risk. This allows rapid alert to ascertain why and how incidents occurred, and facilitates a fast response in the case of adverse events, which may lead to a complaint or litigation. It enables lessons to be learnt and therefore prevent recurrence. This is best achieved in a supportive management environment where a 'fair blame' culture is advocated and makes explicit the circumstances in which disciplinary action may be considered.

10.2 All incidents and near misses will be reported and managed using the CCG's incident reporting system in line with the Policy and Procedure for the Reporting and Management of Incidents and Near Misses.

10.3 All incidents will be graded at source and as a result of a local investigation, local management (when appropriate) will ensure controls are put into place and advise Senior Management of the risk treatment and controls accordingly. Each incident will be assigned to an incident manager who will be responsible for reviewing the grading applied and ensuring that if necessary the Chief Officer is informed of the incident. Training will be provided to enable staff to grade incidents at source.

11. Risk Assessment

11.1 In order to anticipate, rather than react to risks identified, a formal mechanism for risk assessment will be adopted.

11.2 The aim of a risk assessment is to determine how to manage or control the risk and translate these findings into a safe system of work that is then communicated to the appropriate level of management.

11.3 A risk assessment is a careful examination of what could go wrong. Assessors need to weigh up whether there are sufficient controls in place, and if not they must establish the extent of control and ensure that action is proportionate to the level of risk.

11.4 Risk assessments are subjective; therefore, a team of no less than three people should undertake the risk assessment, including preferably the relevant senior manager or lead clinician to ensure ownership of the risks within their own area of responsibility.

11.5 All risks are graded using the risk grading matrix. A copy of the Risk Grading Matrix can be found in Appendix B

12. Risk Grading and Analysis (Acceptable Levels of Risk)

12.1 It is accepted that it is neither realistic nor possible to totally eliminate all risk. It is however, feasible to develop a systematic approach to the management of risk so that adverse consequences are minimised, or in some cases, eliminated.

12.2 The CCG utilises an accepted system for grading risk (see Appendix B), which takes into account parameters that include probability of occurrence and impact on the organisation. A grading system enables a method of quantification which can be used to prioritise risk treatment at all levels. Incidents and risks are graded according to the CCG's risk grading matrix which considers the actual consequence of the incident or potential consequence of the risk and the likelihood of occurrence or recurrence. The grading results in a level of risk to the organisation.

12.3 The risk grading system also covers the different grades of incidents. The level of authority required for managing the different grades of incidents will be described in detail in the incident reporting policy. The following table indicates the authority levels required to act in accordance with the quantification of risk.

	CCG Members / Staff	**CCG Locality Leads /Manager**	**CCG Senior Management**	**CCG Governing Body Level Management**
Insignificant	✓	✓	✓	**X**
Low	✓	✓	✓	**X**
Moderate	**x**	✓	✓	✓
Major	**x**	**x**	✓	✓

13. Risk Evaluation and Prioritisation

The criteria used to evaluate risk covers the following:-

- acceptance criteria within the organisation, i.e., operational standards;
- cost benefit analysis, i.e., balance of cost against the potential benefits;
- human issues, i.e., pain and suffering;
- legislative constraints, i.e., meeting statutory requirements.

14. Risk Treatment

14.1 During the process of risk assessment, analysis and evaluation it is possible to identify controls in place or required to reduce or eliminate risk. These control strategies cover a number of possible solutions, as described below:-

- risk avoidance – discontinuing a hazardous operation/activity;
- risk retention – retaining/accepting risks within financial operations;
- risk transfer – the conventional use of insurance premiums;
- risk reduction – prevention/control of any remaining residual risk.

14.2 Once controls, in place or required, have been identified the risk must be re-graded in order to establish whether the action proposed is adequate and will reduce the residual risk to an acceptable level. These controls and further treatments may be cost neutral or require action that requires investment. At this point it is imperative that action plans are submitted as part of the CCG's usual process for service planning.

14.3 Risks should continue to be monitored by the relevant Team to ensure that the controls remain effective, once the actions have been implemented and the risk has been eliminated the risk may be closed on the risk register and the reasons for the closure recorded in the narrative of the risk register to provide an auditable trail. The CCG recognises that in some cases high risks may be long standing which cannot be reduced to an acceptable level for a number of reasons, and even having been reviewed and accepted by the Governing Body, these risks shall remain upon the Corporate Risk Register and exception reported to Governing Body to serve as a reminder that the risks are still significant.

15. Risk Management and Review

Through a process of audit and monitoring the CCG will undertake a review of the risk control measures regularly. It is anticipated that risk control and monitoring measures will include some or all of the following:-

- aggregated statistical and trend reporting of incidents, complaints and claims to the CCG Governing Body and relevant committees, including the Corporate Governance Support Group;
- audit of implementation of the range of risk management policies, procedures and guidelines throughout the organisation;
- ongoing review of locality / team risk registers;
- annual review of the risk management strategy;
- monitoring of the audit committee and other minutes;
- audits undertaken by internal and external auditors.

16. Communication and consultation

Expert advice is available internally through the Chief Delivery and Integration Officer, through the Commissioning Support Unit (CSU) and externally from specialist advisers dependent upon the type of risk being considered. A list of internal specialist advice is available under Section 4 of this policy. For advice regarding external advice, this is available through the Chief Delivery and Integration Officer. Consideration should be given as to who needs to be informed of the Risk. Internally this process should following the process detailed within Appendix F. Consideration should also be given as to whether any external stakeholders should also be informed as the impact may affect the achievement of their objectives. i.e. Sefton Council.

17. Prevention

The CCG has adopted a proactive and reactive approach to risk. The population of risk registers with the further development of appropriate action plans will provide the CCG with greater knowledge of where our risks lie. As our systems and processes become further defined, the CCG will become more sophisticated in its approach to essential risk prevention.

18. Legal Liabilities and Property Losses

18.1 The CCG is a member of the Clinical Negligence Scheme for Trusts (CNST), Liabilities to Third Parties (LTPS) and Property Expenses Scheme (PES) that are administered by the NHS Litigation Authority (NHSLA). Funding is on a pay as you go basis and contributions are based on a range of criteria such as NHS income, numbers of staff and property values.

18.2 Commissioned services such as secondary care providers, independent contractors and their employees are not directly employed by the CCG and therefore are required to make their own indemnity arrangements. The CCG has responsibility to ensure that governance principles and risk management systems are being developed and applied by all providers. It is therefore possible for negligence proven in the course of a claim to in part be attributed to CCG commissioning the care if the CCG has failed to take reasonable steps to assure itself of the quality of standards of its provider. In these circumstances it is important that the CCG is able to demonstrate that it has taken all reasonable steps, i.e., monitoring performance, to assure itself of the quality of care provided.

18.3 The CCG has established Quality and Performance Review Groups that monitor the quality of contracted provider services and the Quality Committee and Governing Bodies receive reports on performance across all areas.

19. Roles and responsibilities:

19.1 All those working within the CCG have a responsibility to contribute, directly and indirectly to the achievement of the CCG's objectives through the efficient management of risk. It is also important to make explicit how the responsibility of the individual contributes to the lines of management accountability through to the CCG Governing Body.

19.2 There are four identifiable tiers within the CCG: -

- Governing Body Level Management
- Senior Management
- Locality Leads/ Managers
- All Members and Staff

20. Governing Body Level Management

20.1 *Chief Officer*

20.1.1 The Chief Officer has ultimate responsibility for risk management, for meeting all statutory requirements and adhering to guidance issued by NHS England. As such, the Chief Officer must take assurance from the systems and processes for risk management. The CCG will ensure that reporting mechanisms clearly demonstrate that the Chief Officer is informed of significant risk issues. The reporting mechanism will include the presentation of minutes and reports to the CCG by the Audit Committee.

20.1.2 It is the responsibility of the Chief Officer and Senior Management Team to ensure that the standards of risk management are applied at all levels within the CCG and that assurance mechanisms are in place to assure the CCG Governing Body that risk is being managed effectively.

20.2 *Chief Delivery and Integration Officer*

20.2.1 The Chief Delivery and Integration Officer Governing Body and has clear responsibility for governance and risk management. They will ensure the development of a comprehensive system of integrated governance across the CCG and that risk management arrangements are controlled and monitored through robust audit processes. They are the key contact for the auditors. The Chief Delivery and Integration Officer is invited to attend the Quality Committee and Audit Committee on a regular basis. They will be supported by the CSU Head of Governance and a team of specialist staff.

20.3 *Chief Finance Officer*

The Chief Finance Officer has overall fiscal responsibility in the CCG and is responsible for ensuring that the CCG carries out its business within sound financial governance and that risk management arrangements are controlled and monitored through robust accounting mechanisms that are open to public scrutiny on an annual basis. They will seek the Chief Internal Auditors opinion on the effectiveness of internal financial control. The Chief Finance Officer is in attendance/an ex-efficio member of the Audit Committee and Quality Committee. In addition they will be ultimately responsible for any financial implications of plans to minimise risk and the method for incorporating these into business planning.

20.4 *Escalation (Senior Management Team)*

The CCG operates an 'escalation System', which enables any issue with the potential to post a significant risk to the CCG, to be brought immediately to the attention of the Senior Management Team (SMT) without using the formal committee route. The decision to use this route must be approved by a member of the SMT.

20.5 *CCG Governing Body*

20.5.1 The CCG Governing Body recognises that risk management is a fundamental part of good governance and to be effective it is essential that risk management processes are integral to the CCG's culture. The Governing Body is therefore committed to ensuring that risk management forms an integral part of the CCG's philosophy, practices and business plans. Risk management is not viewed or practised as a separate programme and responsibility for implementation is accepted at all levels of the CCG.

20.5.2 The CCG Governing Body will ultimately carry responsibility for monitoring and overseeing risk that is relevant to the nature of its duties and responsibilities; however, the CCG Governing Body has delegated responsibility to the Quality Committee to take an overview of all risk and report directly to the Governing Body. The Audit Committee has responsibility for ensuring the arrangements in place are effective. The CCG will ensure that all Governing Body members receive Risk Management Training as part of their induction or refresher training.

20.6 *Quality Committee*

20.6.1 The Quality Committee has delegated authority from the CCG Governing Body to ensure that risk management is embedded throughout the CCG, including monitoring of all specialist groups with responsibility for risk. The Committee is under the chairmanship of a Clinical Governing Body Member , supported by a Lay Advisor Governing Body Member as Vice Chair, with additional lead clinician input and high level representation from the CCG management team. The Committee is charged with the responsibility for ensuring effective risk management systems are in place across the CCG. The Committee will have the option to establish specialist risk management groups to consider specific areas of risk in more detail on the Committee's behalf if it wishes to do so. The Quality Committee reports to the Governing Body. For further information on the role of the Quality Committee please see Appendix C.

20.6.2 The CCGs Internal Serious Untoward Incident Review Group meets monthly and forms a sub group of the Quality Committee, reporting into it on a monthly basis. For further Information regarding the Role of the Internal Serious Untoward Incident Review Group please see Appendix D.

20.7 *Audit Committee*

The Audit Committee is responsible for providing the Governing Body with assurance that an effective system of integrated governance, risk management and internal control, across the whole of organisation's activities which supports the achievement of the organisation's objectives is in place. In particular the Committee reviews the adequacy and effectiveness of the Quality Committee's arrangements, all risk and control related disclosure statements, particularly the Annual Governance Statement, and the underlying assurance processes which indicate the

degree of the effectiveness of the management of principle risks. For further information regarding the role of the Audit Committee please refer to Appendix E.

20.8 *Senior Management Support*

The CCG Chief Integration and Delivery Office will, in conjunction with the Chief Finance Officer, commission effective management support for governance and risk from CSU.

20.9 *North West Commissioning Support Unit (NWCSU)*

20.9.1 The Chief Delivery and Integration Officer has overall operational responsibility for delivery and review of the risk management strategy, however the NWCSU team will be commissioned to support the delivery of risk management systems and policies within the CCG as part of the Core Offer. The Governance Team at NWCSU will also provide advice and support regarding the analysis and evaluation of risk, ensuring that all risk registers across the organisation are 'dynamic' reflecting the changing risk profile of the organisation. They will also be commissioned to ensure systems are in place to achieve and improve compliance with external assessments and for monitoring all internal audit activity on behalf of the Audit Committee, ensuring that gaps in assurance and associated action plans identified through risk based reviews are completed. They also have responsibility for the risk education programme across in the CCG.

20.9.2 NWCSU will support the Chief Delivery and Integration Officer by preparing for all external inspections and accreditations. They will support the delivery of the Team/Locality risk management and assessment process and the maintenance of the Corporate Risk Register and Governing Body Assurance Framework.

20.9.3 The NWCSU will provide the Chief Nurse with regular information on Serious Untoward Incidents reported from commissioned services across Sefton. They will also support the Chief Nurse in identifying patient safety issues and health and safety & security. They will also manage the Incident Reporting System for both CCGs in Sefton and report regularly to the Governing Body via the Chief Nurse.

20.10 *Other Specialist Expertise:*

Expertise in specific areas of risk may be obtained from a number of sources, both internal and external, such as:-

- Governance / Quality Lead at NHS England /NWCSU
- Health and Safety Lead from NWCSU
- Occupational Health Manager
- Local Counter Fraud Specialist (LCFS)
- NHS Litigation Authority (NHSLA)
- Health & Safety Executive (HSE)

20.11 *NHS England*

As the successor body to the National Patient Safety Agency (NPSA), NHS England co-ordinates the reporting and learning of adverse events occurring in the NHS. The CCG reports all notifiable Patient Safety incidents to NHS England via the National Reporting and Learning System (NRLS) and promotes and monitors compliance with Safety Alerts issued by NHS England. The Chief Delivery and Integration Officer will therefore maintain effective liaison with the governance structures, committees and other groups within the Local Office of NHS England and NWCSU.

20.12 *Locality Leads/ Managers*

They will ensure that:-

- The risk management strategy is implemented within their area of control and promotes risk management as a key management responsibility.
- Risk management responsibilities are properly assigned and accepted at all levels.
- All risks associated with their area of responsibility are risk assessed and the results of these assessments and resulting control mechanisms are recorded on the Team Risk Registers. Control procedures will be periodically reviewed for continued effectiveness.
- A periodic review of the effectiveness of risk management within their area of responsibility is undertaken and action taken to eliminate deficiencies.
- Information, instruction and training are delivered to members / staff appropriate to the findings of risk assessments.
- Safe systems of work are in place and that effectiveness is periodically monitored.
- Outcomes of risk assessments are used as part of the service planning process to assist with planning and resource allocation.
- Information captured by complaints, litigation and incident reporting is used as a means of continuous monitoring and review, leading to risk reduction in services within their area.
- Bringing any significant risks which have been identified, and where local controls are considered to be potentially inadequate to the attention of the Quality Committee or SMT via the inclusion on the Locality / Team Risk Register.
- All staff within attend mandatory risk management training in line with the CCG's mandatory training policy.

20.13 *All CCG Members and staff:-*

- Risk management will form part of their daily duties. All will be able to identify and assess risk; take action to reduce risks to an acceptable level and inform appropriate lead clinicians and managers of unacceptable risks.
- All will be required to participate in activities, which are commensurate with the CCG's risk management arrangements and statutory requirements.
- All have a responsibility to report incidents, which is a key source of information for clinicians and managers on the nature and level of adverse activity within their sphere of responsibility.
- Be aware of emergency procedures e.g., resuscitation, evacuation and fire precaution procedures.
- Will attend risk management training as relevant to their role set out in the CCG's Mandatory Training Policy/ NWCSU Core Skills training policy.

20.14 *Commissioned services, Independent Contractors and their Employers*

Whilst there is no obligation to adopt the CCG Risk Management Strategy, if they do commissioned services will be contributing to the reduction of risk across the area as a whole, and to the improvement of patient and staff safety. In addition, following these procedures will assist in complaint handling, reduce litigation and may assist in the defence of any claims should they arise.

20.15 *Responsibilities of Contractors, agency and locum staff*

Contractors and agency staff working for the CCG are bound by the contents of this Strategy and will be expected to comply with all relevant policies and procedures. Information and training will be provided as necessary to enable contractors and agency staff to fulfil this responsibility.

21. Definitions

Risk management:

21.1 Risk management is a framework for the systematic identification, assessment, treatment and monitoring of risks. Its purpose is to prevent or minimise the possibility of recurrence of risks and their associated consequences, which have potentially adverse effects on the quality of care, both directly provided and commissioned, and safety of patients, staff and visitors, and the financial management of the organisation. It encompasses culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

22.2 Risk: The possibility of incurring misfortune or loss or failing to take advantage of potential opportunities.

Risk = consequences x likelihood

22.3 'Acceptable' risk - It is not feasible to eliminate or avoid all risks and there are some risks identified which require the CCG to go beyond reasonable action to reduce or eliminate.

Where the 'cost' to the organisation to reduce the level of risk outweighs the adverse consequences of the risk occurring, the risk would be considered 'acceptable' to the CCG.

22.4 'Manageable' risk - Some risks identified can be realistically managed, or reduced, within a reasonable, acceptable timescale through cost-effective measures; these are considered 'manageable' risk.

22.5 'High' risk - These are risks which if they occur will have a serious impact on the CCG and threaten the achievement of its objectives. Risks identified as 'high' should always be reported on the Team Risk Register, if necessary they should also be highlighted to the SMT via the Early Warning System.

22. Consultation, approval and ratification process

The policy has been developed and based on good practice in the area of risk management and is presented to the CCG Governing Body for approval. The strategy will then be discussed in more detail by the Audit and Quality Committees and any amendments will be presented to the Governing Body in a revised version.

23. Review and revision arrangements

The strategy will be considered and reviewed by the CCG Governing Body annually and / or when there are changes in NHS requirements or best practice.

24. Dissemination and Implementation:

24.1 For the strategy to be effective the CCG will:-

- Review annually its Risk Management Strategy to ensure it meets the needs of the CCG and the changing environment
- Ensure the risk management services provided meet the needs of the organisation and develops in line with changing requirements
- Continue the development and delivery of an education and training programme which assists members and assist in identifying and managing risk and in complying with the CCG risk management policies. Attendance records will be kept for all risk management training and evaluation forms completed and held by the Workforce Department at NW CSU department.
- Ensure the NWCSU systems capture data effectively.
- Monitor risk management key performance indicators, such as those suggested listed in Appendix G, to measure the performance of the CCG's risk management process. The efficacy and usefulness of these indicators will be reviewed by the Chief Delivery and Integration Officer and the Quality Committee. Consequently they will continue to be refined and developed.
- Encourage the flow of information via risk registers, and disseminate good practice in this regard, within and across the CCG.
- Develop a risk aware culture amongst members and staff through CCG briefings, literature, induction programmes, mandatory training and use of the CCG intranet site.

24.2 The Chief Delivery and Integration Officer will ensure that the Strategy is communicated throughout the CCG via the CCG website and intranet, bulletins, newsletters and in induction and mandatory training/ Core skills sessions. CCG Governing Body members and senior managers will be responsible for confirming receipt of the Risk Management Strategy and for ensuring its content to their respective teams so that all staff are aware of their responsibilities.

25. Education and Training

25.1 The following training will be provided by Commissioning Support Unit (NWCSU) on behalf of the CCG on an ongoing basis:-

- Risk management mandatory training to promote ownership of the Risk Management Strategy, including providing guidance on incident reporting, root cause analysis, risk assessment and the risk registers, and based upon the training needs analysis of all staff.
- Risk management is included in induction training.
- On an ad hoc basis as identified in personal development plans.
- Providing support in response to information notices, i.e., CAS alerts.

25.2 The Quality Committee will review progress against the implementation of the strategy. The review will be based on information available from the Governing Body Assurance Framework, and the Corporate Risk Register and other internal and external audits. In addition the Audit Committee when reviewing the efficiency of risk management systems across the CCG on behalf of the CCG Governing Body; this is primarily done by the work of internal and external audit.

26. Document Control

The Chief Delivery and Integration Officer are responsible for storing current, and archiving, versions of the Risk Management Strategy.

27. Monitoring compliance with and effectiveness of the policy

27.1 The success of risk control measures must be monitored in an appropriate manner to provide information to guide future developments. There are various ways in which the CCG assesses and monitors risk supported by systems managed by CSU. Reactive monitoring occurs through the incident and near miss reporting and monitoring of complaints and claims. Proactive monitoring of adherence to procedures occurs through audit, workplace inspections, staff surveys and performance indicators.

27.2 The CCG committee structure will provide a vehicle for monitoring risk management activity. The Quality Committee is responsible for managing areas of concern on the Corporate Risk Register and will receive information from the incident reporting system and consider policy changes as a result of information from incident reporting.

27.3 Senior Managers shall hold staff to account for ensuring compliance with the strategy within their locality / service area. An effective way of ensuring the strategy is adopted into the culture of the CCG is via the appraisal process when reviewing performance e.g. against the Knowledge and Skills Framework outline. A suggestion of evidence to be looked for is in KSF Dimension Health Safety and Security Levels 1-3.

28. Associated documentation

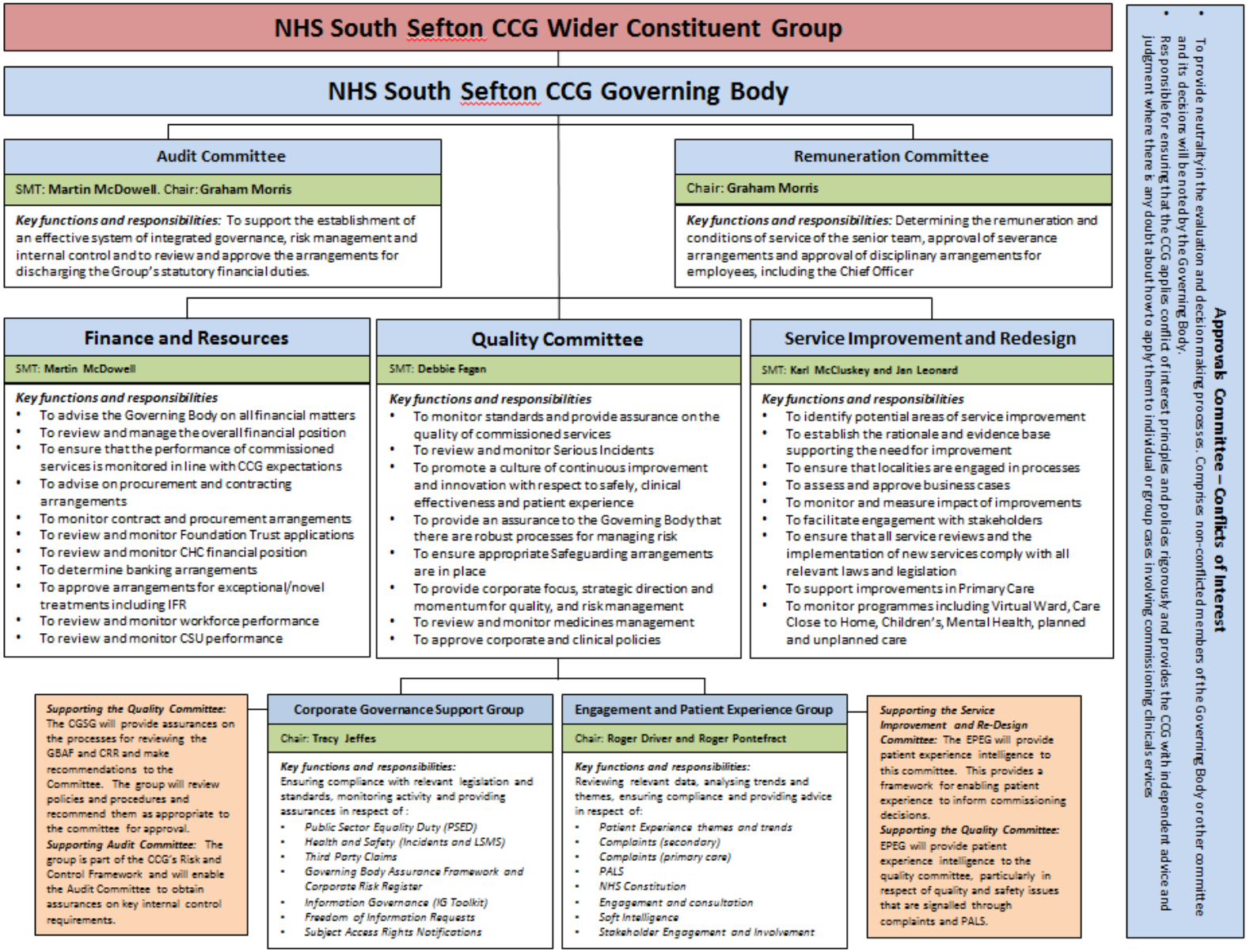
28.1 The Risk Management Strategy is to be followed within the context of the CCG's overarching strategy.

28.2 A range of documents from predecessor organisations will be reviewed, amended and if appropriate adopted by the CCG Governing Body. Such policies will include:-

- policy & procedure for the reporting and management of incidents & near misses;
- policy & procedure for the management of claims;
- complaints comments & concerns policy;
- policy & procedure for the root cause analysis of incidents, complaints and claims;
- health and safety policy;
- moving and handling policy;
- lone workers policy;
- control of substances hazardous to health (coshh) policy;
- management of violence and aggression policy;
- infection control strategy;
- steis reporting procedure;
- whistleblowing policy;
- and any other relevant document.

28.3 These policies will be published the CCG Intranet site once adopted.

Appendix A – South Sefton Governance Structure



Appendix B

Risk Grading Matrix

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

Risk	Score	Colour
Insignificant	1 - 3	
Low	4 - 6	
Moderate	8 - 12	
High	15 - 25	

Significant risk

Significant Risk

A risk which attracts a score of 8 or above on the risk grading matrix constitutes a significant risk and must be recorded on the Corporate Risk Register.

Appendix C

Terms of Reference for Quality Committee

1. Principal Functions

1.1. The Quality Committee shall be established as a committee of the Governing Body in accordance with the CCG's Scheme of Delegation and will have 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.

1.2. The approval of arrangements for safeguarding children and adults remains a matter reserved for the Governing Body. However, monitoring of safeguarding arrangements and activity is part of the Quality Committee's principal functions and duties.

1.3. In the event of overlap or conflict between the roles or responsibilities of the Audit Committee and the Quality Committee of the CCG, the role of the Audit Committee and any decisions made by the Audit Committee shall have precedence over those of the Quality Committee. The main functions of the Quality Committee are:

- to monitor standards and provide assurance on the quality of commissioned services, by the CCG to ensure that local and national standards are met
- to promote a culture of continuous improvement and innovation with respect to safely, clinical effectiveness and patient experience
- to provide an assurance to the Governing Body that there are robust structures, processes and accountabilities in place for identifying and managing significant risks facing the organisation (i.e. strategic, operational, clinical and organisational)
- to provide corporate focus, strategic direction and momentum for quality, and risk management within the CCG.

2. Principal Duties

The principal duties of the Committee are as follows:

2.1. to ensure effective management of governance areas (clinical governance, corporate governance, information governance, research governance, financial governance, risk management and health and safety) and corporate performance in relation to all commissioned services

2.2. to ensure the establishment and maintenance of an effective system of integrated governance, risk management and internal control in line with the Integrated Governance

Handbook (DoH February 2006), across the organisation's activities (both clinical and non-clinical), that support the achievement of the organisation's objectives

2.3. to provide assurance to the Audit Committee, and the Governing Body, that there are robust structures, processes and accountabilities in place for the identification and management of significant risks facing the organisation

2.4. to ensure that the organisation has policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, and to approve such policies

2.5. to work in conjunction with the Service Improvement and Re-Design Committee in ensuring that quality and safety are an integral feature of the strategic planning process

2.6. to receive, scrutinise and monitor progress against reports from external agencies, including, but not limited to, the Care Quality Commission, Monitor and Health and Safety Executive

2.7. receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans

2.8. to ensure that patient experience and patient informs the business of the committee through the establishment of appropriate sub groups and associated reporting arrangements

2.9. to have oversight of the process and compliance issues concerning serious incidents requiring investigation (SIRIs); being informed of Never Events and informing the CCG Governing Body of any escalation or sensitive issues in good time.

2.10. to work collaboratively to identify and promote "best practice", the sharing of experience, expertise and success across the CCG and with key stakeholders

2.11. to monitor the CCG Quality Performance Dashboard and drive year-on-year improvement in performance. The Committee will agree what information, reports, notes or minutes from other committees or North West CSU colleagues that it needs to see on a regular or ad hoc basis and ensure they are scrutinised

2.12. to establish sub-groups or task and finish groups as and when appropriate to assist the Committee discharge its duties effectively. These groups will be required to report to the Quality Committee by submission of meeting notes and key issues reports as stipulated by the Quality Committee.

2.13. the Quality Committee shall monitor the effectiveness of meeting the above duties by:

- reviewing progress against its own programme of business agreed by the Governing Body
- producing an annual report for the CCG Governing Body

2.14. support the Governing Body to meet its Public Sector Equality Duty

2.15. promote research and the use of research across the organisation

2.16. promote education and training across the organisation

2.17. support the improvement of primary medical services and primary care quality

2.18. to review and approve plans for Emergency Planning and Business Continuity

2.19. to review and approve arrangements for the proper safekeeping of records.

3. Membership

3.1. The following will be members of the Committee:

- Clinical Governing Body Member (Chair)
- Lay Governing Body Member
- Practice Manager Governing Body Member
- Chief Finance Officer or nominated deputy
- Chief Nurse or nominated deputy
- Clinical Director Lead for Quality
- CCG Head of Primary Care and Corporate Performance
- A clinical locality representative
- Head of CCG Development

The Chief Officer shall be an ex-officio member

The following leads have an open invitation for each meeting of the Quality Committee:

- Designated Professional Safeguarding Children and Head of Adult Safeguarding.
- Programme Lead for Quality and Safety
- Commissioning Support Unit Quality Leads
- Locality Managers

3.2. All Members are required to nominate a deputy to attend in their absence. Deputies will count towards the quorum but shall be of sufficient seniority to enable decision making.

3.3. All members are expected to attend a minimum of 50% of meetings held.

3.4. Minutes and papers shall also be sent for information to CCG Chair who shall have a standing invitation to attend committee meetings.

4. Chair

A Clinical Governing Body member nominated by the CCG Governing Body shall chair the committee. The Committee shall select a Vice Chair from its membership.

5. Quorum

5.1. The quorum shall consist of the Chair of the Quality Committee or Vice Chair, one Member of the Governing Body that is also a member of the CCG Senior Management Team, a Governing Body Clinician and three other members from within the Quality Committee Membership.

5.2. As per the NHS South Sefton CCG Constitution, the quorum shall exclude any member affected by a Conflict of Interest. If this has the effect of rendering the meeting inquorate then the Chair shall decide whether to adjourn the meeting to permit the co-option of additional members.

6. Frequency of Meetings and Reporting Arrangements

6.1. The Committee will meet at least 8 times per year and submit the ratified minutes of its meeting to the next available Audit Committee and CCG Governing Body.

6.2. The Committee will submit an annual report to the CCG Governing Body.

7. Conduct

7.1. All members are required to maintain accurate statements of their register of interest with the Governing Body. Members should notify the committee chair of any actual, potential or perceived conflicts in relation to the agenda, in advance of the meeting or at the beginning of each meeting. The Chair shall consider such notices in accordance with NHS South Sefton CCG procedure for the management of Conflicts of Interest as set out in the Constitution.

7.2. All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

8. Secretarial Arrangements

8.1. PA to the Chief Nurse shall provide secretarial support to the Committee.

8.2. The agenda for the meetings will be drawn up with the Chair of the Committee.

8.3. The agenda and papers for meetings will be distributed one week in advance of the meeting.

8.4. The minutes of the meeting will be produced in 10 working days.

Appendix D

Terms of Reference for Internal Serious Untoward Incident Group

The following Terms of Reference were approved as part of the 'Performance Management of Serious Incidents/Never Events' policy presented to the Quality Committee in April 2014.

South Sefton CCG Serious Incidents/Never Events Review Group

The CCG's internal Serious Incident/Never Event Review Group acts under delegated authority of the Quality Committee as a line of assurance and specialist advice in supporting the CCG in the discharge of its responsibilities for the performance management of SIs (see Terms of Reference, Appendix 3). The Group will meet on a monthly basis to:

- Review Root Cause Analysis reports from all Never Events, Grade 1 and Grade 2 Serious Incidents and recommend closure where the criterion for closure is met;
- Review all SIs which potentially meet the criteria for a Never Event and to scrutinise such incidents to determine classification;
- Challenge the content, structure and compliance of RCA investigation reports as necessary;
- Where appropriate, determine further assurances required from the provider in order for a decision to be made to close the SI;
- Determine appropriate remedial actions where trends highlight risks (e.g. aggregated reviews of Serious Incidents) and the timescales for reporting, and;
- Act as a decision making forum when the grading of a SI cannot be agreed

The Serious Incident/Never Event Review Group will make recommendations for the closure of SIs/Never Events only once it is satisfied that the SI has been investigated thoroughly and that there are no further risks posed to patient/staff safety.

Additional expertise, knowledge and experience will be utilised depending upon the type of service reporting the incident/event and the type of event reported. The CCG will ensure that the Group has sufficient knowledge and experience of the subject matter to enable an objective assessment of the adequacy of the scope of the review and subsequent review report, together with any recommendations made.

Should any aspect of service quality/safety raise concerns as a result of the review of a RCA investigation report, the CCG's Serious Incident/Never Event Review Group will be responsible for agreeing the actions required to rectify the issue (i.e. referral to the Quality Committee if there are wider performance concerns). This may include appropriate assurances from the provider in relation to action plans, and in particular where Coroner's Rule 43/Prevention of Future Deaths reports have been issued.

Where there is disagreement between the CCG and the relevant provider regarding the outcome of a decision, the provider will be invited to attend a meeting with the Group members to review available evidence and agree a final determination.

Appendix E

TERMS OF REFERENCE FOR THE AUDIT COMMITTEE

1 Principal Functions

The Audit Committee will be established as a Committee of the Governing Body to perform the following functions on behalf of the CCG Governing Body:

i) The Committee is a non-executive committee of the Governing Body and has no executive powers, other than those specifically delegated in these Terms of Reference.

ii) The Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

iii) The Committee is authorised by the Governing Body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

2 Principal Duties

The duties of the committee will be driven by the priorities and associated risks as identified by the CCG. It will be flexible to new and emerging priorities and risks.

The principal duties of the Committee are as follows:

a) Integrated Governance, Risk Management and Internal Control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities that supports the achievement of the CCG's objectives.

Its work will dovetail with that of the Quality Committee, which the CCG is establishing to seek assurance that robust clinical quality is in place.

In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Governance Statement), together with any appropriate independent assurances, prior to endorsement by the CCG.
- the underlying assurance processes that indicate the degree of the achievement of CCG Objectives, the effectiveness of the management of principle risks and the appropriateness of the above disclosure statements.
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from Governing Body level and other senior managers as

appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

b) Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Officer and CCG. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- review and appropriate approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the internal and external auditors to optimise audit resources
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the CCG.
- annual review of the effectiveness of internal audit
- Internal Audit should have access to the Chair of the Audit Committee via the committee secretary.

c) External Audit

The Committee shall review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:

- consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit
- discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the annual plan, and ensure co-ordination, as appropriate, with other external auditors in the local health economy
- discussion with the external auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee
- review all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the CCG and any work carried outside the annual audit plan, together with the appropriateness of management responses.

d) Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the CCG.

These will include, but not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulations/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority etc), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work, such as the Quality Committee.

In reviewing the work of the Integrated Governance Committee and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

e) Counter Fraud

The committee shall satisfy itself that the CCG has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

f) Management

The Committee may request and review reports and positive assurances from Governing Body level management and other managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

g) Financial Reporting

The Audit Committee shall monitor the integrity of the Financial Statements of the CCG and any formal announcements relating to the CCG's financial performance.

The committee shall ensure that the systems for financial reporting to the CCG including those of budgetary control are subject to review as to completeness and accuracy of the information provided to the CCG.

The Audit Committee shall review the annual report and financial statements before submission to the CCG Governing Body, focusing primarily on:

- the wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices and estimation techniques
- unadjusted mis-statements in the financial statements
- significant judgements in preparing of the financial statements
- significant adjustments resulting from the audit
- letter of representation and
- qualitative aspects of financial reporting.

The Committee should also ensure that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Governing Body.

3 Membership

The Committee shall be appointed by the Governing Body and shall consist of not less than three Governing Body members.

The Governing Body shall appoint the Lay Advisor (with a lead for governance) as Chair of the Committee.

The Chair of the CCG shall not be a member of the Committee

The following will be members of the Committee:

- Lay Advisor (Chair)
- Clinical Governing Body Member
- Clinical Governing Body Member

The Chief Finance Officer and appropriate Internal and External Audit representatives shall normally attend meetings. However, at least once a year the Committee should meet privately with the external and internal auditors.

Representatives from NHS Protect may be invited to attend meeting and will normally attend at least one meeting each year.

The appointed internal and external auditors may be invited to attend the committee; however regardless of attendance they and local counter fraud and security management (NHS Protect) providers will have full and unrestricted rights of access to the Audit Committee.

The Chief Officer and other senior managers should be invited to attend, but particularly when the Committee is discussing areas of risk or operation that are the responsibility of that manager.

The Chief Officer should be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control. He or she would normally attend when the committee considers the draft internal audit plan and the annual accounts.

The PA to the Chief Finance Officer or his or her deputy shall be the Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chair and committee members.

The CCG Chair may also be invited to attend one meeting each year in order to form a view on, and understanding of, the committee's operations.

All members are expected to attend a minimum of 50% of meetings held.

4 Chairmanship

The appointed Lay Advisor with a lead for Governance shall chair the committee, a Deputy Chair will also be appointed from the above membership.

5 Quorum

A quorum shall be two members and must include either the Chair or Deputy Chair.

6 Frequency of Meetings and Reporting Arrangements

Meetings shall be held not less than three times a year. The appointed External Auditor or Internal Auditor may request a meeting if they consider that one is necessary.

The minutes of the Audit Committee meetings shall be formally recorded by the Committee Secretary and submitted to the Governing Body.

The Chair of the Committee shall draw to the attention of the CCG Governing Body any issues that require disclosure to the full Governing Body or require executive action.

The Committee will report to the Governing Body annually on its work in support of the Statement on Internal Control / Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and embeddedness of risk management in the organisation, and the integration of governance arrangements.

7 Secretarial arrangements

PA to the Chief Finance Officer (or deputy) shall provide secretarial support to the Committee. The Committee shall be supported administratively by the Committee Secretary, whose duties in this respect will include:

- agreement of agenda with Chair and attendees and collation of papers
- taking the minutes and keeping a record of matters arising and issues to be carried forward
- advising the Committee on pertinent areas

The agenda for the meetings will be drawn up with the Chair of the Committee.

The agenda and papers for meetings will be distributed one week in advance of the meeting.

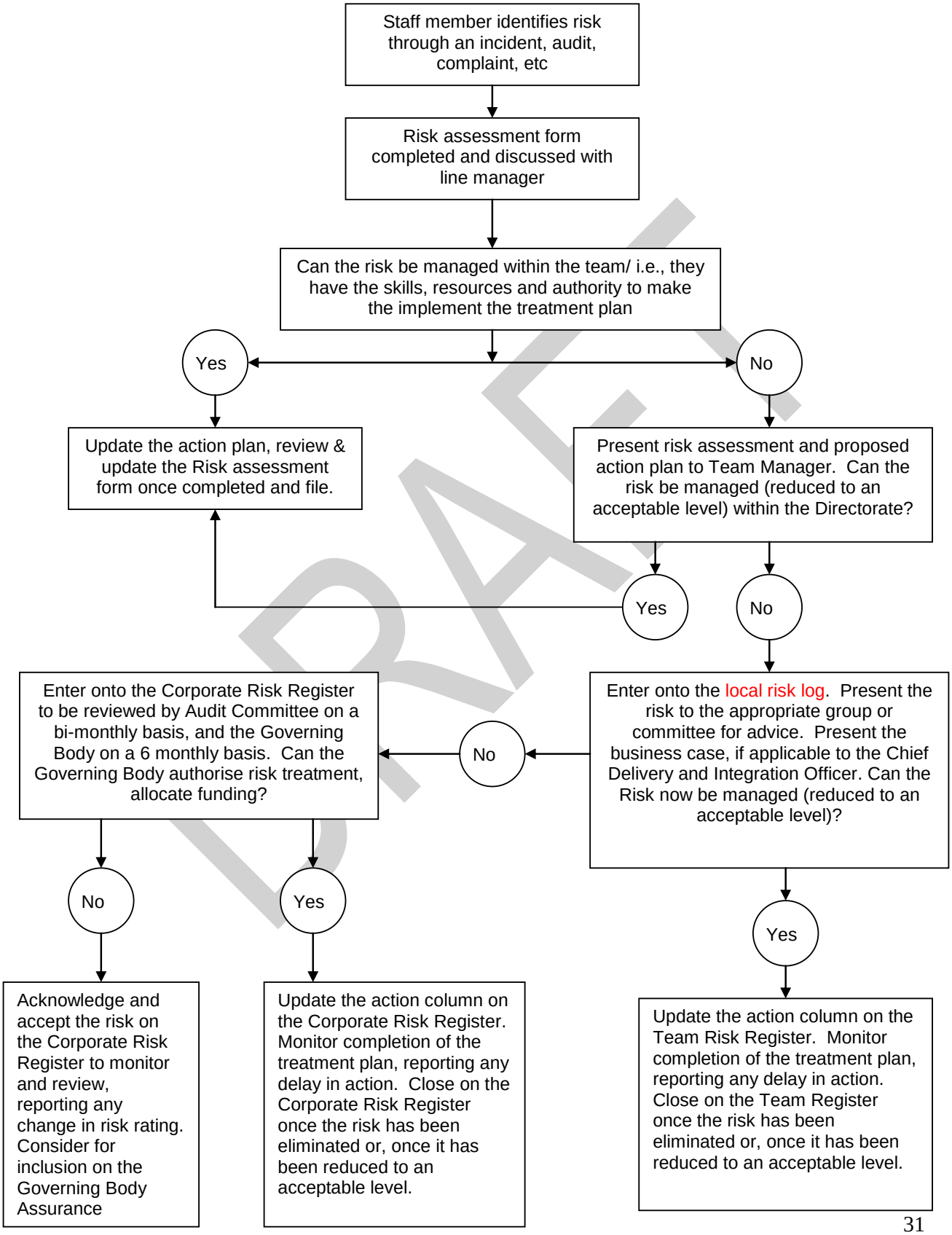
Appendix F

Risk Management Performance Indicators

Performance Indicator	Lead for compiling data
Incident Reporting	
No. of incidents & near misses reported this period compared to previous periods	C&M CSU
% of directorates reporting incidents & near misses	
No. (%) of incidents with actions recorded	
No. (%) of incidents closed with no action recorded	
No. (%) of incidents ongoing for more than 3 months	
Average severity rating of incidents and near misses	
No. (%) of patient safety incidents uploaded to the NPSA NRLS	
Risk Register	
No. of risks added to the Risk Registers	Chief Delivery and Integration Officer
No. of risks closed on the Risk Registers	
No. (%) of red risks on the Risk Registers	
No. (%) of Team with 'live' Risk Registers (i.e., reviewed on a monthly basis)	
Risk Management Training	
% of Staff who are up to date with their mandatory risk management training	Workforce at C&M CSU
Complaints	
No. of formal complaints relating to Commissioned Services received (NOTE – as of 1 April 2009 any verbal complaints not resolved within 24 hours are now logged as a formal complaint)	C&M CSU
No. (%) of complaints acknowledged within 3 working days	
No. (%) of complaints answered within an agreed timescale	
No. (%) of complaints with an initial incident reporting form	
No. (%) of complaints referred to the Ombudsman	
Claims	
No. of claims	C&M CSU
No. (%) of claims in which an initial incident form was completed	
No. (%) of letters of claim acknowledged within 14 days	
Central Alert System (CAS)	
No. of alerts received within this period	C&M CSU
No. (%) of alerts responded to within the timescales	
StEIS (Serious Untoward Incidents)	
No. of StEIS incidents reported to the CCG	C&M CSU
No. (%) of StEIS incidents acknowledged within 3 days	
No. (%) of completed investigation reports received within agreed timescales	
No. (%) of investigation reports reviewed within 10 working days	

Appendix G

Populating the Corporate Risk Register



NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2014

Agenda Item: 14/152	**Author of the Paper:** Fiona Clark Chief Officer Email: fiona.clark@southseftonccg.nhs.uk Tel: 0151 247 7061
Report date: November 2014	

Title: Emergency Prepares and Resilience and Response Statement of Compliance

Summary/Key Issues:

The paper provides a Statement of Compliance that South Sefton Clinical Commissioning Group has undertaken a self-assessment against required areas of the NHS England Core Standards (for EPRR v2.0).

Following assessment, the organisation has been self-assessed as demonstrating the Full compliance against the core standards.

Recommendation

The Governing Body is asked to note the statements of compliance and approve the policy statement.

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				

Links to National Outcomes Framework *(x those that apply)*	
	Preventing people from dying prematurely
	Enhancing quality of life for people with long-term conditions
	Helping people to recover from episodes of ill health or following injury
	Ensuring that people have a positive experience of care
	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
November 2014

1. Executive Summary

3.1 The Accountable Officer for NHS South Sefton Clinical Commissioning Group has a statutory responsibility for the Emergency Preparedness, Resilience and Response arrangements as a category 2 responder under The Civil Contingencies Act 2004, the Health and Social Care Act 2012, NHS England Emergency Planning Framework and other central government guidance. All staff must be aware of their responsibilities in preparing for and for responding to emergencies. The CCG is required to undertake a self-assessment and issues a statement of compliance. This paper sets out the CCGs self-assessment statement.

3.2 The CCG has assessed its self as fully compliant against NHSE's statement for full compliance: "the plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve".

2. Introduction and Background

2.1 The CCG is required under the acts and guidance to have in place an Incident Response plan, Business Continuity plan and a robust 24/7 on call system. The plans detailed in this document are in place to ensure that these responsibilities are met. The CCG is part of the North Mersey on call system.

2.2 Some examples of events that are likely to lead to the declaration of a major incident and require support from the CCG are:

- Major Incidents requiring a multi-agency response – rail, motorway, and air crashes, chemical incidents, terrorist incidents etc;
- Rising tide incident – such as infectious diseases, eg pandemic flu, flooding, fuel shortages;
- Headline news report – sparking a health scare;
- Safeguarding emergency closure of residential / nursing homes;
- Incidents requiring the identification of vulnerable people;
- Naturally occurring emergencies, ie severe weather, flooding;
- Major Internal Incidents.

2.3 All of these may place an immense strain on the resources of the NHS, and the wider community; impact on the vulnerable people in our community and could affect the ability of the CCGs to work normally.

2.4 Notification of a Major Incident occurring will normally be cascaded to the CCG from NHS England but could occur as a result of a local incident at a provider organisation or an incident which solely affects the ability of the CCG to undertake its functions requiring a local Business Continuity response

2.5 Events such as these may require the activation of the CCG Incident Response Plan and/or the Business Continuity plan. This decision will be taken by the On Call officer in consultation, if time allows, with the CCG Accountable Officer. It is important that all staff are familiar with the plans, and are aware of their responsibilities. Staff should ensure that they are regularly updated to any changes in both the incident response plan and the Business Continuity plan. Both are held on the CCG intranet. Accurate contact details of all staff are to be maintained, to ensure that people are accessible during an incident.

2.6 Whilst the Incident Response Plan or Business Continuity plan will only rarely be activated, regular training and exercising will occur, as required under the CCA 2004 and NHS Guidance. South Sefton CCG staff are to become fully involved in both the training and exercises.

2.7 Incidents requiring activation of the plans can occur at any time, day or night, and it is essential that the CCG maintains its preparedness to respond

2.8 Contact details of all managers and staff are held separately and will not form part of any documents placed in the public domain

2.9 Specialist advice and support is available from North West Commissioning Support Unit Resilience Team.

2.10 Both the Incident Response Plan and the Business Continuity plan have been developed against the NHS Core Standards for Business Continuity and Major Incident Response published by NHS England

2.11 A policy statement for business continuity has been prepared on behalf of South Sefton Clinical Commissioning Group.

2.12 The Business Continuity Management and Incident Response Plans for the CCG have been developed. Any additional requirements will be overseen by the CSU Resilience Team and reported to the Governing Body.

2.13 On 31st May 2013 the CCG was able to undertake its duties as a Category 2 Responder, with 24/7 coverage provided through an On-Call rota shared with the other CCGs in North Mersey.

2.14 The Business Continuity and Incident Response plan together with other relevant documentation will be held electronically in a manner allowing access to all staff

3. Policy Statement

3.1 Business Continuity Management (BCM) is an important part of NHS South Sefton CCG risk management arrangements. The Civil Contingencies Act (CCA) 20041 identifies all CCGs as 'Category 2 Responders', and imposes a statutory requirement on each CCG to have robust BCM arrangements in place to manage disruptions to the delivery of services.

3.2 The aim of Business Continuity Management is to prepare for any disruption to the continuity of the business, whether directly - i.e. within the responsibility control or influence of the business, or indirectly - ie due to a major incident occurring to a partner, supplier, dependant or third party, or from a natural disaster.

3.3 It is recognised that plans to recover from any disruption must consider the impacts not only to the CCG staff, premises, technology and operations, but that NHS South Sefton CCG must also plan to maintain its brand, status, relationships and reputation.

3.4 Business Continuity arrangements should ensure that the CCGs continue to meet their legal, statutory and regulatory obligations to its staff and to its dependent stakeholders.

3.5 The CCG has developed the Business Impact Analysis which has identified the critical functions of the CCG and the potential impacts of the loss of staff, effects to communications, data systems, transport and buildings

3.6 In accordance with the requirements of NHS England, NHS South Sefton CCG BCMS will be in accordance with and aligned to the ISO 22301 together with the published NHS Core Standards

3.7 It is the policy of NHS South Sefton Clinical Commissioning Group to develop, implement and maintain a Business Continuity Management System (BCMS) in order to ensure the prompt and efficient recovery of the critical activities from any incident or physical disaster affecting the ability of the CCG to operate and deliver its services in support of the NHS economy.

3.8 It is the policy of NHS South Sefton CCG to take all reasonable steps to ensure that in the event of a service interruption, the organisation will be able to respond appropriately and continue to deliver their essential functions, and that it is able to respond to the needs of their local populations. A service interruption is defined as:

3.9 *'Any incident which threatens personnel, buildings or the operational procedures of an organisation and which requires **special measures** to be taken to restore normal functions.'* (www.cabinetoffice.gov.uk/ukresilience)

3.10 The Cabinet Office's "Expectations and Indicators of Good Practice Set for Category 1 and 2 Responders" describes 7 expectations drawn from the Civil Contingencies Act (2004), Regulations (2005) and guidance:

- Duty to assess risk;
- Duty to maintain plans – Emergency Plan;
- Duty to maintain plans – Business Continuity;
- Duty to communicate with the public;
- Business Continuity Promotion;
- Information sharing;
- Cooperation.

3.11 NHS South Sefton CCG is a Category 2 Responder. As such the CCG will be required to share information and to co-operate with Category 1 Responders in the event of an emergency. The organisation is also required to have Business Continuity plans and Incident Response Plans. These requirements are in place:

3.12 It is requested that the Governing Body is recommended to approve the plans and policy statement

4. Recommendations

It is requested that the Governing Body is authorise the chief office to sign the statement of compliance and to approve the policy statement

Appendices

Appendix 1 – Statement of Compliance

Fiona Clark
Chief Officer
November 2014

STATEMENT OF COMPLIANCE EPRR 2014/15

Click here to enter text. has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v2.0).

Following assessment, the organisation has been self-assessed as demonstrating the Choose an item. compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	The plans and work programme in place appropriately address all the core standards that the organisation is expected to achieve.
Substantial	The plans and work programme in place do not appropriately address one or more the core standard themes, resulting in the organisation being exposed to unnecessary risk.
Partial	The plans and work programme in place do not adequately address multiple core standard themes; resulting in the organisational exposure to a high level of risk.
Non-compliant	The plans and work programme in place do not appropriately address several core standard themes leaving the organisation open to significant error in response and /or an unacceptably high level of risk.

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the Organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the core standards has been or will be confirmed to the organisation's board / governing body.

_____

Signed by the organisation's Accountable Emergency Officer

_____ _____

Date of board / governing body meeting Date signed

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2014

Agenda Item: 14/153	**Author of the Paper:**
Report date: November 2014	Karl McCluskey Chief Strategic Planning & Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7000 Debbie Fagan Chief Nurse and Quality Officer Email: debbie.fagan@southseftonccg.nhs.uk Tel: 0151 247 7000

Title: Integrated Performance Report

Summary/Key Issues:

This report provides summary information on the activity and quality performance of Southport and Formby Clinical Commissioning Group at September 2014 (note time periods of data are different for each source).

Recommendation

The Governing Body is asked to receive the contents of this 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.
	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		
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

South Sefton Clinical Commissioning Group

Integrated Performance Report

October 2014

Contents

Tables

NB: CAVEAT TO THIS REPORT

Not all quality and performance information is available on a South Sefton footprint. Data has been provided at this level where available and Aintree Hospital Foundation Trust level data is used where not.

1. Executive Summary

This report provides summary information on the activity and quality performance of South Sefton Clinical Commissioning Group at October 2014 (note: time periods of data are different for each source).

Key information from this report

Financial performance – the CCG continues to experience financial pressures in the area of acute care and Continuing Healthcare. The CCG has sufficient reserves in place and remains on course to deliver its planned surplus.

Cdifficile – In September 2014 there have been 8 new cases of Cdifficile infection reported for South Sefton CCG patients giving a cumulative total of 34 cases year to date against a tolerance for South Sefton CCG patients of 30. All 8 cases were recorded at Aintree Hospitals NHS Foundation Trust (4 acute Trust acquired and 4 community acquired). The IPC action plan is being implemented and robustly monitored. As previously reported, an existing action plan is being implemented.

MRSA – 0 new cases reported in September 2014, 2 cases reported ytd. Aintree has informed the CCG that they have contacted Regional Office regarding the assigning of the case in July 2014 and to receive information regarding lessons learned.

A&E 4 Hour Waits - Percentage of patients who spent 4 hours or less in A&E (Cumulative) - South Sefton CCG achieved this target cumulatively to September 2014 with 98.78% against the 95% target. Performance cumulatively to September 2014 at Aintree University Hospitals NHS Foundation Trust was just below the target of 95% with 92.24%. 485 attendances were not admitted, transferred or discharged within 4 hours. An exception report has gone to Board detailing a number of changes to practice implemented during September. An activity query notice has been issued due to variances in unplanned care. Further detail is included within the report.

Mixed Sex Accommodation (MSA) - South Sefton CCG reported zero MSA breaches for September 2014.

Cancer 62 Day Screening - Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – South Sefton CCG achieved 96.88% for August against a target of 90% for 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers. Aintree University Hospitals NHS Trust failed the target of 90% in August achieving 80.0%. Further detail is included in the report.

CCG Key Performance Indicators

NHS Constitution Indicators	Footprint	
Ambulance Category A Calls (Red 1)	CCG	
RTT 18 Week Incomplete Pathway	CCG	
Cancer 2 Week GP Referral	CCG	
A&E 4 Hour Waits	CCG	
Other Key Targets		
A&E 4 Hour Waits	AUHT	
Ambulance Category A Calls (Red 1)	NWAS	
Ambulance Category A Calls (Red 2)	CCG	
Ambulance Category A Calls (Red 2)	NWAS	
MRSA	CCG	
MRSA	AUHT	
C.Diff	CCG	
Cancer 62 Day Urgent GP Referral	AUHT	
Cancer 62 Day Screening	AUHT	
PYLL Person (Annual Update)	CCG	
Local Measure: Diabetes	CCG	

Key information continued…

Rate of Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Males and Females) – For males, South Sefton CCG achieved 2592.3 in 2013, which was above the target of 2,029. For females, South Sefton CCG achieved 2,517.70 in 2013, which was above the planned target of 2,128.24. The CCG are working with Public Health at a local and regional level to understand the measures.

Ambulance Clinical Quality – Category A (Red 1) 8 minute response time - South Sefton CCG failed to achieve the target of 75% for the month of September 2014, reaching 64.81% in month, 69.12% (cumulative). Ambulance Clinical Quality – Category A (Red 2) 8 minute response time - South Sefton CCG failed to achieve the target of 75% at September 2014, recording 67.38%, 69.99% (cumulative).

Please note the CCG is measured on the NWAS figures which are also under target for the above 2 indicators, Red 1 being slightly under at 72.16% and Red 2 at 72.96% NWAS is achieving Category 19 Transportation time along with the CCG.

NWAS are experience difficulties in delivering the contract across the North West, with increases in demand in all areas. NHS Southport and Formby and NHS South Sefton CCGs are working with NWAS to undertake a deep dive to further

Key information continued…

understand these increases in demand.

% who had a stroke & spend at least 90% of their time on a stroke unit

South Sefton CCG achieved the target for the Stroke indicator in September 2014. Performance was at 83.33% for the month of September.

Aintree University Hospitals NHS Foundation Trust achieved the 80% stroke target during September 2014; performance was at 90.24%.

& % high risk of Stroke who experience a TIA are assessed and treated within 24 hours -

Aintree University Hospitals NHS Foundation Trust achieved the 60% TIA target during September 2014, performance was 100%.

Friends and Family Test Score – Inpatients and Accident & Emergency (A&E) – NHS England has changed the way Friends and Family data is reported. They will continue to review the % of respondents but no longer receive a Test Score; the following 2 measures will replace the Test Score; Percentage Recommended, Percentage Not Recommended.

Aintree University Hospitals NHS Foundation Trust –

Inpatients

- % of respondents – 41.5%, % recommended – 99%, % not recommended – 0%

England (including Independent Sector Providers) - Inpatients

- % of respondents – 36.6%, % recommended – 94%, % not recommended – 2%

Aintree Hospital - A&E

- % of respondents – 22.6%, % recommended – 83%, % not recommended – 9%

England – A&E

- % of respondents – 19.5%, % recommended – 86%, % not recommended – 7%

Quality Premium Measures

Based on local data performance for the indicators for 2014/15 (April 2014 – September 2014), South Sefton CCG would receive a payment in 2014/15 of £0 against a total possible payment (if all indicators were within tolerance) of £776,065. This is due to poor performance of the access to psychological therapies measure, the avoidable admissions measure, Merseycare and Aintree's underperformance on the medication error reporting measure, the local diabetes measure and underperformance on the ambulance measure, which would result in a 25% reduction to the overall possible payment, plus indicators for which performance is currently unknown due to annual reporting frequencies. The total amount payable under a likely case scenario is £368,631 against a total possible payment (if all indicators were within tolerance) of £776,065.

The current rate for the local measure for diabetes is below the plan of 65.9% with the CCG recording 46.2% for quarter 1. This is a new measure and is updated quarterly. An omission has been found in the calculation for one of the care processes (smoking status) which should increase the overall percentage next quarter.

Activity Variances - Planned Care: focus is on key causes of over-performance at two providers. Increases in Outpatient procedures at Aintree to be investigated at the Information Sub Group. The outcome of the Liverpool Womens Hospital Activity query is a Joint activity Review led by Liverpool CCG as lead

commissioner. Year to date increases in Trauma and orthopaedics are noted at Wrightington Wigan and Leigh.

Activity Variances – Unplanned Care: focus is on two main areas of over-performance at Aintree and Royal. NHS Liverpool CCG carrying out a formal joint investigation of increased activity at Royal. NHS South Sefton CCG, supported by NWCSU, completing investigations on non-elective performance at Aintree and issuing a formal Activity Query Notice to the provider.

2. Financial Position

2.1 Summary

This report focuses on the financial performance of the CCG at October 2014 (Month 7), which is £1.905m (£1.306m in M6) overspent on operational budget areas before the application of Reserves.

The CCG is on target to achieve the planned £2.300m surplus by the end of the year. It also meets the other business rules required by NHS England, as demonstrated in **Table A** below. However, there are risks outlined in **section 2.3** that require monitoring and managing in order to manage and deliver the target, surplus position.

Table A – Financial Dashboard

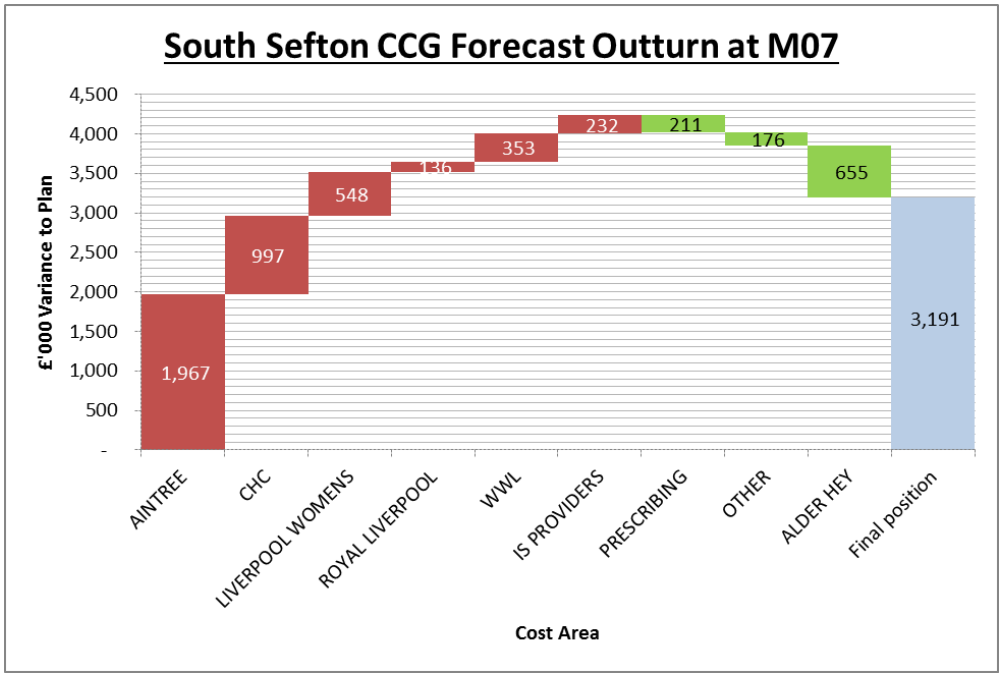
Report Section	Key Performance Indicator		This Month	Prior Month
1	Business Rule (Forecast Outturn)	1% Surplus	✓	✓
		0.5% Contingency Reserve	✓	✓
		2.5% Non-Recurrent Headroom	✓	✓
3	Surplus	Financial Surplus / (Deficit) before the application of reserves - £'000	**-3,191**	**-3,365**
4	QIPP	Unmet QIPP to be identified > 0	**210**	**210**
5	Running Costs (Forecast Outturn)	CCG running costs < National 2014/15 target of £24.78 per head	**21.64**	**21.99**
6	BPPC	NHS - Value YTD > 95%	**99.1%**	**99.1%**
		NHS - Volume YTD > 95%	**91.9%**	**91.8%**
		Non NHS - Value YTD > 95%	**89.1%**	**88.1%**
		Non NHS - Volume YTD > 95%	**92.1%**	**91.4%**

2.2 Position to date

The main financial pressures that the CCG is experiencing are shown below in **Graph 1**. There are significant overspends in acute care, particularly at Aintree University Hospital and Liverpool Women's Hospital. There are also significant overspends in Continuing Healthcare. This is offset partly by significant underspends at Alder Hey NHS Trust, and a modest forecast underspend for prescribing.

Whilst the financial activity period relates to the end of October, the CCG has based its reported position on information received from Acute Trusts to the end of September 2014. Sections 3 to 5 looks at hospital based acute care, and this finance section will therefore focus more on Continuing Healthcare and other financial risks.

Graph 1



Continuing Health Care (Adult)

This area continues to be a major risk for the CCG, with year to date over-spends of £0.803m. The CCG has seen a significant increase in the number of patients being awarded continuing healthcare packages. The budget was increased by 4% from last year's expenditure levels, but the current data shows growth levels closer to 16%.

CSU data relating to individual packages of care is reconciled monthly with invoices received by the CCG. The CCG therefore has greater assurance in terms of year to date spend. CSU finance staff have also reviewed the forecasting tools in place, and additional assurances have been obtained regarding the accuracy of forecasts for existing CHC packages.

A full review of Continuing Healthcare (CHC) is underway, with a focus on receiving assurance in the following areas:

1) Process for approving new CHC cases, and ensuring that entry points are controlled appropriately, as well as reviewing existing packages for appropriateness.
2) Prices charged by providers are in line with the framework and expectations.
3) The data system captures costs in a timely fashion, and records are updated in a timely fashion to allow financial data to be reliable.

The CCG will continue to work with the CSU to investigate activity and costs in this area.

2.3 Evaluation of Risks and Opportunities

A number of risks have emerged. These are outlined below:

- Overspends on Acute cost per case contracts – The CCG has identified some pressures at a number of providers. This pressure has been calculated at £2.814m (2.3% of the relevant budget), and included in the forecast position.

- Continuing Healthcare Costs – The CCG has experienced significant pressures on the growth of CHC cases this year, which is close to 16% compared to a planned

increase in the budget of 4% compared to last years activity. An independent review of CHC cases has commenced by an external consultant and detailed findings from this piece of work will be fed back to the Finance and Resource Committee in due course.

- Continuing Healthcare restitution claims – clarity has been provided by NHS England in respect of CCG obligations for CHC restitution claims. The amount set aside in reserves at the beginning of the year will form a contribution to a national risk pool. Although the CCG will continue to make payments to recipients, this will be refunded in full from the national pool. However, there is a risk that the pool figure may change depending on payouts for CHC restitution claims nationally, and CCGs will be notified in December.

- Estates – Further clarity has now been provided by the organisation that administers the LIFT buildings. The CCG now has estimated charges for all premises, and this is reflected in the latest assessment of reserves. This is subject to on-going review and there is a risk that costs will vary from the latest estimates.

- Prescribing / Drugs costs – Five month's data has been received for this financial year, and the PPA forecast shows an under-spend in respect of prescribing costs. However, the PPA estimates are prone to significant movements throughout the year and Governing Body members are reminded that prescribing forecasts are volatile. In addition, all CCGs have been notified that the prices paid for Category M drugs will increase from 1 October. The CCG has estimated the impact of this increase, and this is reflected in the forecast.

Reserves are set aside as part of budget setting to reflect planned investments, known risks and an element for contingency. As part of the review of risks and mitigations, the finance team and budget holders reviewed the expected expenditure levels for each earmarked reserve. This is summarised in **table B** and shows that the CCG has sufficient reserves to manage the risks identified.

Table B: Reserves analysis

	£'000
Forecast Overspend	3,191
Available reserves	(3,191)
Surplus Reserves	0

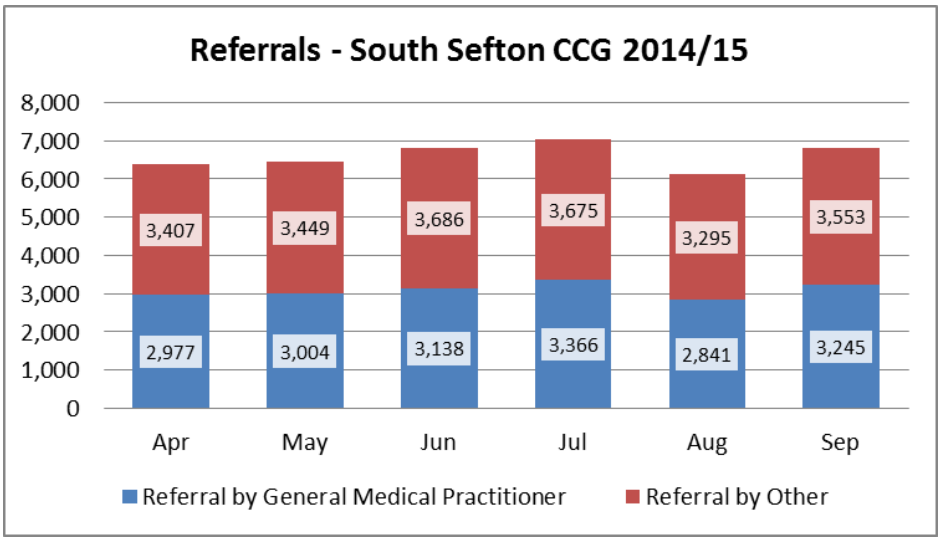
The CCG remains on course to achieve its planned surplus.

3. Referrals

The following section provides an overview of referrals to secondary care to September 2014.

3.1 Referrals by source

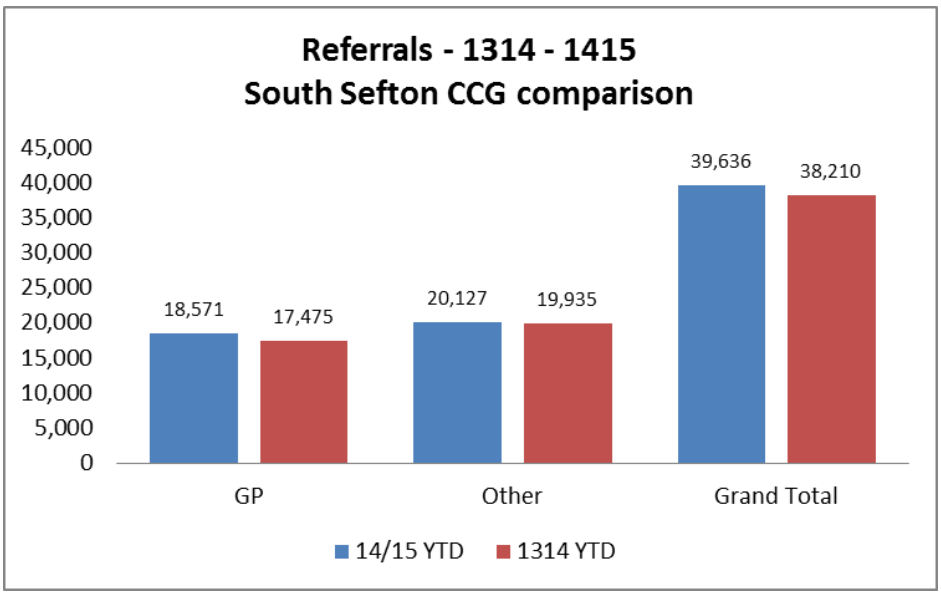
Chart A The number of GP and 'other' referrals for the CCG across all providers for 2014/15.



Below is a data table to show the split of GP and "Other" referrals in 2014/15, including a comparison of YTD in 2013/14. A rise in AHP referrals to paediatric specialties is being investigated. GP referral rates will be monitored at locality and practice level in the new primary care dashboard.

Referral Type	Data Dictionary Code	Description	Apr	May	Jun	Jul	Aug	Sep	14/15 YTD	1314 YTD	YTD Variance
GP	03	GP Ref	2,977	3,004	3,138	3,366	2,841	3,245	18,571	17,475	1,096
GP Total			2,977	3,004	3,138	3,366	2,841	3,245	18,571	17,475	1,096
Other	01	following an emergency admission	183	178	155	199	159	176	1,050	1,066	-16
	02	following a Domiciliary Consultation			2	2	2	1	7	13	-6
	92	A GENERAL DENTAL PRACTITIONER	208	184	210	174	171	147	1,094	1,157	-63
	04	An Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)	239	311	285	273	245	263	1,616	1,899	-283
	05	A CONSULTANT, other than in an Accident and Emergency Department	1,226	1,242	1,297	1,279	1,181	1,308	7,533	7,245	288
	06	self-referral	192	244	293	265	247	271	1,512	1,499	13
	07	A Prosthetist		3		1	2	1	7	17	-10
	10	following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)	255	260	260	279	214	245	1,513	1,220	293
	11	other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	195	208	220	248	215	318	1,404	1,122	282
	12	A General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)	4	2	1	3	10	3	23	30	-7
	13	A Specialist NURSE (Secondary Care)	8	9	3	6	6	6	38	56	-18
	14	An Allied Health Professional	128	95	88	102	86	84	583	438	145
	15	An OPTOMETRIST	8	3	17	5	9	11	53	42	11
	16	An Orthoptist							0	0	0
	17	A National Screening Programme	3	4	1	11	2	6	27	42	-15
	92	A GENERAL DENTAL PRACTITIONER	208	184	210	174	171	147	1,094	1,157	-63
	93	A Community Dental Service	4	1	3	3	2	3	16	15	1
	97	other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode	404	386	472	480	419	396	2,557	2,917	-360
Other Total			3,265	3,314	3,517	3,504	3,141	3,386	20,127	19,935	192
Unknow n			142	135	169	171	154	167	938	800	138
Grand Total			**6,384**	**6,453**	**6,824**	**7,041**	**6,136**	**6,798**	**39,636**	**38,210**	**1,426**

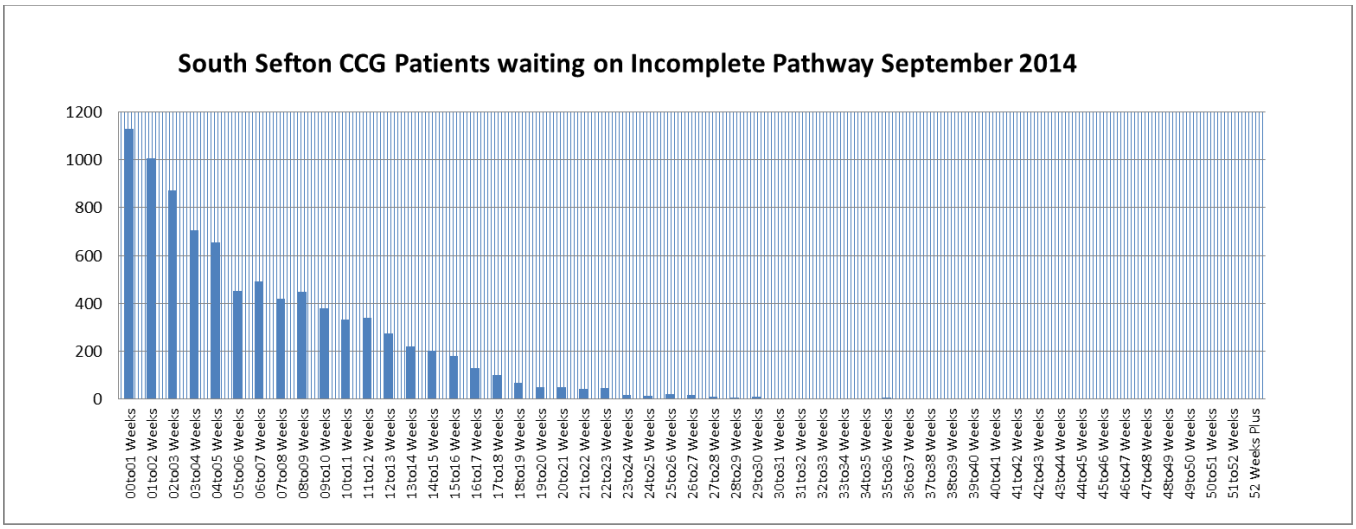
Chart B The number of GP and 'other' referrals for the CCG across all providers comparing 2013/14 and 2014/15 by month.



4. Waiting Times

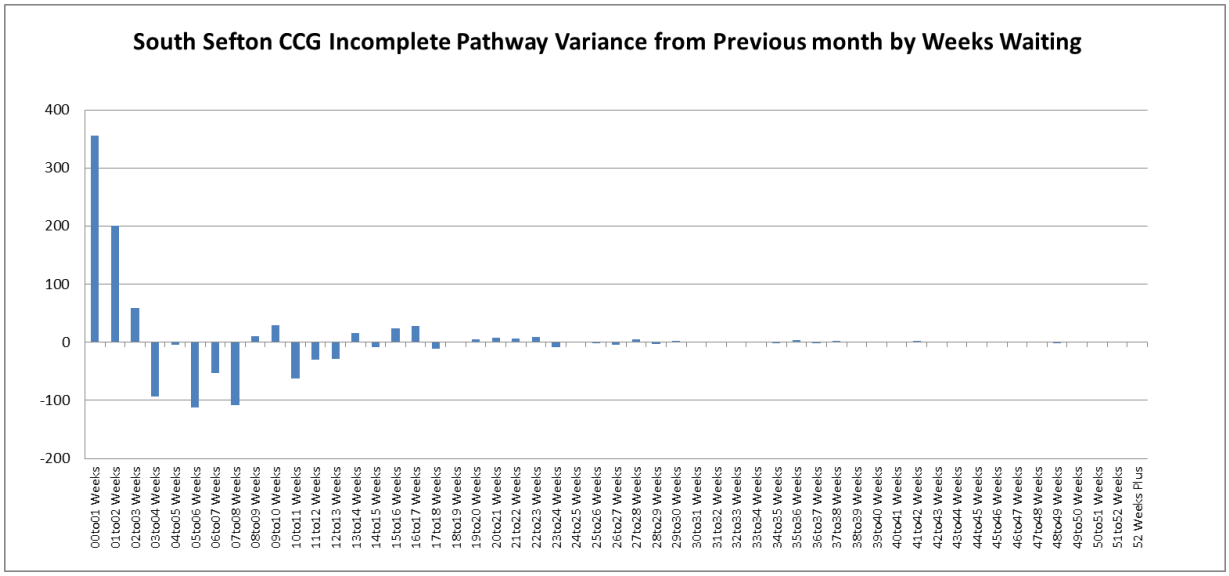
4.1 NHS South Sefton CCG patients waiting

Chart C Patients waiting on an incomplete pathway at the end of September 2014 by weeks waiting



There were 396 patients (4.5%) waiting over 18 weeks on Incomplete Pathways at the end of September 2014. There are no over 52 week waiters.

Chart E Variance of patients waiting on an incomplete pathway at the end of September 2014 compared to August 2014 by weeks waiting.



There were 8,730 patients on the Incomplete Pathway at the end of Sept 2014 an increase of 241 patients (2.8%). Over 18 Week Waiters increased by 31 (8.5%)

4.2 Top 5 Providers

Table A – Patients waiting (in bands) on incomplete pathway for the top 5 Providers.

Trust	0to10 wks	10to18 wks	18to24 wks	24to30 wks	30+ wks	Total
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (REM)	4263	1097	144	32	3	5539
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST (RQ6)	635	174	47	18	6	880
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST (RVY)	520	104	23	5	0	652
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST (REP)	343	191	25	15	4	578
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST (RBS)	269	92	28	12	18	419

4.3 52+ Week Waiters

52 Week Monthly Trend		April	May	June	July	August	September	October	November	December	January	February	March
South Sefton CCG	Complete Admitted (un-adjusted)	0	0	0	1	0	0						
	Complete Non-Admitted	0	0	1	1	0	0						
	Incomplete	0	2	2	0	0	0						
Aintree Trust	Complete Admitted (un-adjusted)	0	0	0	0	0							
	Complete Non-Admitted	0	0	0	0	0							
	Incomplete	0	0	0	0	0							

Please note commissioner level data is published one month ahead of provider level data

5. Planned Care

Performance at month 6, against the planned care elements of the contracts for NHS South Sefton CCG, shows an over-performance of £292k (1.2%). This is mainly driven by the over performance at Aintree University Hospitals NHS Foundation Trust (£367k), and Liverpool Women's NHS Foundation Trust (£147k). These over-performances are offset by under-performances at other Trusts in particular Alder Hey and Royal Liverpool & Broadgreen Hospitals who are showing a combined under spend of -£435k.

5.1 All Providers

Table B All Providers

Provider Name	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	143,289	71,382	72,450	1,068	1.50%	£27,897	£13,894	£14,261	£367	2.64%
Alder Hey Childrens NHS F/T	15,954	7,839	5,842	-1,997	-25.48%	£2,515	£1,265	£992	-£273	-21.58%
Countess of Chester Hospital NHS Foundation Trust	0	0	72	72	0.00%	£0	£0	£12	£12	0.00%
East Cheshire NHS Trust	0	0	2	2	0.00%	£0	£0	£0	£0	0.00%
Liverpool Heart and Chest NHS F/T	964	479	597	118	24.72%	£480	£234	£274	£40	17.14%
Liverpool Womens Hospital NHS F/T	13,833	6,723	7,148	425	6.32%	£3,127	£1,520	£1,666	£147	9.66%
Royal Liverpool & Broadgreen Hospitals	28,270	14,079	13,728	-351	-2.49%	£5,653	£2,815	£2,653	-£162	-5.77%
Southport & Ormskirk Hospital	12,412	6,157	6,849	692	11.23%	£2,614	£1,300	£1,395	£95	7.28%
ST Helens & Knowsley Hospitals	3,564	1,737	1,843	106	6.08%	£965	£474	£500	£27	5.61%
Wirral University Hospital NHS F/T	430	213	203	-10	-4.81%	£120	£60	£60	£0	0.37%
Central Manchester University Hospitals NHS F/T	80	40	59	19	47.50%	£21	£10	£15	£5	48.06%
Fairfield Hospital	137	68	40	-28	-41.61%	£43	£21	£8	-£14	-62.84%
ISIGHT (SOUTHPORT)	361	180	102	-78	-43.49%	£92	£46	£25	-£21	-46.39%
Renacres Hospital	3,042	1,521	2,018	497	32.65%	£1,182	£591	£494	-£97	-16.33%
SPIRE LIVERPOOL HOSPITAL	2,761	1,380	1,429	49	3.51%	£770	£385	£434	£49	12.65%
University Hospital Of South Manchester NHS F/T	102	51	31	-20	-39.62%	£16	£8	£7	-£1	-14.01%
Wrightington, Wigan And Leigh Nhs Foundation Trust	760	380	610	230	60.53%	£294	£147	£265	£118	80.65%
Grand Total	**225,959**	**112,231**	**113,023**	**792**	**0.71%**	**£45,789**	**£22,770**	**£23,062**	**£292**	**1.28%**

5.2 Aintree University Hospitals NHS Foundation Trust

Table C: Month 5 Planned Care - Aintree University Hospitals NHS Foundation Trust by POD

Aintree University Hospitals Planned Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Daycase	11,670	5,812	5,942	130	2.24%	£7,758	£3,864	£3,993	£129	3.35%
Elective	2,139	1,065	1,115	50	4.67%	£5,823	£2,900	£3,036	£136	4.69%
Elective Excess BedDays	1,138	567	628	61	10.81%	£257	£128	£147	£19	14.78%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	480	239	331	92	38.46%	£84	£42	£56	£14	33.25%
OPFANFTF - *Outpatient first attendance non face to face*	524	261	311	50	19.17%	£22	£11	£13	£2	22.63%
OPFASPCL - *Outpatient first attendance single professional consultant led*	29,030	14,462	14,116	-346	-2.39%	£4,416	£2,200	£2,141	-£59	-2.67%
OPFUPMPCL - *Outpatient Follow Up Multi-Professional Outpatient Follow. Up (Consultant Led).*	1,606	800	759	-41	-5.10%	£178	£89	£82	-£6	-6.95%
OPFUPNFTF - *Outpatient follow up non face to face*	1,416	705	611	-94	-13.36%	£32	£16	£15	-£1	-8.63%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	78,682	39,201	38,997	-204	-0.52%	£6,261	£3,119	£2,996	-£123	-3.94%
Outpatient Procedure	16,604	8,269	9,640	1,371	16.58%	£3,065	£1,526	£1,782	£255	16.71%
Grand Total	**143,289**	**71,382**	**72,450**	**1,068**	**1.50%**	**£27,897**	**£13,894**	**£14,261**	**£367**	**2.64%**

5.2.1 Aintree University Hospitals NHS Foundation Trust Key Issues

Planned care month 6 overspend, for contracted activity at South Sefton CCG, is showing a £367k over performance. This is mainly focused on Daycases, Elective and Outpatient Procedures. Daycase and Outpatient Procedures over performance is mirrored at all other CCGs but Elective is largely under performing at other CCGs. Elective over performance has increased from £44k (2%) at month 5 to £136k (5%) at month 6. Top 5 over-performing specialties for outpatient procedures are Diagnostic Imaging, Urology, ENT, cardiology and Breast surgery. The Aintree Information Subgroup is carrying out further analysis of these procedures.

5.3 Liverpool Women's NHS Foundation Trust

Table D: Month 5 Planned Care – Liverpool Womens Aintree University Hospitals NHS Foundation Trust by POD

Lpool Womens Hospital Planned Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
all other outpatients	52	25	28	3	10.79%	£218	£106	£115	£10	9.13%
Daycase	1,105	537	483	-54	-10.06%	£643	£312	£313	£1	0.28%
Elective	327	159	238	79	49.76%	£717	£348	£410	£62	17.75%
Elective Excess BedDays	31	15	5	-10	-66.81%	£6	£3	£1	-£2	-59.05%
One Stop Clinics	481	234	276	42	18.07%	£141	£69	£80	£12	16.73%
OPFANFTF - *Outpatient first attendance non face to face*	0	0	2	2	0.00%	£0	£0	£0	£0	0.00%
OPFASPCL - *Outpatient first attendance single professional consultant led*	2,265	1,101	1,198	97	8.83%	£306	£149	£160	£11	7.72%
OPFUPNFTF - *Outpatient follow up non face to face*	304	148	200	52	35.37%	£7	£3	£5	£1	35.36%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	6,035	2,933	2,966	33	1.12%	£506	£246	£249	£3	1.26%
Outpatient Procedure	3,229	1,569	1,752	183	11.64%	£582	£283	£332	£49	17.40%
Ward Attenders	4	2	0	-2	-100.00%	£0	£0	£0	£0	-100.00%
Grand Total	**13,833**	**6,723**	**7,148**	**425**	**6.32%**	**£3,127**	**£1,520**	**£1,666**	**£147**	**9.66%**

5.3.1 Liverpool Women's Hospital NHS Foundation Trust Key Issues

AQN and responses from LWH discussed in detail at Contract Review meeting on 2nd October. CSU working closely with LCCG as issues in the AQN affect co-commissioners and in particular South Sefton and Knowsley. More details requested on breakdown of Gynaecology outpatient procedures including referrals. Significant case mix shift was noted with LWH now recording higher levels of intermediate and intensive cases on the maternity pathway with levels more than the national average. LCCG has now commissioned Capita to review recording and coding for the two key areas of over performance. This will begin late November. Gynaecology Activity Sub Group to be established to look at overall activity in Gynaecology including outpatient procedures

5.4 Wrightington, Wigan & Leigh NHS Foundation Trust

Table E: Month 5 Planned Care – Wrightington, Wigan & Leigh Hospitals NHS Foundation Trust by POD

Wrightington, Wigan And Leigh Nhs Foundation Trust Planned Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
all other outpatients	4	2	3	1	50.00%	£0	£0	£0	£0	66.61%
Daycase	56	28	34	6	21.43%	£68	£34	£65	£31	90.16%
Elective	28	14	30	16	114.29%	£167	£83	£154	£70	84.21%
Elective Excess BedDays	0	0	2	2	0.00%	£0	£0	£0	£0	0.00%
OPFAMPCL - *OP 1st Attendance Multi-Professional Outpatient First. Attendance (Consultant Led)*	6	3	17	14	466.67%	£0	£0	£2	£1	837.01%
OPFASPCL - *Outpatient first attendance single professional consultant led*	98	49	70	21	42.86%	£11	£6	£7	£1	22.32%
OPFUPMPCL - *OP follow up Multi-Professional Outpatient First. Attendance (Consultant Led)*	42	21	30	9	42.86%	£3	£1	£2	£1	60.76%
OPFUPNFTF - *Outpatient follow up non face to face*	26	13	21	8	61.54%	£1	£0	£0	£0	59.80%
OPFUPSPCL - *Outpatient follow up single professional consultant led*	436	218	350	132	60.55%	£31	£16	£25	£9	57.36%
Outpatient Procedure	64	32	53	21	65.63%	£11	£6	£9	£4	68.06%
Grand Total	**760**	**380**	**610**	**230**	**60.53%**	**£294**	**£147**	**£265**	**£118**	**80.65%**

5.4.1 Wrightington, Wigan & Leigh NHS Foundation Trust Key Issues

Daycase and Elective Inpatients make up 85% of the £118 total overspend in Planned Care. In terms of % variance, Planned Care is reporting a month 6 cost variance of 81% over performance.

The over performance in both Daycase and Elective is attributable to Trauma & Orthopaedics. Within T&O, there is an allocation of activity and finance against HRGs with no 14/15 plan as well as casemix. CSU will investigate further upon the commissioner's request.

6. Unplanned Care

Performance at month 6, against the unplanned care elements of the contracts for NHS South Sefton CCG, shows an over-performance of £669K (3.5%). This is mainly driven by the over performance at Aintree University Hospitals NHS Foundation Trust (£494k), and Royal Liverpool & Broadgreen Hospitals (£138k). No significant unplanned care increases evident at other trusts..

6.1 All Providers

Table F : Month 5 Unplanned Care - All Providers

Provider Name	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
Aintree University Hospitals NHS F/T	50,407	25,273	25,231	-42	-0.16%	£28,075	£14,076	£14,570	£494	3.51%
Alder Hey Childrens NHS F/T	9,195	4,455	4,240	-215	-4.83%	£2,070	£1,005	£947	-£58	-5.77%
Countess of Chester Hospital NHS Foundation Trust	0	0	38	38	0.00%	£0	£0	£11	£11	0.00%
East Cheshire NHS Trust	0	0	7	7	0.00%	£0	£0	£1	£1	0.00%
Liverpool Heart and Chest NHS F/T	108	52	33	-19	-37.12%	£158	£77	£53	-£23	-30.64%
Liverpool Womens Hospital NHS F/T	3,416	1,711	1,770	59	3.42%	£2,786	£1,396	£1,451	£55	3.95%
Royal Liverpool & Broadgreen Hospitals	5,641	2,828	2,998	170	6.00%	£1,982	£994	£1,132	£138	13.94%
Southport & Ormskirk Hospital	6,705	3,341	3,708	367	10.98%	£2,634	£1,310	£1,350	£40	3.07%
ST Helens & Knowsley Hospitals	978	495	440	-55	-11.07%	£388	£197	£201	£4	2.18%
Wirral University Hospital NHS F/T	245	122	159	37	29.82%	£90	£44	£46	£2	4.51%
Central Manchester University Hospitals Nhs Foundation Trust	67	33	32	-1	-4.48%	£16	£8	£5	-£3	-40.17%
University Hospital Of South Manchester Nhs Foundation Trust	41	21	19	-2	-7.95%	£14	£7	£3	-£4	-61.51%
Wrightington, Wigan And Leigh Nhs Foundation Trust	42	21	50	29	138.10%	£15	£8	£19	£11	147.97%
Grand Total	**76,845**	**38,353**	**38,725**	**372**	**0.97%**	**£38,228**	**£19,120**	**£19,789**	**£669**	**3.50%**

6.2 Aintree University Hospitals NHS Foundation Trust

Table G: Month 5 Unplanned Care - Aintree University Hospitals NHS Foundation Trust by POD

Aintree University Hospitals Urgent Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A&E - *Accident & Emergency*	30,748	15,416	15,550	134	0.87%	£3,294	£1,652	£1,692	£41	2.46%
NEL - *Non Elective*	10,592	5,311	5,530	219	4.13%	£22,135	£11,098	£11,545	£448	4.03%
NELNE - *Non Elective Non-Emergency*	40	20	27	7	34.63%	£117	£59	£72	£14	23.43%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	34	17	140	123	721.28%	£8	£4	£33	£29	738.78%
NELST - *Non Elective Short Stay*	1,270	637	720	83	13.08%	£833	£418	£506	£89	21.24%
NELXBD - *Non Elective Excess Bed Day*	7,723	3,872	3,264	-608	-15.70%	£1,689	£847	£721	-£125	-14.79%
Grand Total	**50,407**	**25,273**	**25,231**	**-42**	**-0.16%**	**£28,075**	**£14,076**	**£14,570**	**£494**	**3.51%**

6.2.1 Aintree University Hospitals NHS Foundation Trust Key Issues

A&E attendances this month are slightly up compared to month 5 with the significant increases against non-elective admissions. Year to date attendances at A&E are showing an increase but CDU has shown a marked decrease in month 6.

NHS South Sefton CCG, supported by CSU, has been leading a piece of work to identify the factors that are driving the significant non-elective increases seen in 2014/15 year to date. Since this work commenced, Commissioners have been informally advised by the provider of changes being made to Aintree's non-elective pathways including the Clinical Decision Unit which may be having, or may have, an impact on non-elective admission numbers in 2014/15. The impact of these changes will be fed into the analyses being undertaken. Before formally agreeing to the pathway changes that Aintree have been are implementing since end of September, SSCCG are issuing an Activity Query Notice to Aintree, supported by Aintree's Collaborative Commissioning Forum, in an attempt to substantiate the reasons for the over-performance in the first half of the year. As a condition of the Activity Query Notice the provider is required to meet with the commissioner within ten working days of receipt. This has been scheduled for 27/11/2014.

6.3 The Royal Liverpool and Broadgreen University Hospitals Trust

Table H: Month 5 Unplanned Care - The Royal Liverpool and Broadgreen University Hospitals Trust by POD

The Royal Liverpool Hoispital Urgent Care PODS	Annual Activity Plan	Plan to Date Activity	Actual to date Activity	Variance to date Activity	Activity YTD % Var	Annual Plan Price (£000s)	Price Plan to Date (£000s)	Price Actual to Date (£000s)	Price variance to date (£000s)	Price YTD % Var
A&E - *Accident & Emergency*	4,403	2,208	2,250	42	1.92%	£368	£184	£191	£6	3.49%
AMAU - *Acute Medical unit*	52	26	30	4	15.07%	£5	£3	£3	£0	15.06%
NEL - *Non Elective*	648	325	412	87	26.81%	£1,338	£671	£780	£109	16.22%
NELNE - *Non Elective Non-Emergency*	24	12	13	1	8.04%	£126	£63	£78	£15	24.04%
NELNEXBD - *Non Elective Non-Emergency Excess Bed Day*	102	51	104	53	103.36%	£23	£11	£23	£12	103.35%
NELST - *Non Elective Short Stay*	102	51	66	15	29.06%	£66	£33	£35	£2	7.05%
NELXBD - *Non Elective Excess Bed Day*	310	155	123	-32	-20.86%	£70	£35	£29	-£6	-18.28%
readmissions	0	0	0	0	0.00%	-£13	-£7	-£7	£0	0.00%
Grand Total	**5,641**	**2,828**	**2,998**	**170**	**6.00%**	**£1,982**	**£994**	**£1,132**	**£138**	**13.94%**

6.3.1 The Royal Liverpool and Broadgreen University Hospitals Trust Key Issues

Urgent Care remains an issue within the Trust and non-elective admissions make up almost 90% of the total over-performance, with some notable over-performance also seen in non-elective excess bed-days. CSU analysis indicates that an increase in the volume of admission is responsible for the trust position.

By specialty, activity under the Accident & Emergency, General Medicine and Vascular Surgery make up the bulk of the over-performance in Urgent Care.

LCCG issued a formal Activity Query Notice to the Provider requesting explanations of the unexpected patterns of activity with 2014/15, specifically

- Emergency short stay – Accident and emergency and cardiology
- Non Elective admissions – accident and emergency, general medicine and vascular surgery
- No elective excess bed days - accident and emergency, general medicine and general surgery.

The Trust has previously stated that over performance in urgent care was as a result of the higher level of acuity of patients and increase in demand. The purpose of this information query is to undertake further analysis to substantiate the reasons for over performance.

7. Mental Health

7.1 Mersey Care NHS Trust Contract

Table I NHS South Sefton CCG – Shadow PbR Cluster Activity

	NHS South Sefton CCG			
PBR Cluster	2014/15 Plan	Caseload (Sep-2014)	Variance from Plan	% Variance
0 Variance	34	28	(6)	-18%
1 Common Mental Health Problems (Low Severity)	23	28	5	22%
2 Common Mental Health Problems (Low Severity with greater need)	48	36	(12)	-25%
3 Non-Psychotic (Moderate Severity)	274	231	(43)	-16%
4 Non-Psychotic (Severe)	169	230	61	36%
5 Non-psychotic Disorders (Very Severe)	32	49	17	53%
6 Non-Psychotic Disorder of Over-Valued Ideas	43	53	10	23%
7 Enduring Non-Psychotic Disorders (High Disability)	133	175	42	32%
8 Non-Psychotic Chaotic and Challenging Disorders	83	83	-	0%
10 First Episode Psychosis	93	105	12	13%
11 On-going Recurrent Psychosis (Low Symptoms)	414	419	5	1%
12 On-going or Recurrent Psychosis (High Disability)	312	325	13	4%
13 On-going or Recurrent Psychosis (High Symptom & Disability)	112	101	(11)	-10%
14 Psychotic Crisis	17	19	2	12%
15 Severe Psychotic Depression	7	6	(1)	-14%
16 Psychosis & Affective Disorder (High Substance Misuse & Engagement)	33	34	1	3%
17 Psychosis and Affective Disorder – Difficult to Engage	58	58	-	0%
18 Cognitive Impairment (Low Need)	347	245	(102)	-29%
19 Cognitive Impairment or Dementia Complicated (Moderate Need)	462	648	186	40%
20 Cognitive Impairment or Dementia Complicated (High Need)	148	183	35	24%
21 Cognitive Impairment or Dementia (High Physical or Engagement)	45	46	1	2%
Reviewed Not Clustered	36	69	33	92%
No Cluster or Review	144	206	62	43%
Total	3,067	3,377	310	10%

7.1.1 Key Performance Indicators - CPA follow up

Table J - CPA - Percentage of People under followed up within 7 days of discharge

			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
CB_B19	The % of people under adult mental illness specialities who were followed up within 7 days of discharge from psychiatric inpatient care	95%	100.00%	100.00%	100.00%	87.50%	93.75%	100.00%

The above table shows current NHS South Sefton CCG performance achieving 100% against the 95% target.

The Trust reports this KPI on a monthly basis but the consequence of the breach is based on the quarterly response. At Quarter 2 the Trust reported 95.9%

Table K – CPA Follow up 2 days (48 hrs) for higher risk groups

			Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
MH_KPI.40	CPA Follow up 2 days (48 hours) for higher risk groups are defined as individuals requiring follow up within 2 days (48 hours) by CRHT, Early Intervention, Assertive Outreach or Homeless Outreach Teams.	95.0%	50.0%	100.0%	100.0%	100.00%	100.00%	100.00%

The above table shows current NHS South Sefton CCG performance achieving 100% against the 95% target.

7.2 Inclusion Matters Sefton

Since IAPT was established in 2008 there has been a national target for IAPT services to achieve a penetration prevalence of 15% by Q4 2014/15 against local prevalence figures which is based on people entering psychological therapies.

The National Target is based on the Adult Psychiatric Morbidity Survey (2000) data which was applied to all areas to determine the prevalence figure for people who have depression and or anxiety disorders. For Sefton this figure was identified as 43,377 people which broken down by CCG equates to:

Southport & Formby: 19,079
South Sefton: 24,298

Since establishment in 2009 Inclusion Matters Sefton (IMS) have been reporting good progress with the a year end figure of 13% across both CCGs being reported at the end of March 2014 and consequently for NHS England and Quality Premium purposes , both CCGs believed that the current trajectory would enable a 15% prevalence target to be achieved. In August 2014 on scrutiny of the activity it became apparent that IMS were not applying the nationally mandated definition for measuring this KPI and based on applying the correct definition the following outturn was forecast for each area:

Southport & Formby: 9.9%
South Sefton: 10.8%

The Provider was required to produce a remedial action plan detailing a range of activities to ensure the 15% prevalence target is achieved by the end of Quarter 4 and since week commencing 29th September 2014 IMS have been providing a weekly update on the numbers of people entering psychological therapies which is being closely monitored by commissioners and the position is forecasted to improve. At Month 6 the forecast is;

Southport & Formby: 9.53%
South Sefton: 11.13%

A further update will be provided in the November report.

Table L- PHQ13_6 Proportion of people who complete treatment who are moving to recovery

South Sefton	Apr	May	Jun	Q1	Jul	Aug	Sep	Q2	Total	FOT
Entered (KPI4)	176	257	237	670	231	188	263	682	1352	2704
Entered (KPI4) HSCIC	175	190	210	575					575	2300
Completed (KPI5)	163	184	140	487	208	152	219	579	1066	2132
Completed (KPI5) HSCIC	150	175	125	450					450	1800
Moved to recovery (KPI6)	59	87	51	197	95	64	92	251	448	896
Moved to recovery (KPI6) HSCIC	55	80	45	180					180	720
Entered Below Caseness (KPI6b)	14	8	7	29	11	9	13	33	62	124
Entered Below Caseness (KPI6b) HSCIC	10	10	5	25					25	100
Prevalence	0.72%	1.06%	0.98%	2.76%	0.95%	0.77%	1.08%	2.81%	5.56%	11.13%
Recovery	39.6%	49.4%	38.3%	43.0%	48.2%	44.8%	44.7%	46.0%	44.6%	44.6%
Prevalence HSCIC	0.72%	0.78%	0.86%	2.37%					2.37%	9.47%
Recovery HSCIC	39.3%	48.5%	37.5%	42.4%					42.4%	42.4%

The above table includes the figures submitted by the Provider and the figures published by the HSCIC. The Provider has highlighted an issue with the way in which the HSCIC are calculating the IAPT data submitted to them. The HSCIC is showing that Quarter 1 KPI's as lower than what the Provider is reporting. A formal query has been raised by the Provider with HSCIC as to why this is happening and how this can be resolved.

8. Liverpool Community Health NHS Trust Performance

8.1 Key Issues

- Impact of Virtual Ward and Urgent Care Pilots on the following services; District nursing, Community Matrons, Ward 35 admissions
- Operational Issues for a number of services; District Nursing, Treatment Rooms
- Interface with Acute Provider, Aintree University Hospital, increased referrals; Rehab at Home, Respiratory Service, IV Therapy
- Service Pressure - Community Equipment
- Waiting Times - The Trust has reported significant waiting times for Paediatric Occupational Therapy and Speech and Language Therapy at Month 6.
- CQC Action Plan - The Care Quality Commission's (CQC) has published its report on Liverpool Community Health NHS Trust (LCH) following their inspection of services in May 2014.This inspection followed the publication in January of the CQC reports into Intermediate Care Service (Ward 35), Community Equipment Service and District Nursing, which resulted in warning notices being issued. The CQC has lifted these warning notices following their latest inspection and has given an overall rating for LCH as 'Requires Improvement'. The Trust has published its full Improvement Plan which outlines the progress the organisation has already made, and the new strategic priorities that have been agreed to help transform community services LCH's Medical Director provided a verbal update at the CRM/CQPG on 9h October 2014 and advised that the Trust has developed an Action Plan which has been submitted to the CQC. In addition the Trust has developed an Action Plan following a recent Single Item QSG (Quality Surveillance Group) Meeting with NHS England, this will be monitored at the monthly Commissioning Forum Meetings with CCGs and will feed into the Trust's overarching Improvement Plan, this was discussed at the Collaborative Forum on 2nd October 2014.
- Quality Compliance & Key Performance Indicators - A number of Quality Compliance & Key Performance Indicators are non-compliant and under performing at Month 6.

- Delayed Transfers of Care indicator is perfomring well and additional intermediate care beds have been commissioned as part of resilience monies with a focus on step up as opposed to step down.
- The CCG Quality team are having conversations with LCH and the CSU regarding entry points and assessments for CHC patients.

The above issues are being addressed at Contract and Clinical Quality and Performance Group and the Finance and Information subgroup meetings.

9. Third Sector Contracts

- NHS Contracts 2014/15 with Third Sector Providers have been signed by all Parties and signed versions of the Contracts issued. The contracts are block therefore there is limited financial risk to the CCG.
- Contract Management meetings have taken place with Providers and actions resulting from these meetings are being progressed.

10.0 Quality and Performance

10.1 NHS South Sefton CCG Performance Dashboard

		Current Period				
Performance Indicators	**Data Period**	**Target**	**Actual**	**Direction of Travel**	**Exception Commentary**	**Actions**
IPM						
Treating and caring for people in a safe environment and protecting them from avoidable harm						
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(CCG)**	14/15 - September	30	34 (29 following local appeals)	↑	8 new cases reported in September 2014. A total of 34 cases reported YTD compared to a plan of 30 cases. All cases reported in September were aligned to Aintree Hospital (4 apportioned to acute trust and 4 apportioned to community trusts). Of the 34 cases reported YTD 32 cases have been reported by Aintree Hospital (13 apportioned to community and 19 apportioned to community), 1 case reported by St Helens and Knowsley Hospital (apportioned to acute) and 1 case reported by Southport and Ormskirk Hospital (apportioned to community).	Aintree University Hospital submitted their C.Dif Action Pan at the October CQPG meeting and provided an update at the November meeting. The CCG continues to consider appeals at the montly appeals meetings, the next meeting is scheduled to be held in December. Aintree University Hospital achived their C.Dif trajectory in September.Out of the 11 local appeals submitted by Aintree, all 11 were upheld, 5 were South Sefton CCG, 5 Liverpool CCG and 1 Bury CCG. Following appeals, the revised local C-dif cases for the CCG will be 29. *Please Note - Data has been taken from the National HCAI Database - this is updated centrally therefore not all local appeals will be reflected in the table.*
Incidence of healthcare associated infection (HCAI) C.difficile (Cumulative) **(Aintree)**	14/15 - September	41	35 (24 follwing local appeals)	↓	6 new cases have been reported in September brining the year to date value to 35. Aintree remain below plan for the year.	Following the local appeals process - Aintree submitted 11 appeals and all 11 were upheld, 5 South Sefton CCG, 5 Liverpool CCG and 1 Bury CCG, following appeals, the revised local C-dif cases for Aintree will be 24.
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(CCG)**	14/15 - September	0	2	↔	No new cases have been reported in September but the CCG remains red and will do for the remainder of the year due to the zero tolerance plan. The previous cases where reported against Aintree with one in May (Acute) and the other in July (Community)	Aintree Hospital reported a case in May 14, however following review by NHS England this case was found to be community aquired and attributed to South Sefton CCG. A second South Sefton case was initially reported by Aintree in July following a recent PIR (post infection review) NHS England attributed this case to Aintree Hospital. At the CQPG on the 8th October the Trust informed commissioners they had requested details of the decission making process from regional office and the reasons for assigning case to the Trust. At the November CQPG, the Trust confirmed that they are still awaiting feedback from NHS England. Please Note - *Data has been taken from the National HCAI Database - this is updated centrally therefore not all local appeals will be reflected in the table.*
Incidence of healthcare associated infection (HCAI) MRSA (Cumulative) **(Aintree)**	14/15 - September	0	1	↔	Conflicting data from HCAI database, which states 1 case reported in May 2014. Unify2 data reports 0 cases in May but 1 case in July 2014.	The CCG has queried the Nationally reported figures for Aintree as the HCAI data base and Unify 2 state conflicting figures. As mentioned above the May 14 case has been attributed to Community / South Sefton CCG so should therefore be removed from Aintree Hospital. Following the findings of the recent NHS Engllland PIR - Aintree will have 1 MRSA case attributed to them in July or August 14.*Please Note - Data has been taken from the National HCAI Database - this is updated centrally therefore not all local appeals will be reflected in the table.*

Enhancing quality of life for people with long term conditions						
Patient experience of primary care i) GP Services	Jul-Sept 13 and Jan-Mar 14		6.56%	New Measure	Percentage of respondents reporting poor patient experience of primary care in GP Services	
Patient experience of primary care ii) GP Out of Hours services	Jul-Sept 13 and Jan-Mar 14		9.52%	New Measure	Percentage of respondents reporting poor patient experience of GP Out of Hours Services	
Patient experience of primary care i) GP Services ii) GP Out of Hours services (Combined)	Jul-Sept 13 and Jan-Mar 14	6%	6.92%	New Measure	The CCG reported a percentage of negative responses above the 6% threshold.	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s(Cumulative)	14/15 - September	102.29	130.19	New Plans	This measure now has a plan which is based on the same period previous year. The increase in actual admissions is 9 above the same period last year.	Patient level data is being shared with practices to analyse inappropriate admissions and possible actions to adderess
Unplanned hospitalisation for chronic ambulatory care sensitive conditions(Cumulative)	14/15 - September	432.24	489.57	New Plans	This measure now has a plan which is based on the same period previous year. The increase in actual admissions is 89 above the same period last year.	Patient level data is being shared with practices to analyse inappropriate admissions and possible actions to adderess
Emergency Admissions Composite Indicator(Cumulative)	14/15 - September	1062.30	1,111.20	New Plans	This measure now includes a monthly plan, this is based on the plan set within the Outcome Measure framework and has been split using last years seasonal Performance. The number of admissions have increase by 228 from the same period last year.	Patient level data is being shared with practices to analyse inappropriate admissions and possible actions to adderess
IAPT - Prevalence	14/15 - September	15%	5.56%		Annual Plan, monthly plan = 1.25%. The CCG is not on target to achieve 15% by the end of the year. To achieve the access rate for the first 6 months (7.5%) the CCG required a further 470 patients accessing the service.	Identified issue with provider not applying nationally mandated definition of KPI. Action plan in place to ensure target met by end Q4 2014/15
IAPT - Recovery Rate	14/15 - September	50%	44.62%		The CCG marginally missed out on the 50% target for the first 6 months of the year. The 50% target has not been achieved so far during 2014/15.	
Helping people to recover from episodes of ill health or following injury						
Patient reported outcomes measures for elective procedures: Groin hernia	2012/13	Eng Ave 0.085	0.068	Refreshed data	The CCG improved on the previous years rate but failed to achieve a score higher than that of the England average.	
Patient reported outcomes measures for elective procedures: Hip replacement	2012/13	Eng Ave 0.438	0.430	Refreshed data	The CCG improved on the previous years rate but failed to achieve a score higher than that of the England average.	
Patient reported outcomes measures for elective procedures: Knee replacement	2012/13	Eng Ave 0.318	0.343	Refreshed data	The CCG improved on both the previous years rate and achieved above the England average.	
Emergency readmissions within 30 days of discharge from hospital (Cumulative)	14/15 - September		15.50			
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)(Cumulative)	14/15 - September	55.8	62.00	New Plans	This measure now has a plan which is based on the same period previous year. The increase in actual admissions is 4 above the same period last year.	Children's and Respiratory programme leads meeting to address
Emergency admissions for acute conditions that should not usually require hospital admission(Cumulative)	14/15 - September	521.78	613.25	New Plans	This measure now has a plan which is based on the same period previous year. The increase in actual admissions is 142 above the same period last year.	Patient level data is being shared with practices to analyse inappropriate admissions and possible actions to adderess
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit **(CCG)**	14/15 - September	80%	83.33%	↓		
SQU06_01 - % who had a stroke & spend at least 90% of their time on a stroke unit **(Aintree)**	14/15 - September	80%	90.24%	↑		
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(CCG)**	14/15 - September	60%	80%	↓		
SQU06_02 - % high risk of Stroke who experience a TIA are assessed and treated within 24 hours **(Aintree)**	14/15 - September	60%	100%	↔		

Mental health						
Mental Health Measure - Care Programme Approach (CPA) - 95% (Cumulative) **(CCG)**	14/15 - Qtr1	95%	100.00%			
Preventing people from dying prematurely						
Under 75 mortality rate from cancer	2013		158.70			
Under 75 mortality rate from cardiovascular disease	2013		72.60			
Under 75 mortality rate from liver disease	2013		22.60			
Under 75 mortality rate from respiratory disease	2013		38.00			
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare (Person)	2013	2,029.00	2,592.30	↓	South Sefton achieved above the planned figure for the latest data and is also a decreased performance from 2012 which had a rate of 2029.8. For 2013 the rate for Males was 2669.2, a drop from the previous year (2179.2). Females also had a drop in performance with a rate of 2517.7 compared with 1875.7 in 2012.	The annual variation is significant and the CCG is working with Public Health locally and regionally to understand this. Indications at present are that the PYLL is significantly susceptible to fluctuations due to changes such as young deaths, which introduces major swings, particularly at CCG level.
Cancer waits – 2 week wait						
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(CCG)**	14/15 - August	93%	95.25%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93% (Cumulative) **(Aintree)**	14/15 - August	93%	97.40%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(CCG)**	14/15 - August	93%	95.81%	↔		
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93% (Cumulative) **(Aintree)**	14/15 - August	93%	95.65%	↔		
Cancer waits – 31 days						
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(CCG)**	14/15 - August	96%	98.67%	↔		
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96% (Cumulative) **(Aintree)**	14/15 - August	96%	99.26%	↔		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(CCG)**	14/15 - August	94%	95.69%	↓		
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (Cumulative) **(Aintree)**	14/15 - August	94%	100%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(CCG)**	14/15 - August	94%	96.67%	↑		
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94% (Cumulative) **(Aintree)**	14/15 - August	94%	100%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(CCG)**	14/15 - August	98%	100%	↔		
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (Cumulative) **(Aintree)**	14/15 - August	98%	100%	↔		

Cancer waits – 62 days						
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set (Cumulative) **(CCG)**	14/15 - August		93.33%	↔		
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set (Cumulative) **(Aintree)**	14/15 - August		91.26%	↔		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(CCG)**	14/15 - August	90%	96.88%	↑		
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (Cumulative) **(Aintree)**	14/15 - August	90%	84.09%	↓	Aintree failed the target for August and year to date, partly from previous months breaches, also in August there was 1 breach out of a total of 5 patients. The patient waited 87 days and the breach occurred due to patient holidays. First seen and first treatment trust being Aintree.	The service is currently falling below the 90% target for August with 1 confirmed breach in the month. This breach is a direct result of patient choice as the patient declined the first offer of a date for Colonoscopy due to going on holiday for a 5 week period (43 days lost). First diagnostic test (Colonoscopy) performed on day 54, followed by subsequent staging investigations and MDT discussion before surgery was performed on day 87. The number of treatments for the month remains low (5 treatments). This is a direct result of the split of the Bowel Cancer Screening service between Aintree (55%) and the Royal Liverpool (45%) with each Trust taking patients from their own areas. This change took place on the 3rd February 2014 and as a result has impacted upon the activity of the Aintree screening centre with a decrease in treatment activity for this group of cancers.
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(CCG)**	14/15 - August	85%	87.36%	↔		
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85% (Cumulative) **(Aintree)**	14/15 - August	85%	84.78%	↑	Aintree achieved the target for August but failed it year to date due to previous months performance. In August there were 4 breaches out of 39.5 patients in total. Underperformance reported YTD relates to breaches in May and June 2014.	Whilst this standard had been achieved in July , the Trust failed to deliver this in August and September. However, Quarter 2 overall was delivered for this standard (unvaildated data). Causes of underperformance were due to complex pathways and patient choice. An exception report has gone to Board detailing a number of remedial actions which have been put in place.
Mixed Sex Accommodation Breaches						
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(CCG)**	14/15 - September	0.00	0.00	↔		
Mixed Sex Accommodation (MSA) Breaches per 1000 FCE **(Aintree)**	14/15 - September	0.00	0.00	↔		
Referral To Treatment waiting times for non-urgent consultant-led treatment						
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(CCG)**	14/15 - September	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed admitted pathways (un-adjusted) **(Aintree)**	14/15 - September	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(CCG)**	14/15 - September	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for completed non-admitted pathways **(Aintree)**	14/15 - September	0	0	↔		
The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(CCG)**	14/15 - September	0	0	↔		

The number of Referral to Treatment (RTT) pathways greater than 52 weeks for incomplete pathways. **(Aintree)**	14/15 - September	0	0	↔		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(CCG)**	14/15 - September	90%	92.70%	↓		
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90% **(Aintree)**	14/15 - September	90%	92.96%	↔		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(CCG)**	14/15 - September	95%	96.36%	↓		
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95% **(Aintree)**	14/15 - September	95%	96.60%	↓		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(CCG)**	14/15 - September	92%	95.46%	↔		
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92% **(Aintree)**	14/15 - September	92%	96.44%	↓		
A&E waits						
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(CCG)**	14/15 - September	95.00%	98.36%	↔		
Percentage of patients who spent 4 hours or less in A&E (Cumulative) **(Aintree)**	14/15 - September	95.00%	92.24%	↔	The target not achieved in month (94%) and also year to date. The Trust has not achieved for any previous month in 2014/15.	Whilst the September performance 91.82% for Type 1 and 93.96% for all types was a small improvement over August, this still remains below the standard required. A projection had been submitted to Monitor of 92.83% for all types for Q2 – the final position was 92.29%. The causes of underperformance are multi-factorial, but are largely due to capacity to assess and make decisions promptly in AED (either through lack of physical capacity or inefficient processes), and ability to maintain flow into assessment areas and through to wards. An exception report has gone to Aintree's Board detailing a number of changes to practice implemented during September. The CCG have issued an activity query notice which will be discussed 27/11/14
Diagnostic test waiting times						
% of patients waiting 6 weeks or more for a Diagnostic Test **(CCG)**	14/15 - September	1.00%	0.69%	↕		
% of patients waiting 6 weeks or more for a Diagnostic Test **(Aintree)**	14/15 - September	1.00%	0.94%	↕		
Category A ambulance calls						
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(CCG)** (Cumulative)	14/15 - September	75%	69.12%	↓	The CCG failed to achieve the 75% year to date and also did not achieve the target in month (Sept) recording 64.81% This is a drop against August which achieved 71.6%.	NWAS has acknowledged a number of issues are contributing to poor performance levels. Activity levels are currently at a level greater than anything previously experienced by NWAS. In addition the health economies have introduced more community based services with the intention of deflecting and reducing demand on NWAS. Commissioners have been working with NWAS at county level to understand the nature and causes of this demand to enable agreement on how best to respond to the demand. It has been disappointing that data provided by NWAS has not been timely and in a format that has enabled a proper understanding of the increases. NWAS taking number of steps to increase number of Paramedics coming out of Universities. Aiming to recruit 50 extra Paramedics in November b) NWAS to agree fixed contracts with the voluntary sector. e.g Red Cross, St. Johns ambulance. c) Letter sent out to Healthcare Professionals(HCPs) re: HCPs calling PES vehicles straightaway, HCPs should utilise PTS and other options first. d) Clinical Transfers – there have been number of issues between the Royal Liverpool and Broadgreen sites. Royal Medical Director having talks with NWAS re: transfers between hot and cold sites. NWAS will also take forward with Whiston. An audit at Whiston has showed approximately 68% inappropriate transfers.
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(CCG)** (Cumulative)	14/15 - September	75%	69.99%	↓	The CCG failed to achieve the 75% year to date and also did not achieve the target in month (Sept) recording 67.38%. This is a slight improvement from August which recorded a percentage of 65.7%.	
Ambulance clinical quality - Category 19 transportation time **(CCG)** (Cumulative)	14/15 - September	95%	95.72%	↔		
Ambulance clinical quality – Category A (Red 1) 8 minute response time **(NWAS)** (Cumulative)	14/15 - September	75%	72.16%	↔	NWAS failed to achieve the 75% year to date and also did not achieve the target in month (Sept) recording 71.52%	
Ambulance clinical quality – Category A (Red 2) 8 minute response time **(NWAS)** (Cumulative)	14/15 - September	75%	72.96%	↔	NWAS failed to achieve the 75% year to date and also did not achieve the target in month (Sept) recording 73.29%	
Ambulance clinical quality - Category 19 transportation time **(NWAS)** (Cumulative)	14/15 - September	95%	95.30%	↔		
Local Measure						
Diabetes Care Processes	14/15 - September	65.9%	46.2%	New Measure	This measure makes up part of the quality premium and will be measures quarterly. Current figures show the CCG is under performing against plan.	

10.2 CCG Outcomes Indicator Set (OIS)

The CCG Outcomes Indicator Set (OIS) is still in development but is designed to provide clear, comparative information for CCGs about the quality of health services and the associated health outcomes. The indicators measure outcomes at CCG level to help inform priority setting and drive local improvement. The areas covered by the indicators contribute to the five domains of the NHS Outcomes Framework. The table below provides the published South Sefton CCG position. Many of the indicators are published annually, with the majority updated in September of each year.

CCG Outcomes Indicator Set
South Sefton CCG

↑ Increase in performance
↓ Decrease in performance
↔ No change in performance

Ref.	Indicator Description	Reporting Period	Last reported data	Trend	Data
Preventing people from dying prematurely					
1.1 i	Potential years of life lost considered amenable to healthcare (MALES)	2013	2,669.2	↓	DSR (per 100,000)
1.1 ii	Potential years of life lost considered amenable to healthcare (FEMALES)	2013	2,517.7	↓	DSR (per 100,000)
1.2	Under 75 mortality rate from CVD	2013	72.6	↓	DSR (per 100,000)
1.4	Myocardial infarction, stroke and stage 5 kidney disease in people with diabetes	2011/12	1.46	New Indicator	ISR (per 100 with diabetes)
1.6	Under 75 mortality rate from Respiratory Disease	2013	38	↓	DSR (per 100,000)
1.7	Under 75 mortality rate from Liver Disease	2013	22.6	↑	DSR (per 100,000)
1.8	Emergency admissions for alcohol related liver disease	Apr 2013 - Mar 2014 (Provisional)	63.7	↓	DSR (per 100,000)
1.9	Under 75 mortality rate from Cancer	2013	158.7	↑	DSR (per 100,000)
1.14	Smoking status at time of delivery	Quarter 4 - 2013/14	14.9%	↓	Percentage of deliveries

Ref.	Indicator Description	Reporting Period	Last reported data	Trend	Data
Enhancing quality of life for people with long term conditions					
2.1	Health-related quality of life for people with long-term conditions	July 2013 - March 2014	0.699	↓	DSR (per 100,000)
2.2	People feeling supported to manage their condition	July 2013 - March 2014	65.8	↓	Weighted %
2.5	People with diabetes diagnosed less than a year referred to structured education	2011/12	8.2%	New Indicator	Percentage offered or attended
2.6	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	Apr 2013 - Mar 2014 (Provisional)	1,020.2	↓	DSR (per 100,000)
2.7	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Apr 2013 - Mar 2014 (Provisional)	344.4	↑	DSR (per 100,000)
2.8	Complications associated with diabetes including emergency admissions for diabetic ketoacidosis and lower limb amputation	2011/12	9.11	New Indicator	ISR (per 100 with diabetes)
2.15	Health-related quality of life for carers	July 2013 - March 2014	0.775	↓	DSA
Helping people to recover from episodes of ill health or following injury					
3.1	Emergency admissions for acute conditions that should not usually need hospital admission	Apr 2013 - Mar 2014 (Provisional)	1,284.9	↑	DSR (per 100,000)
3.2	Emergency re-admissions within 30 days of discharge from hospital	2011/12	12	↑	ISR (per 100,00)
3.3a	Patient reported outcome measures for elective procedures: hip replacement	2012/13	0.420	↑	case mix adjusted health gain
3.3b	Patient reported outcome measures for elective procedures: knee replacement	2012/13	0.333	↑	case mix adjusted health gain
3.3c	Patient reported outcome measures for elective procedures: groin hernia	2012/13	0.068	↑	case mix adjusted health gain
3.3d	Patient reported outcome measures for elective procedures: varicose veins	2012/13	*Data suppressed due to small numbers*		case mix adjusted health gain
3.4	Emergency admissions for children with lower respiratory tract infections	Apr 2013 - Mar 2014 (Provisional)	464.6	↓	DSR (per 100,000)

Ref.	Indicator Description	Reporting Period	Last reported data	Trend	Data
Ensuring that people have a positive experience of care					
4.1	Patient experience of GP out-of-hours services	July 2013 - March 2014	72.45	↓	Percentage (adjusted)
Treating and caring for people in a safe environment and protecting them from avoidable harm					
5.3	Incidence of Healthcare Associated Infection (HCAI) – Methicillin-resistant Staphylococcus aureus (MRSA)	Jun-14	0	↑	Count
5.4	Incidence of Healthcare Associated Infection (HCAI) – C. difficile	Jun-14	7	↓	Count (N.B. this is not adjusted for registered pop)

10.3 Friends and Family – Aintree Hospitals NHS Foundation Trust

Table M Friends and Family – Aintree Hospitals NHS Foundation Trust

Clinical Area	Response Rate (RR) Target	RR Actual (Sept 2014)	RR - Trajectory From Previous Month (Aug 14)	Percentage Recommended (Eng. Average)	Percentage Recommended (Sept 2014)	PR - Trajectory From Previous Month (Aug 14)	Percentage Not Recommended (Eng. Average)	Percentage Not Recommended (Sept 2014)	PNR - Trajectory From Previous Month (Aug 14)
Inpatients	20%	41.5%	↑	94%	99%	New Measure	2%	0%	New Measure
A&E	20%	22.6%	↑	86%	83%	New Measure	7%	9%	New Measure

The Friends and Family Test Indicator now comprises of three parts:

- % Response Rate
- % Recommended
- % Not Recommended

The Trust achieved the A&E response rate target achiving 22.6% in September against a target of 20%, however they missed the national average for percentage recommended by 3% and the national average for not recommended by 2%. As % recommended is a new measure performance will be monitored and regular updates provided to the CCG's EPEG meetings.

The Trust achieved the Inpatient response rate target achiving 41.5% in September against a target of 20% and also exceeded the NHS England average for recommended and not recommended target.

Aintree Hospital have also agreed to share best practice and support other providers regarding improving response rates for FFT especially promoting the use of SMS, text, smartphone apps and telephone surveys to encourage patient participation.

10.4 Complaints

It was agreed that Complaints would only be included on a Quarterly basis in line with provider contract reporting requirements. The Trust's Quarter report will be approved by board in November, the nexy update will be provided in the December report.

10.5 Serious Untoward Incidents (SUIs)

10.5.1 NHS South Sefton CCG

Table N NHS South Sefton CCG reported Serious Untoward Incidents

Incidents Split by Type

Row Labels	Apr	May	Jun	Jul	Aug	Sep	YTD
Admission of under 18s to adult mental health ward		1					1
Child Death			1	3			4
Delayed diagnosis				1			1
Drug Incident (general)					1		1
Maternity service		1					1
Pressure ulcer - (Grade 3)	3	3	5	7	5	4	27
Pressure ulcer - (Grade 4)	3	4	4		1	2	14
Slips/Trips/Falls					1		1
Suicide by Outpatient (in receipt)						1	1
Unexpected Death of Community Patient (in receipt)						1	1
Grand Total	**6**	**9**	**10**	**11**	**8**	**8**	**52**

Incident split by provider

Row Labels	Apr	May	Jun	Jul	Aug	Sep	
Aintree University Hospital NHS Foundation Trust				1	2		3
Alder Hey Children's NHS Foundation Trust			1	1			2
Liverpool Community Health NHS Trust	6	7	9	9	6	6	43
Liverpool Women's NHS Foundation Trust		1					1
Mersey Care NHS Trust		1				2	3
Grand Total	**6**	**9**	**10**	**11**	**8**	**8**	**52**

For South Sefton CCG patients there have been 8 serious incidents reported in September 2014, 52 SUIs reported YTD and zero Never Events. Year to date there have been 4 repeated incidents reported, detailed below;

- 27x Pressure Ulcer (Grade 3)
- 14x Pressure Ulcer (Grade 4)
- 4x Child Deaths

The majority of incidents occurred within Liverpool Community Health, the Trust is currently undertaking an aggregated pressure ulcer review with South Sefton and Liverpool CCGs.

All incident investigations and action plans are discussed in detail at the CCG's Monthly SUI Management Group Meeting.

10.5.2 Aintree University Hospitals NHS Foundation Trust

Table O Aintree University Hospitals NHS Foundation Trust Reported Serious Untoward Incidents

Row Labels	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	YTD
Knowsley CCG							
Failure to act upon test results		2					2
Unexpected Death (general)		1					1
Liverpool CCG							
Delayed diagnosis			1				1
Failure to act upon test results		1					1
Sub-optimal care of the deteriorating patient						1	1
Sefton CCG							
Delayed diagnosis				1			1
Drug Incident (general)					1		1
Slips/Trips/Falls					1		1
Grand Total		**4**	**1**	**1**	**2**	**1**	**9**

There has been 1 serious incident reported in September 2014 relating to 'Sub-optimal care of the deteriorating patient'. The trust has reported 9 incidents YTD.

The trust has reported 1 repeated incidents YTD relating to the following;

1. 2x Failure to act upon test results (Knowsley CCG patients).
2. 2x Delayed Diagnosis (1 Liverpool and 1 South Sefton CCGs patients).

All incident investigations and action plans are discussed in detail at SUI/Complaints Monthly Management Group.

11. Primary Care

11.1 Background

The primary care dashboard has been developed during the summer of 2014 with the intention of being used in localities so that colleagues from practices are able to see data compared to their peers in a timely and consistent format. From this, localities can use this data to request further analysis, raise queries with providers, determine local priorities for action, understand demand, and monitor improvement.

11.2 Content

The dashboard is still evolving, but at this stage the following sections are included: Urgent care (A&E attendances and emergency admissions for children and adults separately), Demand (referrals, Choose & Book information, cancer and urgent referrals), and Prescribing indicators. Future developments during Autumn 2014 include QOF data, financial information, and public health indicators.

11.3 Format

The data is presented for all practices, grouped to locality level and RAG rated to illustrate easily variation from the CCG average, where green is better than CCG average by 10% or more, and red is worse than CCG average. Amber is defined as better than CCG average but within 10%. Data is refreshed monthly, where possible and will have a 6 week time lag from month end for secondary care data and prescribing data, and less frequent updates for the likes of annual QOF data. The dashboards have been presented to Quality Committee and to localities, and feedback has been positive. The dashboards will be available on the new Cheshire & Merseyside Intelligence Portal (CMiP)

11.4 Summary of performance

A summary of the primary care dashboard measures at locality level for data relating to June 2014 is presented below. The criteria for the Red, Amber, Green rating is described above in section 11.3

	A&E Attendance rate per 1,000 for under 19's (12 Mths to Jun-14)	A&E Attendance rate per 1,000 for over 19's (12 Mths to Jun-14)	Emergency Admission rate per 1,000 for under 19's (12 Mths to Jun-14)	Emergency Admission rate per 1,000 for over 19's (12 Mths to Jun-14)
Bootle	422.6	351.9	56.1	144.4
Crosby	258.2	223.3	43.7	104.7
Maghull	126.0	225.1	70.5	108.9
Seaforth & Litherland	340.6	303.9	53.1	121.9
South Sefton CCG	*305.3*	*276.3*	*54.0*	*119.9*

Locality	GP referrals (JUNE 14)	GP urgent referrals as a % of all GP referrals	GP referrals / 1,000 patients	Cancer Fast Track / 1,000 patients	% Choose & Book
Bootle	865	6.7%	21.57	2.10	18.2%
Crosby & Waterloo	901	10.8%	19.09	1.55	23.2%
Maghull	632	15.8%	22.35	1.38	27.2%
Seaforth & Litherland	738	7.6%	18.84	1.91	19.9%
South Sefton CCG	*3136*	*9.9%*	*20.27*	*1.75*	*21.8%*

12.Programme Update

12.1 2014/15 Milestones

All programme milestones are green except for the following exceptions:

- Neurology: Clinical and Programme leads not yet identified.

12.2 CCG Strategic Performance

Newly developed strategic performance dashboard to monitor progress against four main CCG performance indicators.

The dashboards are all produced in a standard format using Accident and Emergency department and emergency admissions data extracted from Secondary User Services (SUS) files.

Emergency activity for the majority of dashboards are extracted using established Programme Budgeting Codes

- 02 (A-X) Cancers & Tumours
- 04 (A-X) Endocrine, Nutritional and Metabolic Disorders (Diabetes)
- 05 (A-X)Mental Health Disorders
- 07 (A-X) Neurological Problems
- 10 (A-X) Problems of circulation (Cardiovascular)
- 11 (A-X) Problems of the respiratory system

For the other programme areas Children and Young People are defined by age under 19 years old, Acute Kidney Injury (AKI) and Liver Disease are reviewed by the use of Primary Diagnosis Codes specified by NHS Right Care and Palliative Care is evaluated through Unbundled HRG codes which is the NHS England preferred choice.

A&E Attendances are measured by the use of Diagnosis Codes as produced by the Health and Social Care Information Centre. These codes are a broad classification of the types of diagnoses that patients require attendance in A&E.

CCG performance is broken down to show activity at locality and programme level.

Locality and programme leads will review Dashboards each month to identify areas of concern and support future service developments.

South Sefton CCG received National Recognition for the work and development of the Programme Dashboards when they were presented at the NHS England CSU BI Leads Network meeting in London.

CCG Locality Programme Dashboard

The CCG Locality Programme Dashboard has been created to identify performance at Programme Level by Locality.
This will be required to inform future Service Planning, Development and Implementation.

The 3 parts of Information on the Dashboard are:

1) KPI

KPI is based on a RAG rating of RED, AMBER, GREEN

RED means YTD activity has increased this financial year.
AMBER means YTD performance has either stayed the same as last financial year or reduced by 0.9%
GREEN means YTD performance is 1% or more improved on last financial year.

2) Trend

Performance Improved	↓
	↓
	↓
	=
	=
	=
	↑
	↑
Adverse Performance	↑

The Key for the trend above shows 9 possible performance outcomes, the best being ↓ and the worst being ↑
The arrow indicates direction of activity, up arrow is increased activity and the down arrown indicates activity has decreasead when compared against last financial year
The colour of the arrow is the in-month performance.

3) Sparkline

The sparkline information shows the YTD activity plotted per month and indicates current financial year trend.

South Sefton CCG Programme Locality Dashboard

August 2014

All Activity		AE Attendance			Emergency Admissions			Emergency Bed Days			Emergency Re-admissions		
CCG Level		KPI 1	Trend	Sparkline	KPI 2	Trend	Sparkline	KPI 3	Trend	Sparkline	KPI 4	Trend	Sparkline
Locality	Bootle	6.8%	↑		12.8%	↑		13.1%	↑		22.4%	↑	
	Crosby	3.4%	↑		6.6%	↑		-5.2%	↓		11.4%	↑	
	Maghull	16.1%	↑		9.3%	↑		1.4%	↑		-6.0%	↓	
	Seaforth & Litherland	-1.3%	↓		10.4%	↑		-13.8%	↓		-4.1%	↓	

Activity - Programme		AE Attendance			Emergency Admissions			Emergency Bed Days			Emergency Re-admissions		
Bootle		KPI 1	Trend	Sparkline	KPI 2	Trend	Sparkline	KPI 3	Trend	Sparkline	KPI 4	Trend	Sparkline
	Acute Kidney Injury (AKI)				172.7%	↑		58.0%	↑		100.0%	↑	
	Cancer				25.7%	↑		-9.3%	↓				
	Cardiovascular	20.0%	↑		31.1%	↑		0.9%	↑		-10.0%	↓	
	Childrens and Young People	5.7%	↑		50.9%	↑		4.6%	↑		116.7%	↑	
	Diabetes				106.7%	↑		87.6%	↑		350.0%	↑	
	Liver Disease				-10.7%	↓		23.1%	↑		23.1%	↑	
	Mental Health	-22.4%	↓		-42.1%	↓		6.3%	↑				
	Neurology	-50.0%	↓		-7.2%	↓		-20.7%	↓		2.9%	↑	
	Palliative Care				32.5%	↑		22.6%	↑		8.3%	↑	
	Respiratory	-5.6%	↓		0.4%	↑		-12.1%	↓		3.3%	↑	
Crosby		KPI 1	Trend	Sparkline	KPI 2	Trend	Sparkline	KPI 3	Trend	Sparkline	KPI 4	Trend	Sparkline
	Acute Kidney Injury (AKI)				130.8%	↑		202.0%	↑		133.3%	↑	
	Cancer				14.0%	↑		33.4%	↑				
	Cardiovascular	-18.2%	↓		1.0%	↑		-19.0%	↓		23.3%	↑	
	Childrens and Young People	-5.7%	↓		44.9%	↑		8.2%	↑		25.0%	↑	
	Diabetes				-5.4%	↓		-6.7%	↓		0.0%	=	
	Liver Disease				2.8%	↑		-12.5%	↓		-12.5%	↓	
	Mental Health	6.3%	↑		-42.4%	↓		-64.6%	↓				
	Neurology	-63.6%	↓		-16.4%	↓		-19.4%	↓		-16.7%	↓	
	Palliative Care				28.2%	↑		28.0%	↑		42.9%	↑	
	Respiratory	-32.9%	↓		-13.7%	↓		-34.6%	↓		21.1%	↑	
Maghull		KPI 1	Trend	Sparkline	KPI 2	Trend	Sparkline	KPI 3	Trend	Sparkline	KPI 4	Trend	Sparkline
	Acute Kidney Injury (AKI)				137.5%	↑		-20.3%	↓		200.0%	↑	
	Cancer				0.0%	=		-38.1%	↓				
	Cardiovascular	-38.5%	↓		14.9%	↑		4.7%	↑		-11.1%	↓	
	Childrens and Young People	-0.3%	=		22.1%	↑		0.7%	↑		-80.0%	↓	
	Diabetes				9.7%	↑		38.3%	↑		-10.0%	↓	
	Liver Disease				20.8%	↑		33.3%	↑		33.3%	↑	
	Mental Health	-6.7%	↓		-15.8%	↓		-49.4%	↓				
	Neurology	-70.0%	↓		-6.7%	↓		-11.1%	↓		-15.4%	↓	
	Palliative Care				60.9%	↑		33.3%	↑		40.0%	↑	
	Respiratory	50.0%	↑		9.0%	↑		-13.4%	↓		18.5%	↑	
Seaforth & Litherland		KPI 1	Trend	Sparkline	KPI 2	Trend	Sparkline	KPI 3	Trend	Sparkline	KPI 4	Trend	Sparkline
	Acute Kidney Injury (AKI)				150.0%	↑		316.1%	↑			↑	
	Cancer				-23.4%	↓		-37.4%	↓				
	Cardiovascular	-50.0%	↓		-1.9%	↓		-22.7%	↓		0.0%	=	
	Childrens and Young People	7.8%	↑		78.8%	↑		43.9%	↑		75.0%	↑	
	Diabetes				22.9%	↑		14.6%	↑		83.3%	↑	
	Liver Disease				-29.6%	↓		-57.1%	↓		-57.1%	↓	
	Mental Health	-2.9%	↓		-48.1%	↓		-69.3%	↓				
	Neurology	-44.4%	↓		-21.9%	↓		-42.0%	↓		-45.5%	↓	
	Palliative Care				4.2%	↑		-15.9%	↓		27.3%	↑	
	Respiratory	25.3%	↑		4.0%	↑		-16.7%	↓		12.8%	↑	

AE Attendances for Childrens and Young People excludes Attendances at Liverpool Community due to Age Recording Discrepancies.

Appendix 1

NHS Data Dictionary Source of Referral descriptions

The source of referral of each Consultant Out-Patient Episode.

National Codes:

GP referral

03 referral from a GENERAL MEDICAL PRACTITIONER

Other referrals group includes all those listed below

Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

01 following an emergency admission
02 following a Domiciliary Consultation
10 following an Accident and Emergency Attendance (including Minor Injuries Units and Walk In Centres)
11 other - initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

Not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

92 referral from a GENERAL DENTAL PRACTITIONER
12 referral from a General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)
04 referral from an Accident and Emergency Department (including Minor Injuries Units and Walk In Centres)
05 referral from a CONSULTANT, other than in an Accident and Emergency Department
06 self-referral
07 referral from a Prosthetist
13 referral from a Specialist NURSE (Secondary Care)
14 referral from an Allied Health Professional
15 referral from an OPTOMETRIST
16 referral from an Orthoptist
17 referral from a National Screening Programme
93 referral from a Community Dental Service
97 other - not initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode

Note: The classification has been listed in logical sequence rather than numeric order.

Where a PATIENT is referred by a GENERAL PRACTITIONER acting in the capacity of a General Practitioner with a Special Interest (GPwSI), National Code 12 - 'referral from a General Practitioner with a Special Interest (GPwSI) or Dentist with a Special Interest (DwSI)' should be used.

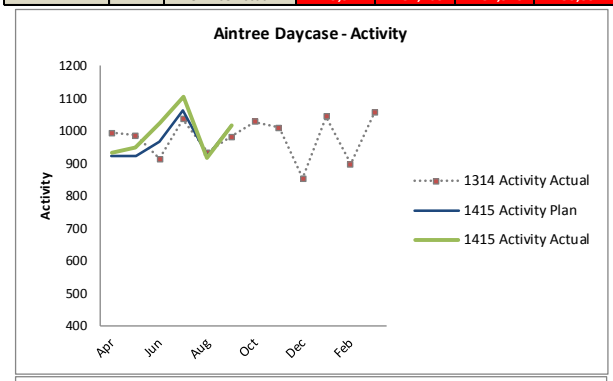
Where a PATIENT is referred by that GENERAL PRACTITIONER acting in their capacity as an ordinary GENERAL MEDICAL PRACTITIONER, or as an ordinary GENERAL DENTAL PRACTITIONER, National Code 03 - referral from a GENERAL MEDICAL PRACTITIONER or National Code 92 - referral from a GENERAL DENTAL PRACTITIONER should be used as appropriate.

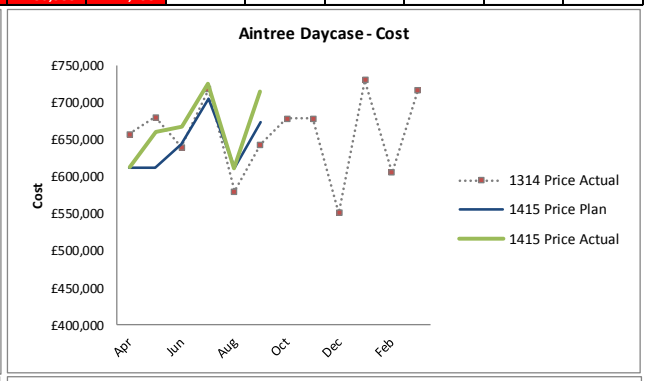
Two Week Wait Referrals made by Specialist NURSES in Primary Care, under the authority of the GENERAL MEDICAL PRACTITIONER leading their team, should continue to be classified as referrals from the GENERAL PRACTITIONER (National Code 03 - referral from a GENERAL MEDICAL PRACTITIONER). Referrals from Specialist NURSES in Secondary Care should be classified as National Code 13 - referral from a Specialist Nurse (Secondary Care).

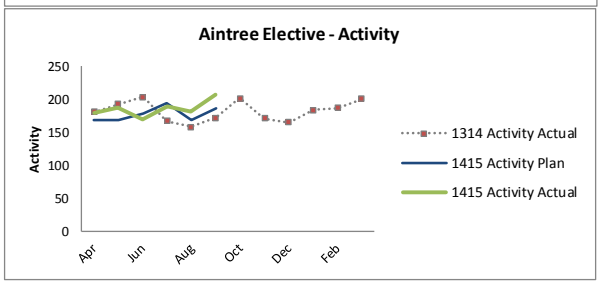
Appendix 1 Main Provider Activity & Finance Annual Comparison

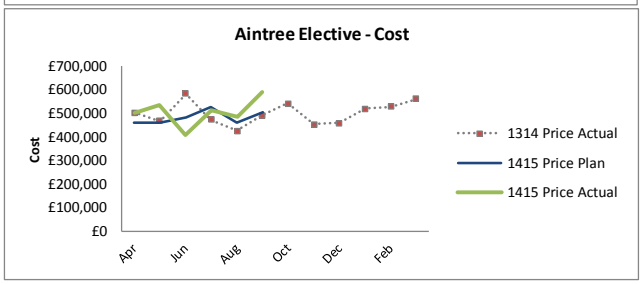
Table P: Month 5 Planned Care - Aintree University Hospitals NHS Foundation Trust 13/14 – 14/15 Comparison.

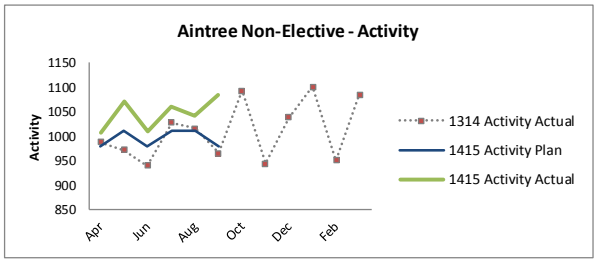
Aintree University Hospitals NHS F/T South Sefton CCG			2014/15											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	923	923	969	1061	923	1015						
		1415 Activity Actual	931	950	1026	1105	917	1015						
	Price	1415 Price Plan	£613,314	£613,314	£643,980	£705,312	£613,314	£674,646						
		1415 Price Actual	£613,530	£661,008	£668,302	£725,227	£611,195	£714,542						
Elective	Activity	1415 Activity Plan	169	169	178	194	169	186						
		1415 Activity Actual	180	188	169	190	181	207						
	Price	1415 Price Plan	£460,306	£460,306	£483,322	£529,352	£460,306	£506,337						
		1415 Price Actual	£501,422	£536,883	£407,857	£512,442	£486,687	£590,615						
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	978	1011	978	1011	1011	978						
		1415 Activity Actual	1007	1071	1010	1061	1042	1085						
	Price	1415 Price Plan	£1,897,370	£1,960,616	£1,897,370	£1,960,616	£1,960,616	£1,897,370						
		1415 Price Actual	£1,967,154	£2,153,752	£2,009,680	£2,007,291	£2,019,047	£1,971,551						
AandE	Activity	1415 Activity Plan	2527	2611	2527	2611	2611	2527						
		1415 Activity Actual	2552	2651	2633	2624	2560	2534						
	Price	1415 Price Plan	£270,763	£279,789	£270,763	£279,789	£279,789	£270,763						
		1415 Price Actual	£275,927	£287,705	£287,973	£283,394	£280,388	£277,458						

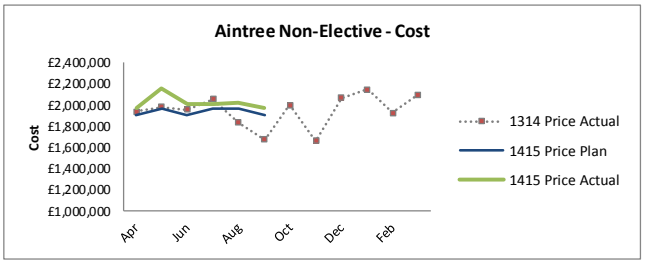


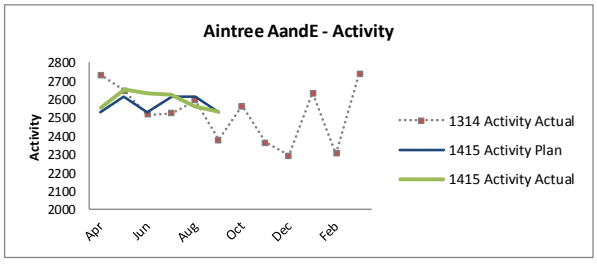












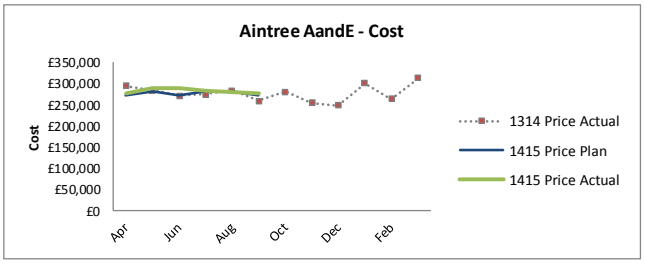
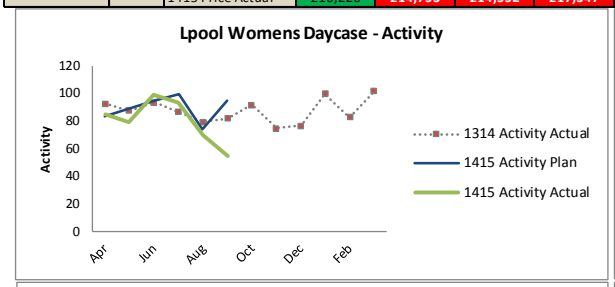
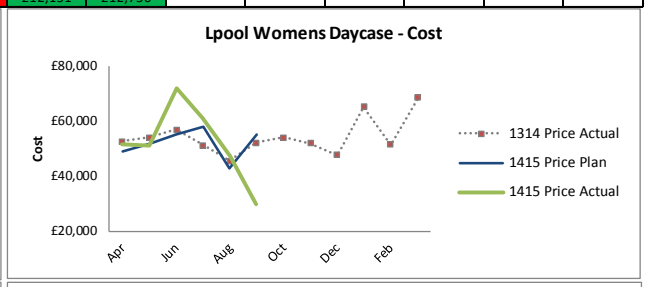
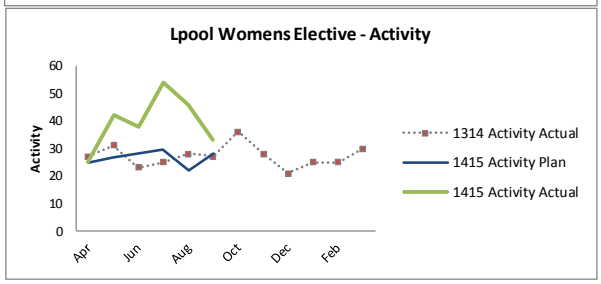


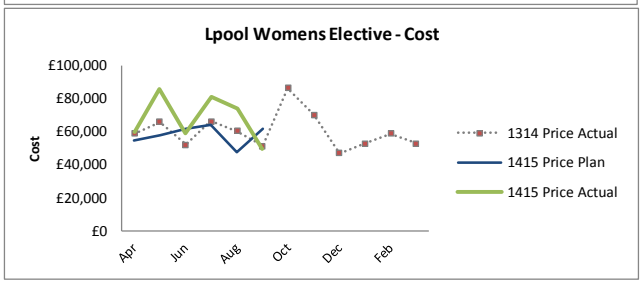
Table Q: Month 5 Planned Care – Liverpool Women's Hospital NHS Foundation Trust 13/14 – 14/15 Comparison.

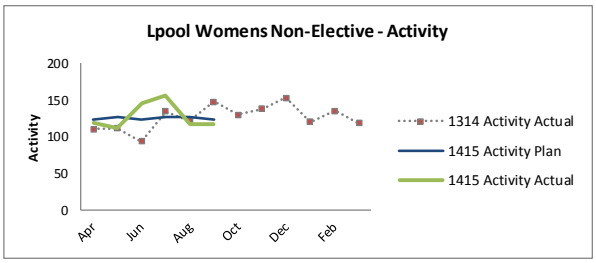
Liverpool Womens Hospital South Sefton CCG			2014/15											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	84	90	95	99	74	95						
		1415 Activity Actual	85	80	99	94	70	55						
	Price	1415 Price Plan	£48,833	£52,045	£55,258	£57,828	£43,050	£55,258						
		1415 Price Actual	£51,580	£51,317	£71,771	£60,982	£47,574	£29,922						
Elective	Activity	1415 Activity Plan	25	26	28	29	22	28						
		1415 Activity Actual	25	42	38	54	46	33						
	Price	1415 Price Plan	£54,488	£58,072	£61,657	£64,525	£48,035	£61,657						
		1415 Price Actual	£60,106	£85,777	£59,466	£81,343	£74,213	£49,371						
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	123	127	123	127	127	123						
		1415 Activity Actual	118	112	146	155	116	117						
	Price	1415 Price Plan	£208,357	£215,980	£208,357	£215,980	£215,980	£208,357						
		1415 Price Actual	£204,996	£195,892	£248,939	£265,849	£202,205	£208,097						
AandE	Activity	1415 Activity Plan	138	144	138	144	144	138						
		1415 Activity Actual	112	168	157	184	130	141						
	Price	1415 Price Plan	£12,873	£13,344	£12,873	£13,344	£13,344	£12,873						
		1415 Price Actual	£10,226	£14,753	£14,552	£17,347	£12,151	£12,736						

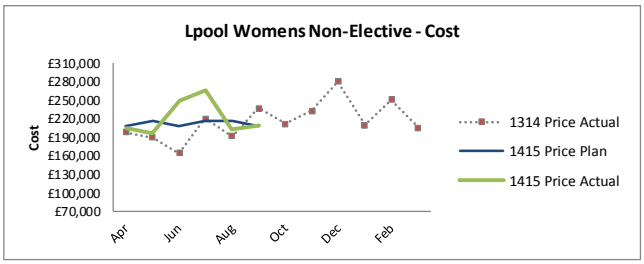


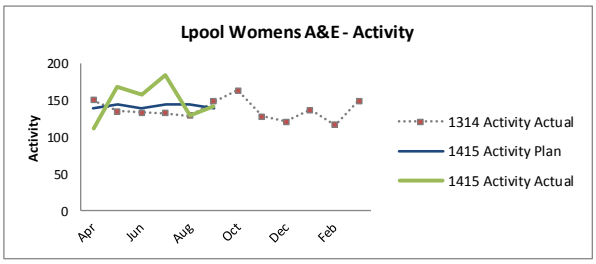












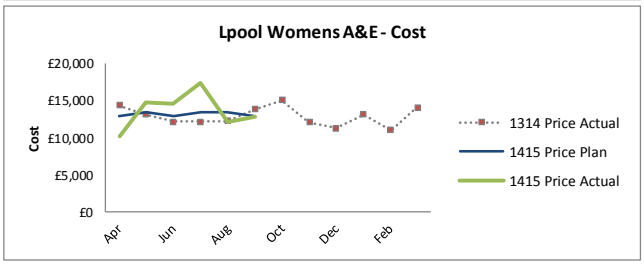
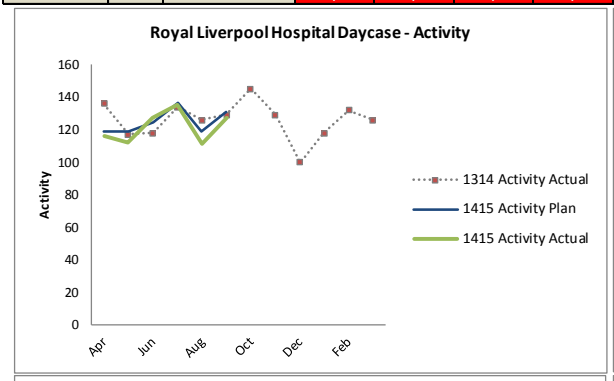
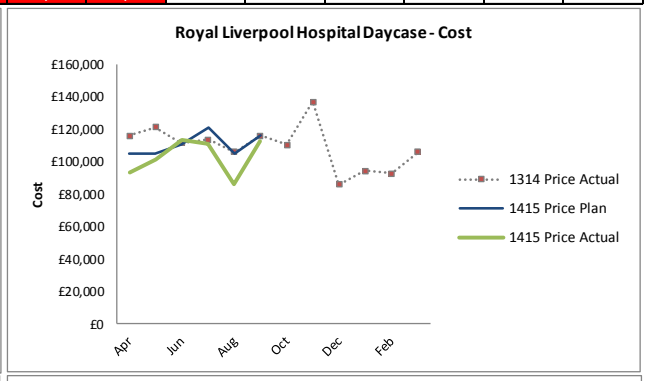
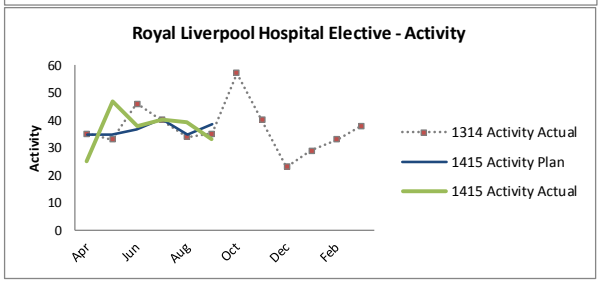


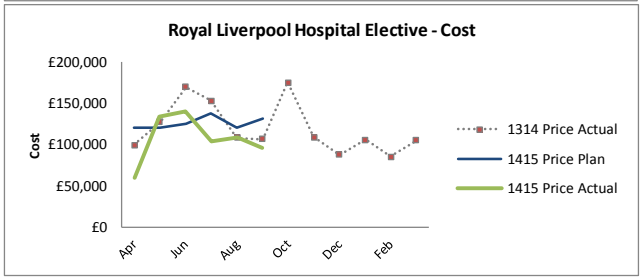
Table R: Month 5 Planned Care – Royal Liverpool & Broadgreen Liverpool Women's Hospital NHS Foundation Trust 13/14 – 14/15 Comparison.

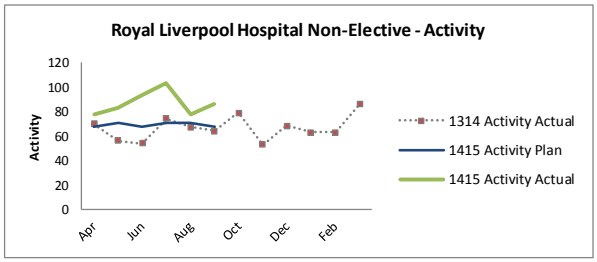
Royal Liverpool Hospital South Sefton CCG			2014/15											
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Daycase	Activity	1415 Activity Plan	119	119	125	137	119	131						
		1415 Activity Actual	116	112	127	135	111	127						
	Price	1415 Price Plan	£105,580	£105,580	£110,859	£121,417	£105,580	£116,138						
		1415 Price Actual	£93,425	£101,245	£113,637	£110,940	£86,338	£112,440						
Elective	Activity	1415 Activity Plan	35	35	37	40	35	38						
		1415 Activity Actual	25	47	38	40	39	33						
	Price	1415 Price Plan	£119,760	£119,760	£125,748	£137,724	£119,760	£131,736						
		1415 Price Actual	£59,269	£133,850	£139,497	£104,079	£109,147	£96,458						
Non-Elective (NEL and NELST)	Activity	1415 Activity Plan	68	70	68	70	70	68						
		1415 Activity Actual	78	83	94	103	78	86						
	Price	1415 Price Plan	£126,114	£130,318	£126,114	£130,318	£130,318	£126,114						
		1415 Price Actual	£140,993	£118,945	£142,782	£179,965	£160,353	£159,767						
AandE	Activity	1415 Activity Plan	362	374	362	374	374	362						
		1415 Activity Actual	394	365	361	385	378	367						
	Price	1415 Price Plan	£30,232	£31,240	£30,232	£31,240	£31,240	£30,232						
		1415 Price Actual	£32,676	£31,503	£30,287	£32,661	£32,747	£30,988						

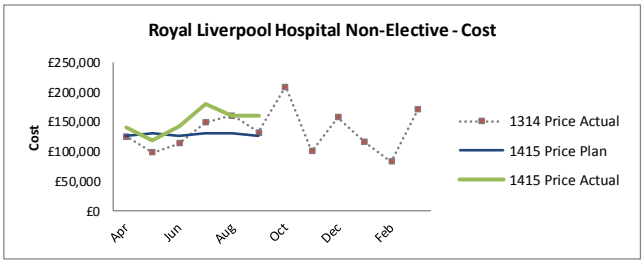


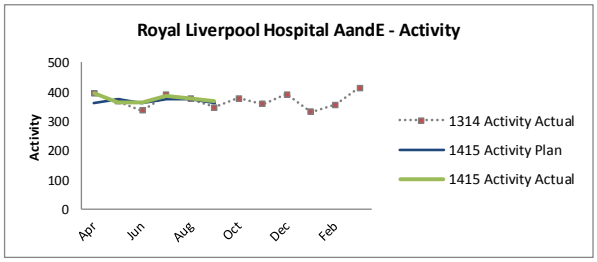


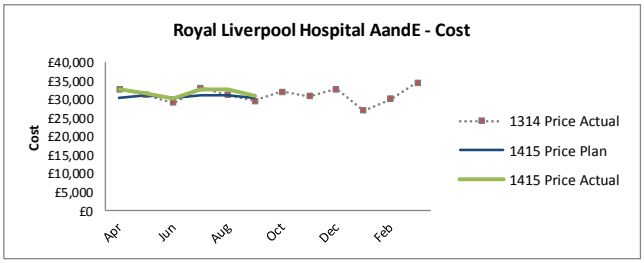












NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2014

Agenda Item: 14/154	**Author of the Paper:** Karl McCluskey Chief Strategy and Outcomes Officer Email: karl.mccluskey@southseftonccg.nhs.uk Tel: 0151 247 7006
Report date: November 2014	

Title: Update on CCG Strategy

Summary/Key Issues:

This paper provides a briefing and overview on progress against the strategic plan, strategic programmes and specifically programmes related to mental health, South Sefton Transformation, Care Closer to Home and Intermediate Care.

An approach moving from strategy to delivery is set out reflecting the current direction for travel and progress that has been made.

Recommendation

The Governing Body is asked to receive this briefing and note the progress against the strategic plan.

Receive	x
Approve	
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
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.

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Process	Yes	No	N/A	Comments/Detail
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	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

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Clinical Commissioning Group

Report to the Governing Body
November 2014

1. Introduction

This paper provides a briefing for the Governing Body on key areas related to the CCG Strategic Plan. An overview of progress is described with specific reference to further work that is now being developed to take plans to the next stage of development and implementation. All of the work and progress has "integration" expressly reflected and as such includes many and all aspects related to the Better Care Fund. This approach continues to ensure that "integration" is part and parcel of our daily work to deliver against our strategic plan and not something separate and discreet.

2. Strategic Programmes

2.1 All of the strategic programmes have identified associated and underpinning schemes. The Project Management Office (PMO) has developed a "Programme Milestone Dashboard", to identify the key actions required to develop, progress and implement programmes and their associated schemes. This is designed as a management tool to assist in programme development as well as providing assurance on programme progression. The latest version of the programme milestone dashboard is attached in Appendix 1. This clearly indicates that the required progress has been made across all programme areas. The Neurology programme has progressed, however, leadership on this has yet to be agreed. Action is in hand to resolve this.

2.2 In addition to the above, the PMO has developed a further dashboard ("Locality Programme Dashboard"), focusing on delivery and impact for individual programmes, by locality. The construct of this has been based on the key strategic areas drawn from the CCG's Strategic Plan and the defined KPI's:

- A&E Attendances;
- Emergency Admissions;
- 30 day re-admission rates to Hospital;
- Reduction in Bed Days.

2.3 The purpose of this dashboard is to enable programmes and localities to assess and monitor the impact on a locality basis, identify areas of opportunity for improved performance and target schemes in a more specific way, sensitive to the locality. A summary of this dashboard is contained in Appendix 2. It should be noted that while there are a range of RAG rated positions identified for programmes in specific localities; this is reflective of the stage of implementation that many programmes are at. The Service Improvement & Re-Design Committee will monitor and review delivery and performance on programmes in localities to test, challenge and address delivery issues.

3. Mental Health Programme

The Sefton Mental Health Task Group has continued to make good progress on developing its work stream and it is currently actively involved in the following developments.

3.1 Working with localities to explore how the primary care interface with Mental Health services can be developed further.

3.2 Mersey Care Home Liaison Service: the existing service specification has been redrafted to reflect CCG priorities (Virtual Ward/Care Closer to Home/ End of Life) and ensure that better outcomes are achieved. It is intended that the new service will commence in 2015/16.

3.3 Dementia - increasing diagnosis: the monthly dementia diagnosis rates are now being shared with all locality leads and GP practices and work is progressing with localities to identify any issues that may be perceived as barriers to timely diagnosis. Work continues, via localities, to support timely diagnosis. NHS Southport and Formby CCG and NHS South Sefton CCG will work closely with North West CSU on the roll out of the Dementia Data Quality Toolkit within primary care. It is intended that there will be follow up on queries following the initial run and work with localities / GP practices to support appropriate timely diagnosis were possible. In addition, NHS Southport and Formby CCG and NHS South Sefton CCG will work with Mersey Care NHS Trust to explore how current GP liaison services can support improved diagnosis.

3.4 Dementia: the Task Group will shortly be establishing a working group with partners to map how a new dementia pathway would look in Sefton.

3.5 Crisis Concordat: as part of the national drive to improve standards of care for people experiencing crisis work has commenced with partners to become signatories to the Crisis Concordat by 31st December 2014, after which a detailed action plan will be developed for services/agencies within Mersey Care NHS Trust's footprint.

3.6 Outcomes: the Task Group has met with Mersey Care NHS Trust and it is taking forward the work on developing measurable outcomes. At the end of March 2015 these will be agreed with commissioners and work will commence in 2015/16 to implement them for 2016/17 in line with the procurement of the Trust's replacement IT system.

3.7 IAPT: progress continues on the re-procurement exercise which is currently being run with aim of having a new IAPT services in place for both CCGs on 1st April 2015. This exercise will be concluded by the end of November 2014.

3.8 Time to Talk event: this is linked to Joint LA/PH/CCG/Fire/Police Mental Health Wider Determinants group aimed at developing the Health and Wellbeing Board's Mental Health Strategy for Sefton which the Local Authority is leading on.

3.9 Strategic Partnership Board: both Sefton CCGs will be represented on Mersey Care NHS Trust Strategic Partnership Board which will shortly be established. This will enable board level dialogue about strategic and key operational issues with all of the trust's key partners, ie CCGs, Local Authorities, NHS England specialised

commissioning and neighbouring providers such as LCH and acute Trusts. This will enable the priorities of the mental health work stream to be developed with high level support.

4. South Sefton Transformation

4.1 Following the previous papers considered and endorsed by the South Sefton Governing Body, the following progress can be confirmed:

4.1.1 the locality purpose and definition have been agreed and shared with localities;

4.1.2 a community model and Blue Print for the shape of locality services is in place;

4.1.3 the augmented governance structures moving the Virtual Ward Steering Group to a Transformation Board, with enhanced partner membership has been achieved;

4.1.4 the Virtual Ward Operational Delivery Group has refined its terms of reference and reporting arrangements to support the wider transformation approach across South Sefton;

4.1.5 a significant plan of work to support the integration of community teams with GP's is in train, with colleagues, clinicians and management from LCH;

4.1.6 an organisational development plan is being developed to further support community support the community team – GP interface is being developed. This is intended to be practice specific and in recognition of the varying working arrangements between practices;

4.1.7 Programme Leads for all transformation schemes have been confirmed;

4.1.8 an enhanced PMO methodology and framework is in place to enable programmes to be developed in a consistent format, with a standard approach to risk assessment and progress reporting;

4.1.9 PMO meetings with each programme lead are in place to describe and capture the programme actions, risks and delivery progress are in place across November and December.

4.2 Following the conclusion of the first round of PMO Programme reviews, it is intended that a summary position and progress report will be developed for the next Governing Body meeting in January.

5. Care Closer to Home

5.1 The revised Care Closer to Home Strategy is now in its second iteration and is currently out to consultation with partners, Southport and Ormskirk NHS Trust, Liverpool Community Health, Mersey Care NHS Trust and Sefton Borough Council. The new thrust remains focused on the following programmes:

- Urgent Care;
- Primary Care;
- Community Support;
- Elective Care;
- Intermediated Care.

5.2 The governance structures and arrangements are being revised, based on the above programmes, with a focus on delivery, combined ownership. Attention is also being given to the way in which social care and mental health form part of these programmes, such that they are fully integrated and not peripheral to what are often considered to be “traditional health areas”.

5.3 Significant work on the development of the locality model has been conducted with the membership, partners and staff. This has now been drawn together from the range of engagement and facilitated sessions for the CCG clinical leadership to refine. The intention is that the locality model will be clearly developed and agreed by the end of December. This will further support the orientation of the Care Closer to Home programmes to achieve our ambition to develop locality orientated services build around the patient with their GP and supporting services.

6. Intermediate Care

An extensive piece of work has been progressed, assessing and mapping the variety of intermediate care pathways and resources that are in place, currently across the borough, from a combined CCG and council perspective. This has highlighted enormous pathway complexity and significant navigational issues. A blueprint for a revised pathway and configuration of resources and capacity has been developed and consulted on with partners. This work is scheduled for conclusion following a wider engagement event on 3rd December and the intention is to progress to implementation by April in line with the CCG’s corporate objective related to this area.

7. Moving From Strategy to Delivery

7.1 While the strategic programmes have progressed, there is recognition that there is a need to further optimise programmes in an effort to amplify the opportunity that programmes present in terms of potential for reductions in unplanned activity. In addition, the CCG has recognised the crucial role that localities have in delivery, which needs to be further developed. The challenge going forward is for the CCG to develop and deliver programme plans that relate to localities, is sensitive to their local demographic and targets specific areas of opportunity to impact the greatest effect on the local population, in terms of health & wellbeing.

7.2 In support of the locality approach, individual locality packs have been produced for every CCG locality. These have been shared with the locality clinical, managerial

leads and locality groups. These packs have provided data and information on the health profiles, disease incidence and occurrence at a local level. In addition, these packs have enabled a comparison to be made between localities across a range of parameters (hospital admissions, deprivation, life expectancy, disease burden etc). The locality packs are aimed to support localities in determining their own priorities and target programmes, with clinical buy-in. Further work is required to enable localities to conclude their decision on priorities and assist them in the development of their programme plans.

7.3 In further support of locality development and embedding of strategic programmes, a draft framework and approach has been developed through the Senior Management Team. This framework is designed to ensure absolute connectivity between CCG expenditure (Primary Care, Secondary Care, Community Care, Continuing Care and Mental Health), programmes and localities. At the heart of this, are very clear lines of responsibility and accountability to enable:

- synergy between clinical and managerial effort;
- optimise effort versus return in terms of reducing unplanned activity;
- align effort with areas of opportunity, to support optimal reduction in unplanned activity;
- an absolute relationship between programmes / their initiatives and a quantum value of unplanned activity that should be managed and transferred from one element of the system to another e.g. Secondary Care to Community Care.

7.4 The diagram below describes the emphasis that the CCG is placing on locality development, with the Strategic Programmes focused on supporting and targeting health needs as pertinent to each locality. This focus and prioritisation will then help inform, build and deliver “our blue print” across the key four areas of Primary Care, Intermediate Care, Elective Care and Community Support & Services.

Diagram 1 - Locality Framework

7.5 To further support this approach, work in underway within the CCG to confirm current levels of investment across the commissioning portfolio and to develop a range of informed scenarios for the Governing Body to debate and consider in the context of

its five year strategic plan. This work is progressing well and it is envisaged that the next Governing Body development session will be utilised to explore a range of investment scenarios which can be refined and agreed. These will then be used to inform and direct the work of localities and programmes in delivering against the strategic investment plan set out by the CCG. It will also enable a programme of investment for our Locality Framework in relation to Primary Care, Intermediate Care, Elective Care and Community Support and Services.

7.6 By the beginning of December, the CCG will have a blueprint for all of the areas set out in the diagram above, which are connected and complementary to support our clinical commissioning strategy.

7.7 These will be shared and explored through the Health and Wellbeing Board Structures, including the provider forum to develop the clarity for 1st April 2015 and also with our stakeholders through EPEG, Healthwatch, CVS and during our Big Chats.

7.8 This discussion has been developed with our CCG membership, though it is acknowledged continued engagement is vital.

7.9 It is planned to run a series of sessions from January through to March 2015 facilitated by the Kings Fund.

8. Recommendations

8.1 The Governing Body is requested to recognise the work that has been made in relation to delivery against the CCG's Strategic Plan and be assured that the necessary progress is being made.

8.2 It is also asked that the Governing Board endorse the approach and direction that is being taken in relation to the strategic programmes and embedding these within the locality model, with the development of a supporting strategic investment plan.

Appendices

Appendix 1 Programme Milestones
Appendix 2 Programme Dashboard

Karl McCluskey
November 2014

South Sefton Programme Milestone Dashboard - June 2014

SOUTH SEFTON CCG PROGRAMME DASHBOARD									
Programmes	Programme schemes	Q	I	P	P	Area	Target Date	Update	RAG
Children's	Review of Children's therapies (SALT, physiotherapy, Occupational Therapists etc.)	x	x	x	x	Other	Mar-15	Ongoing but progressing as planned	
Mental Health Dementia	Commissioned Asperger's pilot service - 12 month pilot (Start tender for full service)	x				Integrated Care	Jul-14	Pilot Service commissioned. The service has started receiving referrals, delays in recruitment delayed. Full roll out to 1/9. KPI data due Dec 14	
Mental Health & Dementia	Enhance Age Concern Befriending - based on data from Merseycare regarding level of need	x			x	Integrated Care	Dec-14	All contracts now complete - awaiting KPI data Dec -14	
Mental Health & Dementia	Review model for care navigators	x		x		Integrated Care	Dec-14	Not sure if this is the model required. Explore links to PH case for Wellness centre to ensure MH and Dementia included in development of spec	
Mental Health & Dementia	Enhance Self Support Programme - based on data from Merseycare regarding level of need	x			x	Integrated Care	Dec-14	Review is ongoing.	
Mental Health & Dementia	Re-define and specify Merseycare Care home Liaison Service (inc Acute)	x		x		Integrated Care	Dec-14	Review is ongoing, visits initiated.	
Mental Health & Dementia	Review pilot Street Cars / A&E Scheme	x	x		x	Integrated Care	Jan-15	Pilot underway. Future funding identified via resilience funding	
Mental Health & Dementia	Review Recovery model based on definitive treatment plans and expected outcomes, with enhanced support network - support commissioning plans for 2015/16	x		x		Integrated Care	Mar-15	Suite of outcome measures identified - final set to be agreed with CCG. Aim to implememt 2016/17 contracts	
Mental Health & Dementia	Achieve Dementia Diagnosis rates - 67%	x				Integrated Care	Mar-15	Meet with locality leads to include in monthly meeting. Develop Dashboard	
Respiratory	Develop Patient Led self-care pilot programme (PLSCPP), including exercise / Rehab activity	x	x	x	x	Community rehab	Dec-14	Original draft document not received. New draft programme completed by CVS and CCG. Clinical review by LCH and CCG clinical leads. Planned now for Early December	
Respiratory	Review Respiratory care pathway - Nice Guidance 2014/15 - includes all elements of pathway. Also Identify Primary Care Training needs	x	x	x	x	Integrated Care	Dec-14	Key area to develop is Primary Care programme, which will require training across next few years usng PLT as minimum.	
Respiratory	Review and assess need for enhanced rehab / Hospital at Home / Supportive Discharge	x	x	x	x	Integrated Care	Dec-14	Current service not optimised,reconfigure service to meet locality requirements. Dr Chamberlain leading. Phase 1(Co-locate) complete by end November. Phase 2 new spec implemented by end December	
Respiratory	Audit of Patient Led self-care pilot programme	x		x		Integrated Care	Jan-15	see above	
Respiratory	Develop & Deliver COPD/Asthma Awareness Programme - The Missing Millions	x	x	x	x	Integrated Care	Dec-14	To take place in Strand Bootle, Nov 20th & 21st. Test asthma and COPD. PH and CVS linked in.	
Respiratory	Implement targeted respiratory care project (Bootle Locality) to provide holistic review and management of respiratory patients.	x	x		x	Integrated Care	Jan-15	On target	

South Sefton Programme Milestone Dashboard - June 2014

SOUTH SEFTON CCG PROGRAMME DASHBOARD

Programmes	Programme schemes	Q	I	P	P	Area	Target Date	Update	RAG
CVD	Review CVD related prescribing - CCG outlier	x				Integrated Care	Jul-14	Meeting to be rescheduled with meds management in September due to A/L	
CVD	Develop Community Cardiac Rehab specification. Commissioned Aintree and LCH to work together to provide service.	x		x	x	Integrated Care	Sep-14	LCH and Aintree now working together plan to commence the community rehab programme from 1st September. Meeting to be arranged with CSU regarding KPIs and performance management.	
CVD	Hypertension management - Development of plan including Peer review, analysis of data - QOF registers, exception coding.	x		x	x	Integrated Care	Feb-15	Exploring potential of telemedicine pilot. Need a hypertension campaign to get it back on the primary care agenda. Development of SS CVD strategy group planned to support future work	
Unplanned	Virtual Ward - Self Care Reablement Service	x			x	Integrated Care	Sep-14	Service to start test phase 22/09	
Unplanned	Virtual Ward - Urgent Care Pilot (June) & Full Roll Out (Nov)	x	x	x		Integrated Care	Nov-14	Pilot started in June (Bootle). Rolled out to Crosby at the start of September. Awaiting data however feedback possitive	
Unplanned	Virtual Ward - DVT Pathway	x				Integrated Care	Mar-15	Issues due to lack of data flow from provider. CSU to raise next contract meeting	
Primary Care	Local Quality Contact monitoring. Further strategic plans being developed, focus on links to Integrated Locality Care	x		x		Primary Care	TBC 2014/15	Planning work underway with PMO, Paper outlining suggested contract review process to be taken to SIR group	
Neurology	Develop Neurology Programme - Link with NW Coast academic Health Science Network	x				Primary Care	TBC 2014/15	Need to identify programme lead and GP lead	
EOL	Increase resource for Advanced Care Practitioner to 1 WTE	x		x		Integrated Care	Oct-14	Post gone to advert. Looking to understand how post can link with EOL facilaitator and Aintree's clinical transform lead to ensure works as single approach.	
EOL	Commission additional beds for EOL	x				Integrated Care	Sep-14	Meeting with SSP in November to discuss GP cover. Also in discussion with finance regarding funding for EOL beds	
EOL	Review discharge planning models (Woodland)	x			x	Integrated Care	Dec-14	Ongoing	
EOL	Develop joint approach between LA &Health - Care home contracting to ensure consistency of care	x	x			Integrated Care	Mar-14	Discussions ongoing - CCG to share strategy	
Diabetes	Jointly develop targeted Public Health Plan to underpin CCG Strategy (2014/15) Prevention. Linked to PH Obesity strategy	x			x	Integrated Care	TBC 2014/15	Meeting planned in September to progress strategy	
Diabetes	Pharma diabetes education project with Gap practices. Explore potential benefits of further projects	x		x	x	Integrated Care	Sep-14	Diabetes GP leads reviewing how scheme can be taken forward - GP & Practice nurse mentoring and Uni. course under consideration	
Diabetes	Use of health trainers currently part of Virtual Ward. Potential capacity and could be used differently.	x		x	x	Integrated Care	Oct-14	Part of wider strategic planning currently underway for scheme	
Cancer	Enhanced Screening Provision - (Access Bowel Scope)	x			x	Other	Aug-14	Live	

South Sefton Programme Milestone Dashboard - June 2014

SOUTH SEFTON CCG PROGRAMME DASHBOARD									
Programmes	Programme schemes	Q	I	P	P	Area	Target Date	Update	RAG
Cancer	Redesign lung diagnostic pathway	x			x	Other	Aug-14	Live	
Cancer	Ovarian - Audit of current activity before potential pathway change	x			x	Other	Aug-14	Implementation of pathway reviewing community element of scanning - Decision est. March 2015	
Cancer	Bowel Cancer screening - address uptake (NHS England action)	x			x	Other	Aug-14	NHSE Task Group 2 yr plan for increasing cancer screening uptake inplace. Complete	
Cancer	Be clear on / tailored cancer awareness campaign	x			x	Primary Care	Oct-14	Currently live. National report to follow.	
Cancer	Audit of unplanned admissions with cancer diagnosis to identify potential of GP intervention	x		x		Primary Care	Dec-14	Audit complete. Clinical lead to report back Dec 14	
Cancer	Exploring use of LQP to support earlier diagnosis of cancer in Primary Care	x		x		Primary Care	Jan-14	Link with Primary Care lead before SIR group in January	
Ophthalmology	Phase 2 Procurement community to deliver 20% of current outpatient activity in community	x		x		Care closer to Home	Jan-15	Case for change to SIR group - review viability of scheme. Start procurement Feb-15.	

Key	Trend
Performance improved	↓
	↓
	↓
	=
	=
	=
	↑
	↑
Activity increased	↑

Direction of Arrow indicates whether activity is increasing (up arrow) or decreasing (down arrow).
Colour of Arrow indicates whether last months performance was above (red arrow) or below (green arrow) when compared against the same months from previous years activity total.
The equals sign and the colour amber indicate similar performance this financial year compared with last financial year.
The Sparkline shows this years YTD performance.

Programme Dashboards

Programme Dashboards have been designed and created through joint collaboration between Business Intelligence leads from the CSU & CCG and work commenced on the 30th June.

Cardiovascular was the first dashboard produced in draft format on the 4th July and on a monthly basis we now update and refresh dashboards for 10 key programme areas ranging from Acute Kidney Injury (AKI) to Respiratory.

The dashboards are all produced in a standard format using Emergency and A&E activity data. Emergency Spell Data and A&E Attendances are extracted from Secondary User Services (SUS) files. Targets are based on financial year 2013/14 and a 1% saving is measured using a Red, Amber and Rating (RAG) rating system.

Emergency activity for the majority of dashboards are extracted using established Programme Budgeting Codes

- 02 (A Cancers & Tumours
- 04 (A Endocrine, Nutritional and Metabolic Disorders (Diabetes)
- 05 (A-X) Mental Health Disorders
- 07 (A-X) Neurological Problems
- 10 (A Problems of circulation (Cardiovascular)
- 11 (A Problems of the respiratory system

For the other programme areas Childrens and Younger People are monitored by age group less than 19 years old, Acute Kidney Injury (AKI) and Liver Disease are reviewed by the use of Primary Diagnosis Codes specified by Right Care and Palliative Care is evaluated through Unbundled HRG codes which is the NHS England preferred choice of coverage.
A&E Attendances are measured by the use of Diagnosis Codes as produced by the Health and Social Care Information Centre. These codes are a broad classification of the types of diagnoses that patients require attendance in A&E.
On the 1st October, South Sefton CCG and Southport & Formby CCG received National Recognition for the work and development of the Programme Dashboards when they were presented at the CSU BI Leads Network meeting in London.

August 2014 KPI Target 1% reduction on 2013/14 activity

All Activity		AE Attendance			Emergency Admissions			Emergency Bed Days			Emergency Re-admissions		
CCG Level		KPI 1	Trend	Sparkline	KPI 2	Trend	Sparkline	KPI 3	Trend	Sparkline	KPI 4	Trend	Sparkline
Locality	Bootle	6.8%	↑		12.8%	↑		13.1%	↑		22.4%	↑	
	Crosby	3.4%	↑		6.6%	↑		-5.2%	↓		11.4%	↑	
	Maghull	16.1%	↑		9.3%	↑		1.4%	↑		-6.0%	↓	
	Seaforth & Litherland	-1.3%	↓		10.4%	↑		-13.8%	↓		-4.1%	↓	

Activity by Programme		AE Attendance			Emergency Admissions			Emergency Bed Days			Emergency Re-admissions		
Bootle	Programmes	KPI 1	Trend	Sparkline	KPI 2	Trend	Sparkline	KPI 3	Trend	Sparkline	KPI 4	Trend	Sparkline
	Acute Kidney Injury (AKI)				172.7%	↑		58.0%	↑		100.0%	↑	
	Cancer				25.7%	↑		-9.3%	↓				
	Cardiovascular	20.0%	↑		31.1%	↑		0.9%	↑		-10.0%	↓	
	Childrens and Young People	5.7%	↑		50.9%	↑		4.6%	↑		116.7%	↑	
	Diabetes				106.7%	↑		87.6%	↑		350.0%	↑	
	Liver Disease				-10.7%	↓		23.1%	↑		23.1%	↑	
	Mental Health	-22.4%	↓		-42.1%	↓		6.3%	↑				
	Neurology	-50.0%	↓		-7.2%	↓		-20.7%	↓		2.9%	↑	
	Palliative Care				32.5%	↑		22.6%	↑		8.3%	↑	
	Respiratory	-5.6%	↓		0.4%	↑		-12.1%	↓		3.3%	↑	
Crosby	Programmes	KPI 1	Trend	Sparkline	KPI 2	Trend	Sparkline	KPI 3	Trend	Sparkline	KPI 4	Trend	Sparkline
	Acute Kidney Injury (AKI)				130.8%	↑		202.0%	↑		133.3%	↑	
	Cancer				14.0%	↑		33.4%	↑				
	Cardiovascular	-18.2%	↓		1.0%	↑		-19.0%	↓		23.3%	↑	
	Childrens and Young People	-5.7%	↓		44.9%	↑		8.2%	↑		25.0%	↑	
	Diabetes				-5.4%	↓		-6.7%	↓		0.0%	=	
	Liver Disease				2.8%	↑		-12.5%	↓		-12.5%	↓	
	Mental Health	6.3%	↑		-42.4%	↓		-64.6%	↓				
	Neurology	-63.6%	↓		-16.4%	↓		-19.4%	↓		-16.7%	↓	
	Palliative Care				28.2%	↑		28.0%	↑		42.9%	↑	
	Respiratory	-32.9%	↓		-13.7%	↓		-34.6%	↓		21.1%	↑	
Maghull	Programmes	KPI 1	Trend	Sparkline	KPI 2	Trend	Sparkline	KPI 3	Trend	Sparkline	KPI 4	Trend	Sparkline
	Acute Kidney Injury (AKI)				137.5%	↑		-20.3%	↓		200.0%	↑	
	Cancer				0.0%	=		-38.1%	↓				
	Cardiovascular	-38.5%	↓		14.9%	↑		4.7%	↑		-11.1%	↓	
	Childrens and Young People	-0.3%	=		22.1%	↑		0.7%	↑		-80.0%	↓	
	Diabetes				9.7%	↑		38.3%	↑		-10.0%	↓	
	Liver Disease				20.8%	↑		33.3%	↑		33.3%	↑	
	Mental Health	-6.7%	↓		-15.8%	↓		-49.4%	↓				
	Neurology	-70.0%	↓		-6.7%	↓		-11.1%	↓		-15.4%	↓	
	Palliative Care				60.9%	↑		33.3%	↑		40.0%	↑	
	Respiratory	50.0%	↑		9.0%	↑		-13.4%	↓		18.5%	↑	
Seaforth & Litherland	Programmes	KPI 1	Trend	Sparkline	KPI 2	Trend	Sparkline	KPI 3	Trend	Sparkline	KPI 4	Trend	Sparkline
	Acute Kidney Injury (AKI)				150.0%	↑		316.1%	↑			↑	
	Cancer				-23.4%	↓		-37.4%	↓				
	Cardiovascular	-50.0%	↓		-1.9%	↓		-22.7%	↓		0.0%	=	
	Childrens and Young People	7.8%	↑		78.8%	↑		43.9%	↑		75.0%	↑	
	Diabetes				22.9%	↑		14.6%	↑		83.3%	↑	
	Liver Disease				-29.6%	↓		-57.1%	↓		-57.1%	↓	
	Mental Health	-2.9%	↓		-48.1%	↓		-69.3%	↓				
	Neurology	-44.4%	↓		-21.9%	↓		-42.0%	↓		-45.5%	↓	
	Palliative Care				4.2%	↑		-15.9%	↓		27.3%	↑	
	Respiratory	25.3%	↑		4.0%	↑		-16.7%	↓		12.8%	↑	

AE Attendances for Childrens and Young People excludes Attendances at Liverpool Community due to Age Recording Discrepancies.

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2014

Agenda Item: 14/156	**Author of the Paper:** Dwayne Johnson Director for Older Citizens Sefton Metropolitan Borough Council Email: dwayne.johnson@sefton.gov.uk Tel: 0151 247 7000
Report date: November 2014	
Title: Care Act 2014	

Summary/Key Issues:

This report updates the Governing Body Committee on the approach and progress to implementation of the Act in Sefton.

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.
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				
Clinical Engagement				
Equality Impact Assessment				
Legal Advice Sought				
Resource Implications Considered				
Locality Engagement				
Presented to other Committees				

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

NHS
South Sefton
Clinical Commissioning Group

Report to the Governing Body
November 2014

1. Executive Summary

To inform the CCGs of the approach and the progress to implementation of the Act in Sefton.

2. Introduction and Background

2.1 The Act outlines the most significant change in Adult Social Care in decades with changes to underpinning legislation, eligibility criteria, funding, changes to the status of Adult Safeguarding and a host of other associated areas which are likely to impact across the community.

2.2 New requirements, duties and responsibilities will be implemented from April 2015 with full implementation of the financial aspects planned for April 2016. The underpinning principles of the Act are: discretion, duty, rationing, appropriateness, suitability and necessity. The council will remain the gatekeeper of public money. The key requirements include:

- There is a duty to promote a person's well-being;
- Personal Budgets become a formal requirement - but that is just the name for the sum of money allocated. In Sefton we already have direct payments, managed personal budgets, through which incapacitated people can have the benefits of direct payments, without the personal responsibility;
- Carers will qualify for enforceable rights for the first time, not just assessment;
- The Dilnot 'care costs' cap provisions have now been put in, and drive the main planks of the Act, eg the duty to provide, above the cap, and the notion of daily living costs which are not to be counted;
- The charging framework is itself streamlined, with the differences to be fleshed out in regulations. Deferred payments for the cost of care at home will be introduced;
- Counselling and advocacy are themselves to be made into social care services – a council could pay for advocacy;
- 'Information' and 'advice' are also seen as services;
- All councils must have Safeguarding Boards and will be under a duty to make enquiries when having been alerted to someone at risk;
- There is to be a geographically-based obligation to provide prevention and reduction measures;
- There is a duty to provide an information service;
- There's to be a geographically-based general duty to shape the market so as to secure diverse provision of services to enable all people to help themselves.
- There are market failure fall-back obligations, in the event of failure - so this is more of a development for CQC, which is given financial sustainability assessment functions in statute for the first time;

- The Bill re-iterates the notion of a duty to co-operate between agencies;
- There is an integration-directed principle supposed to underpin all of the above, for the promotion of well-being.

2.3 The guidelines have recently been published leaving us with approximately 160 days to implement the Act. To oversee the implementation of The Act in Sefton, we have tasked key staff to implement different components of the Act overseen by the Councils Adult Social Care (ASC) Transformation Board. Since the guidelines have been produced we have begun to engage with the CCGs and the voluntary sector. Sefton is well placed to work with the CCGs on the principles of integration however more progress will be expected on pooling budgets. It is proposed that the Director of Older people meet with key senior staff from the CCGs to explore the principles further.

2.4 To support the implementation a one off grant of £125,000 has been provided and this has been used in the following three ways:

- A full-time post in the Council's finance team has been identified to support the financial implementation of the changes in the Act;
- £25K to support the Liverpool City region work on finance and workforce. There is opportunity to connect with the sub regional work the CCGs have commissioned on workforce and following a meeting with Fiona Clarke we have already made contact with key people to explore this further;
- The remainder will be used for bespoke tasks.

Additional funding has been identified to fund the implementation of the Act. At this stage it is difficult to say whether this will be able to meet all of the requirements of the Act.

2.5 In addition there are two regional groups that have been established and we are currently aligning our local work to ensure that there is no duplication:

- North-West regional ADASS group – we have representation on this group and they are an excellent source of information, communication and sharing best practice. This has included carrying out local stocktakes and workforce readiness surveys;
- Liverpool City Region group – this group is looking at a range of areas with each authority taking an overall lead for one subject, Sefton is leading on pre-paid cards.

Updates from each of these regional groups are presented on a monthly basis to the ASC Board.

2.6 As part of the initial implementation of the Act the Council have completed three self-assessments to determine our readiness for the changes. The first self-assessment was completed in August and shows that we were on track at that point. The assessment was repeated in September and again demonstrated that we were progressing well in all areas.

The third self-assessment relates to workforce readiness and has been submitted to Skills for Care, although there are some areas that need more attention the general analysis of our performance is positive and we are well developed in areas such as:

- Understanding your current workforce;
- Identifying tasks required;
- Leadership and Management;
- Identifying data sources;
- Co-production to gather or analyse data;
- Sharing data;
- Understanding of how workforce changes will affect people who need care and support;
- Understanding of how workforce changes impact on the local population;
- Developing integrated ways of working;
- Market position statements and workforce strategy.

3. Key Issues

3.1 An important aspect of the Act is to deliver a more preventive based approach. Work is underway to develop this further with public health and the CCGs.

3.2 There are a number of requirements for assessment and eligibility that need to be in place prior to full implementation in April 2015. A self-assessment template has been developed and we need to consider the following:

- The total extent of current and future needs for care and support;
- What need is eligible for both adults and carers and how these can be met subject to a financial assessment;
- Care and support planning with active involvement from the service user;
- Processes in relation to transition to adult care and support for children, young carers and child's carers.

3.3 Currently work is underway to assess all of the charging implications of the Care Act to ensure full implementation by April 2015. Key areas that are currently being considered and worked upon:

- There are changes to the financial assessment for people who have a property; work is underway to estimate the numbers of people affected by this, also there will need to be changes to IT to accommodate the differences;
- There will need to be a change to the domiciliary and residential care policy in light of the new aspects of the Care Act.

3.4 A comprehensive action plan is been developed to give support and guidance for the Adults Safeguarding Board in relation to the Care Act. The risk areas are:

- Review the Safeguarding Adults Board Serious Case Review Policy to ensure that it incorporates all relevant requirements from the Care Act and guidance;
- Develop and implement an engagement plan to ensure agencies are robustly engaged, supported and able to respond to their responsibilities to take part in Safeguarding Adult Reviews;
- Require all agencies that will have a statutory duty under the Care Act to report against their contribution to the Board and the delivery of the plan for the Annual Report.

We will engage with the CCGs on these matters.

3.5 A stocktake in relation to integration and partnership working will take place over the next two months. This stocktake will focus on the six key areas:

- Integration, cooperation and partnerships;
- The boundary with the NHS;
- Delayed transfer of care;
- Working with housing authorities and providers;
- Working with employment and welfare services;
- Delegation of local authority functions.

The stocktake will be reported through the ASC Board and we will work with the CCGs on these areas. Any risk factors identified will be reported to the CCGs and the Council.

3.6 We are currently negotiating with the Carers' Centre a service re-design to support our implementation of the Care Act and Better Care Fund. We will also be reviewing the current process that supports Carers' Assessments to ensure that we will be compliant with the duties under the Care Act.

4. Recommendations

That the Governing Body receives the contents of the report, noting in particular points 2.3 and 3.5 and agrees to work with Sefton Council.

Dwayne Johnson
November 2014

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
November 2014

Agenda Item: 14/156	**Author of the Paper:** Jan Leonard Chief Redesign and Commissioning Officer Email: jan.leonard@southportandformbyccg.nhs.uk Tel: 01704 387034
Report date: November 2014	

Title: Commissioning Policy Review

Summary/Key Issues:

Historically local Primary Care Trusts jointly agreed a Commissioning Policy; this was known as the Cheshire and Merseyside Prior Approval Scheme and incorporated Procedures of Limited Clinical Value (2011). The policy was due for review and Cheshire and Merseyside Commissioning Support Unit (CSU) were commissioned to undertake the review on behalf of all the Cheshire and Merseyside Clinical Commissioning Groups (CCGs).

This paper presents the Governing Body with details of the review, the engagement undertaken, the financial impact and the full policy.

The full policy is included in Appendix A and the Fertility policy in appendix B (this forms part of the Commissioning policy). Appendix C contains the Equality Impact Assessment that was undertaken.

The Governing Body is asked to approve the policy.

Recommendation

The Governing Body is asked to approve this policy.

Receive	
Approve	x
Ratify	

NHS
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Clinical Commissioning Group

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

Process	Yes	No	N/A	Comments/Detail
Patient and Public Engagement	x			Public consultation has taken place
Clinical Engagement	x			
Equality Impact Assessment	x			The revised policy has been equality impact assessed. The report is included in Appendix C.
Legal Advice Sought		x		
Resource Implications Considered	x			
Locality Engagement	x			
Presented to other Committees	x			Quality Committee, Finance and Resource Committee in July 2014

Links to National Outcomes Framework	
	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

Report to the Governing Body
November 2014

1. Introduction and Background

1.1 Historically local Primary Care Trusts jointly agreed a Commissioning Policy; this was known as the Cheshire and Merseyside Prior Approval Scheme and incorporated Procedures of Limited Clinical Value (2011). The policy was due for review and Cheshire and Merseyside Commissioning Support Unit (CSU) were commissioned to undertake the review on behalf of all the Cheshire and Merseyside Clinical Commissioning Groups (CCGs).

CCGs are legally obliged to have in place and publish arrangements for making decisions and adopting policies on whether particular health care interventions are to be made available. The revised Commissioning Policy is intended to be a statement of such arrangements and act as a guidance document for patients, clinicians and other referrers in primary and secondary care. It sets out the eligibility criteria under which the CCG will commission the service, either via existing contracts or on an individual basis. It gives guidance to referrers on the policies of the CCGs in relation to the commissioning of procedures of low clinical priority, thresholds for certain treatment and those procedures requiring individual approval. In making these arrangements, CCG has had regard to relevant law and guidance, including their duties under the National Health Service Act 2006, the Health and Social Care Act 2012 and the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012; the Joint Strategic Needs Assessment; and relevant guidance issued by NHS England.

1.2 The Review Process

A seven stage approach was developed and agreed which involved:

Stage 1	Policy stimulation - practice or evidence
Stage 2	Evidence review
Stage 3	Pre Equality Impact Assessment
Stage 4	Production of a potential policy for CCG primary approval
Stage 5	Engagement- patients, carers, members of the public, referrers and providers
Stage 6	Review consultation findings, final approval by CCG and full Equality Impact Assessment
Stage 7	Policy Implementation and monitoring

A full evidence review was undertaken by CSU considering NICE guidance and the most up to date clinical evidence base. This was been supported by Public Health who undertook independent reviews in a number of areas.

Following this review CSU developed draft policies for consultation.

1.3 Public Consultation

Cheshire and Merseyside Clinical Commissioning Groups wanted to ensure that local patients, carers and members of the public were aware of NICE guidance and to gauge opinion in respect of the guidance when forming policy on procedures of low clinical priority.

The need for formal consultation (90 days) was agreed for all 12 CCGs in January 2014. 10 CCGs (including NHS South Sefton CCG) began the process on 6th January and 9 closed their consultation on 7th April, NHS Knowsley CCG extended their consultation for a further 10 days until 17th April. NHS Wirral CCG and NHS Liverpool CCG started their process later and closed on 30th April and 3rd June respectively.

To support the consultation plain English summaries were produced covering each of the 37 specialties (and 99 treatments/procedures). Each summary was colour-coded to denote whether the NICE or national guidance was recommending major, moderate or no change to the status quo. A two- page summary document answered a series of questions in lay terms.

This collaboration consultation across the Cheshire and Merseyside footprint resulted in 5,827 people visiting the CSU website, 535 people completing the survey and 72 public events taking place during the formal consultation period.

A number of engagement activities and public events took place across South Sefton CCG which were widely publicised during the 90-day formal consultation process:

- Presentations to public groups;
- Presentation to the Health Overview and Scrutiny Committee;
- Posters in CCG GP Member Practices;
- Availability of information in alternative formats;
- Plain English summaries covering each of the 37 specialties (and 99 treatments/procedures);
- Each summary was colour-coded (as depicted above) to denote whether the NICE or national guidance was recommending major, moderate or no change to the status quo;
- A suite of CSU-hosted web pages to which CCGs could direct a wide range of audiences with varying levels of understanding. The suite of web pages offered ascending levels of detail so viewers could access the information they needed;
- An online survey to gather feedback from patients, carers and non-clinicians;
- A dedicated, separate e-mail address was also set up to gather feedback from clinicians;
- A template press release to support locality communications leads to promote the policy review;
- A template poster so CCG engagement leads could promote local engagement.

In addition, a Freephone helpline was set up to accept feedback from callers with no access to the Internet. The Communications Team also produced a patient letter explaining why the review was needed and how to feedback comments to support this process.

1.4 Results

12 responses were received from within the NHS South Sefton Clinical Commissioning Group locality. Of the 12 responses, 33% of respondents were aged between 24-34, a further 33% were aged 65+, 16% were aged 45-54 and a further 16% were aged 55-64.

The majority of the respondents stated that they were commenting generally and not on a specific area of the consultation.

1.5 Post Consultation Process

Following the conclusion of each CCG's 90-day formal consultation process a number of activities took place:

- A structured approach to handling patient and public feedback was adopted in order to ensure all views were considered. All survey data for each CCG was compiled into a report;
- All clinical feedback was considered and collated to inform the policy;
- Provider feedback was considered and collated to inform the policy;
- An equality impact assessment was undertaken to ensure adherence to the Equality Duty 2010. As a result a number of changes were made to the draft policy;
- A Clinical Commissioning Group Position Meeting took place to promote discussion between CCGs, and seek agreement to a single policy across all Cheshire & Mersey CCGs, taking into consideration the patient, carer and public feedback, alongside feedback which has been received from clinicians and providers;
- The final draft policy was provided to CCGs on 2nd July 2014, each CCG is now asked to formally consider whether it would like to adopt the updated policy;
- The revised policy will be issued to providers via a contract variation following Governing body approval.

2.0 Key Issues

The Policy has been updated to include new statements about the following:-

Section	Area
3	Diabetes Continuous Blood Glucose Monitoring
4	Adenoidectomy Sinus x-ray Rhinohpyma
7	Asymptomatic Gallstones
9	Chronic Fatigue Syndrome Non NHS Drug and Alcohol Rehabilitation Private Mental Health Services
10	Bobath Therapy Trophic Electrical Stimulation Functional Electrical Stimulation
11	Cataracts Coloured Lens Filters Intra Ocular Telescope
13	Cranial Banding
16	Early Management of Back Pain Peripheral Nerve Field Stimulation Endoscopic Lumber Decompression Percutaneous Disc Decompression Non Rigid Stabilisation Techniques Lateral Interbody Fusion Percutaneous Intradiscal Laser Ablation Transaxial Interbody Lumbosacral Fusion Therapeutic Endoscopic Division of Epidural Adhesions Automated Percutaneous Mechanical Lumbar Discectomy Prosthetic Intervertal Disc Replacement Bone Morphogenetic Proteins Hyluronic Acid and Derivatives Injections Palmer Fasciectomy Hip Arthroscopy Surgical Removal Bunions Surgical Treatment Morton's Neuroma Surgical Treatment Plantar Fasciitis
17	Circumcision Reversal Male Sterilisation Extracorporeal Shockwave Therapy Hyperthermia for Prostadynia
18	Hyperhidrosis Chelation Therapy for Vascular Occlusion

A number of other areas included in the previous policy have had changes made to the criteria or wording.

Two significant areas also reviewed within the policy are varicose veins and fertility treatment.

2.1 Varicose Veins

The New NICE guidance recommends that all patients with symptoms are offered advice, reassurance and interventional treatments, eg endothermal ablation, foam sclerotherapy and surgery. Implementing the NICE guidance for varicose veins will require additional resources and the cost assumptions have again been shared with CCGs. However discussions with providers and CCGs indicated that there was some concerns about the assumptions made by NICE. The Public health team conducted a review and found that:

- The disease codes used may not be fully comprehensive;
- The prevalence of varicose veins was assumed to be 25%, although this could range between 20 – 40%;
- There was an assumption that the ratio of surgery to endothermal ablation, ablation to foam and guided sclerotherapy is 52%:35%:13%. This needs to be tested out in practice;
- NICE expect around 70% of procedures in future to consist of ablation therapy, this needs to be tested out.

There was also concern about the capacity within existing vascular services to cope with additional demand.

Based on these findings, it is recommended that the 12 CCGs in Cheshire and Merseyside commit to an extension of the review and consultation on this new guidance.

2.2 Fertility Treatment

NICE published updated guidance last year. The recommendations include:

- offering 3 full cycles of IVF treatment to women aged under 40;
- extending the upper age limit to receive treatment to 40;
- offer women aged 40 and up to 42, 1 full cycle provided they have never previously had IVF.

CCGs are not duty-bound to adhere to NICE guidance but must demonstrate that they have given them proper consideration and have good reasons for not following them. NICE has published a draft statement to help eliminate the so called ‘postcode lottery’ of treatment and support for people with fertility problems. Clearly infertility and the wish to have a child is a very emotive issue. There have recently been a number of successful legal challenges in this area. The equality analysis report undertaken as part of the policy review recommended that CCGs adopt NICE guidelines for Fertility services as part of meeting the Public Sector Equality Duty under advancing the equality of opportunity.

The revised policy takes into account these changes as well as a number of other recommendations have been made as part of this work relating to pre-conceptual guidance and the number of embryos transferred in line with the NICE Guidance.

There has been no change to the definition of childlessness.

Cost summary

NHS Funded IVF Cycles received	Increase to 3 Cycles	Increase in Age extension	Cycles using ICSI	Total Increase annual	Year 1 40%	Year 2 80%	Year 3 100%	Year 4 100%	Year 5 100%	Total
47	22	5	2	29	£80,607	£121,612	£142,114	£73,139	£73,139	£490,611

Funding has been set-aside in reserves to fund increases in fertility treatment. The CCG has also included increases in this area within its 5 year financial plan.

3. Conclusions

The policy has made a number of changes based on the best available evidence and guidance. The views of the public and providers have been sought and these have been reflected in the final document. It is not possible to make an assessment of the financial impact of all the changes given the wide variety of procedures covered and the small numbers affected in many cases.

4. Recommendations

- The Governing Body is asked to approve the adoption the revised Commissioning Policy and Revised Fertility Policy.

- It is recommended that collaboratively CCGs review the impact of the new NICE guidance on varicose veins.

Appendices

Appendix A - Commissioning Policy
Appendix B - Infertility Policy
Appendix C - Equality Impact Assessment

Jan Leonard
November 2014

CHESHIRE & MERSEYSIDE

Commissioning Policy

CRITERIA

2014/15

Proposed Review Date: September 2015

Introduction

The Cheshire and Merseyside CCGs are legally obliged to have in place and publish arrangements for making decisions and adopting policies on whether particular health care interventions are to be made available in Cheshire and Merseyside. This document is intended to be a statement of such arrangements made by the Cheshire and Merseyside CCGs and act as a guidance document for patients, clinicians and other referrers in primary and secondary care. It sets out the eligibility criteria under which Cheshire and Merseyside CCGs will commission the service, either via existing contracts or on an individual basis. It gives guidance to referrers on the policies of the CCGs in relation to the commissioning of procedures of low clinical priority, thresholds for certain treatment and those procedures requiring individual approval.

In making these arrangements, the Cheshire and Merseyside CCGs have had regard to relevant law and guidance, including their duties under the National Health Service Act 2006, the Health and Social Care Act 2012 and the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012; the Joint Strategic Needs Assessment; and relevant guidance issued by NHS England.

The Cheshire and Merseyside CCGs have a duty to secure continuous improvement in the quality of services and patient outcomes, but are also under a duty to exercise their functions effectively, efficiently and economically. Therefore, health benefits must be maximised from the resources available. As new services become available, demand increases and procedures that give maximum health gain must be prioritised. This means that certain procedures will not be commissioned by CCGs unless exceptional clinical grounds can be demonstrated. The success of the scheme will depend upon commitment by GPs and other clinicians to restrict referrals falling outside this protocol.

The NHS standard contract specifies that the Co-ordinating Commissioner will agree with the Provider the circumstances where the Provider will need to seek prior approval (PA) to confirm the appropriateness of a proposed intervention or course of treatment. It is expected that such schemes focus on procedures of limited/low clinical effectiveness, or infrequent high cost and/or complex procedures. In designing and implementing PA schemes, individual patient needs must remain paramount. (Reference Guidance on the Standard NHS contract for Acute Hospital Services, community and Mental Health & Learning Disabilities.

Ideally the Co-ordinating Commissioner will agree a single set of PA requirements with which each Provider is expected to comply. However, there may be exceptional circumstances in which an Associate CCG needs to specify its own PA requirements. Agreeing a Cheshire and Merseyside Prior Approval Policy will improve equity of access to services, value for money and clinical effectiveness across the network.

CCGs will not pay for activity unless it meets the criteria set out in the document or individual approval has been given and the Referral and Approval Process as set out has been followed. This prior approval scheme will be incorporated into all NHS standard NHS contracts agreed by CCGs. Compliance with this policy will be monitored via regular benchmarking reports and case note audits.

To support this approach a set of Core Clinical Eligibility Criteria have been developed and are set out below, patients may be referred in accordance with the referral process if they meet these criteria. In some limited circumstances, a ‘Procedure of Lower Clinical Priority’ (PLCP) may be the most clinically appropriate

intervention for a patient. In these circumstances, agreed eligibility criteria have been established and these are explained, in the later sections of the document, if the criteria are met the procedure will be commissioned by the CCG.

Core Clinical Eligibility

Patients may be referred in accordance with the referral process where they meet any of the following Core Clinical Eligibility criteria:

- All NICE Technology Appraisals will be implemented.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually available on the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. Leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- Any patient who needs urgent treatment will always be treated.
- No treatment is completely ruled out if an individual patient's circumstances are exceptional. Requests for consideration of exceptional circumstances should be made to the patients responsible CCG – see the exceptionality criteria in this policy and the contact details at Appendix 1.
- Children under 16 years are eligible for surgery to alter appearance, improve scars, excise facial or other body lesions, where such conditions cause obvious psychological distress.

Referral & Approval Process

Interventions specified in this document are not commissioned unless clinical criteria are met, except in exceptional circumstances. Where clinical criteria are met treatment identified will form part of the normal contract activity.

If a General Practitioner/Optometrist/Dentist considers a patient might reasonably fulfil the eligibility criteria for a Procedure of Lower Clinical Priority, as detailed in this document **(i.e. they meet the specific criteria listed for each treatment)** the General Practitioner/Optometrist/Dentist should follow the process for referral. If in doubt over the local process, the referring clinician should contact the General Practitioner. Failure to comply with the local process may delay a decision being made. The referral letter should include specific information regarding the patient's **potential** eligibility.

Diagnostic procedures to be performed with the sole purpose of determining whether or not a Procedure of Lower Clinical Priority is feasible ***should not*** be carried out unless the eligibility criteria are met or approval has been given by the CCG or GP (as set out in the approval process of the patients responsible CCG) or as agreed by the CCG as an exceptional case.

The referral process to secondary care will be determined by the responsible CCGs. Referrals will either:

- Have been prior approved by the CCG.
  OR
- Clearly state how the patient meets the criteria.
  OR
- Be for a clinical opinion to obtain further information to assess the patient's eligibility.

GPs should <u>not</u> refer unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. In cases where there may be an element of doubt the GP should discuss the case with the IFR Team in the first instance.

If the referral letter does not clearly outline how the patient meets the criteria then the letter should be returned to the referrer for more information and the CCG notified. Where a GP requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given to the GP and the patient returned to the GP's care, in order for the GP to make a decision on future treatment.

The secondary care consultant will also determine whether the procedure is clinically appropriate for a patient and whether the eligibility criteria for the procedure are fulfilled or not and may request additional information before seeing the patient. Patients who fulfil the criteria may then be placed on a waiting list according to their clinical need. The patient's notes should clearly reflect exactly how the criteria were fulfilled, to allow for case note audit to support contract management. Should the patient not meet the eligibility criteria this should be recorded in the patient's notes and the consultant should return the referral back to the GP with a copy to the CCG, explaining why the patient is not eligible for treatment.

Should a patient not fulfil the clinical criteria but the referring clinician is willing to support the application as **<u>clinically exceptional</u>**, the case can be referred to the IFR Team for assessment contact details for the IFR team can be found in Appendix 1.

Exceptionality

In dealing with exceptional case requests for an intervention that is considered to be a poor use of NHS resources, the Cheshire & Merseyside CCGs have endorsed through the CCG Alliance the following description of exceptionality contained in a paper by the NW Medicines and Treatment Group:

The patient has a clinical picture that is significantly different to the general population of patients with that condition ***and as a result of that difference;*** *the patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition.*

Further details on exceptionality can be found at this link:

http://www.nhsconfed.org/Publications/Documents/Priority%20setting%20managing%20individual%20funding%20requests.pdf

The Cheshire & Merseyside CCGs are of the opinion that exceptionality should be defined solely in clinical terms. To consider social and other non-clinical factors automatically introduces inequality, implying that some patients have a higher intrinsic social worth than others with the same condition. It runs contrary to a basic tenet of the NHS namely, that people with equal need should be treated equally. Therefore non-clinical factors will not be considered except where this policy explicitly provides otherwise.

In essence, exceptionality is a question of equity. The CCG must justify the grounds upon which it is choosing to fund treatment for a particular patient when the treatment is unavailable to others with the condition.

Psychological Distress

Psychological distress alone will not be accepted as a reason to fund surgery except where this policy explicitly provides otherwise Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image but it should not be regarded as route into aesthetic surgery.

Unless specifically stated otherwise in the policy any application citing psychological distress will need to be considered as an IFR. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases ideally an NHS psychologist with expertise in body image or an NHS mental health professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention

Personal Data (including Photographs)

In making referrals to the IFR Team, clinicians and other referrers in primary and secondary care should bear in mind their obligations under the Data Protection Act 1998 and their duty of confidence to patients. Where information about patients (including photographs) is sent to the IFR Team and is lost or inadvertently disclosed to a third party before it is safely received by the IFR Team, the referrer will be legally responsible for any breach of the Data Protection Act 1998 or the law of confidence.

Therefore, please consider taking the following precautions when using the Royal Mail to forward any information about patients including photographic evidence:

- Clearly label the envelope to a named individual i.e. first name & surname, and job title.
- Where your contact details are not on the items sent, include a compliment slip indicating the sender and their contact details in the event of damage to the envelope or package.
- Use the Royal Mail Signed for 1st Class service, rather than the ordinary mail, to reduce the risk of the post going to the wrong place or getting lost.

Information in Payment: Costs incurred for photographic evidence will be the responsibility of the referrer. Photographic evidence is often required in cases which are being considered on exceptionality. They are reviewed by clinical member/s of the IFR team only.'

Medicines Management

Prior approval for treatment should always be sought from the responsible Medicine Management Team when using medicines as follows:

- Any new PbR excluded drug where the drug has not yet been approved / prioritised for use in agreement with the local CCG.
- Any existing PbR excluded drugs to be used outside of previously agreed clinical pathways/indication.
- Any PbR excluded drugs that are being used out with the parameters set by NICE both in terms of disease scores or drug use. It must not be assumed that a new drug in the same class as one already approved by NICE can be used, this must be subject to the process in Point 1.
- Any drug used out with NICE GUIDANCE (where guidance is in existence).
- Any proposed new drug / new use of an existing drug (whether covered by NICE or PBR excluded or not) should first be approved by the relevant Area Medicines Management Committee, and funding (where needed) agreed in advance of its use by the relevant CCG.
- Any medicines that are classed by the CCG as being of limited clinical value.
- Any medicines that will be supplied via a homecare company agreement.

The Clinical Commissioning Group does not expect to provide funding for patients to continue treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have on-going access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

NOTE: funding for all solid and haematological cancers are now the responsibility of NHS England.

Conditions & Interventions

The conditions & interventions have been broken down into speciality groups.

GPs should only refer if the patient meets the criteria set out or individual approval has been given by the CCG as set out in the CCGs process as explained above. Requests for purely cosmetic surgery will not be considered except where this policy explicitly provides otherwise. Patients meeting the core clinical eligibility criteria set out above can be referred, all other referrals should be made in accordance with the specified criteria and referral process. The CCG may request photographic evidence to support a request for treatment.

From time to time, CCGs may need to make commissioning decisions that may suspend some treatments/criteria currently specified within this policy.

Evidence

At the time of publication the evidence presented was the lost current available. Where reference is made to publications over five years old, this still represents the most up to date view.

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
1.	**Complementary Therapies**			
1.1	Complementary Therapies	Not routinely commissioned unless recommended by NICE guidance.	*Complementary and alternative medicine* – NHS Choices 2012. http://www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/inquiries/homeopathy-/	
2.	**Dermatology**			
2.1	Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)	Only be commissioned in the following circumstances: Severe scarring following: • acne once the active disease is controlled. • chicken pox. Or • trauma (including post-surgical). Procedures will only be performed on the head and neck area. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Modernisation Agency's Action on Plastic Surgery 2005. Hædersdal, M., Togsverd-Bo, K., & Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. *Journal of the European Academy of Dermatology and Venereology*, *22*, 267–78. Department of Dermatology, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark. Collated on NHS evidence website suggests that short-term efficacy from optical treatments for acne vulgaris with the most consistent outcomes for PDT. www.evidence.nhs.uk Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013)	

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
			Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	
2.2	Surgical or Laser Therapy Treatments for Minor Skin Lesions e.g. benign pigmented moles, milia, skin tags, keratoses (basal cell papillomata), sebaceous cysts, corn/callous dermatofibromas, comedones, molluscum contagiosum chalazion Surgical Treatment for Removal of Lipoma in Secondary Care.	Will be commissioned in any of the following circumstances: • Symptomatic e.g. ongoing pain or functional impairment. • Risk of infection. • Significant facial disfigurement. • All vascular lesions on the face except benign, acquired vascular lesions such as thread veins. Will only be commissioned where severely functionally disabling and/ or subject to repeated trauma due to size and/or position. Lipomas that are under 5cms should be observed only unless the above applies.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Modernisation Agency's Action on Plastic Surgery 2005. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Noninvasive lipoma size reduction using high-intensity focused ultrasound – Dermatologic Surgery 2013 Oct;39(10):1446-51.	Uncomplicated benign skin lesions should NOT be referred. Send suspected malignancy on appropriate pathway. Consider if benefit outweighs risk associated with surgery. Consider Primary Care or community service. Lipomas located on the body that are over 5cms in diameter, or in a sub-fascial position, which have also shown rapid growth and are painful should be referred to an appropriate skin cancer clinic.
2.3 NEW	Treatments for Skin Pigment Disorders.	NHS Cosmetic Camouflage is commissioned. This is provided by Changing Faces formerly the Red Cross.*	No guidance found. http://www.changingfaces.org.uk/Skin-Camouflage	Initially the recommended NHS suitable treatment for

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
		Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	hypo – pigmentation is biopsy of suspicious lesions only. Access to a qualified camouflage beautician should be available on the NHS for Cosmetic Camouflage and other skin conditions requiring camouflage. * Access available for Wirral patients via Dermatology Department.
2.4	Surgical Laser Therapy for Viral Warts (excluding Genital Warts) from Secondary Care Providers.	Will be commissioned in any of the following circumstances: • Severe Pain substantially interfering with functional abilities. • Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment. Or • Extensive warts (particularly in the immune-suppressed patient). • Facial warts. Patients with the above exceptional symptoms may	Modernisation Agency's Action on Plastic Surgery 2005. Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service patient.co.uk/doctor/viral-warts-excluding-verrucae http://www.patient.co.uk/doctor/verrucae	Most viral warts will clear spontaneously or following application of topical treatments. 65% are likely to disappear spontaneously within 2 years. There are numerous OTC preparations available. Community

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
		need specialist assessment, usually by a dermatologist.		treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care.
3.	**Diabetes**			
3.1 NEW	Continuous Glucose Monitoring Systems for Continuous Glucose Monitoring in Type 1 Diabetes Mellitus.	Not routinely commissioned and only considered if **ALL** of the following criteria are met; • Type I diabetes • AND currently on a sensor augmented continuous subcutaneous insulin pump in strict accordance with NICE appraisal TAG 151. • AND $HbA_{1c} \geq 8.5\%$ OR experiencing severe hypoglycaemic attacks which require intervention by a carer. • AND selected to use an approved sensor augmented pump system of high specification with a low Mean Absolute Relative Difference (MARD) value. • AND managed by a recognised centre of excellence in diabetes (currently using a minimum of 20 continuous infusion pumps per annum). • AND motivated to comply with the requirements. • The device should be withdrawn from patients who fail to achieve clinically	Continuous glucose monitoring systems for type 1 diabetes mellitus – Cochrane Database of Systematic Reviews, 2012. Beneficial effect of real-time continuous glucose monitoring system on glycaemic control in type 1 diabetic patients: systematic review and meta-analysis of randomized trials. – European Journal of Endocrinology. 2012 Apr; 166(4):567-74. Glycaemic control in type 1 diabetes during real time continuous glucose monitoring compared with self-monitoring of blood glucose: meta-analysis of randomised controlled trials using individual patient data - BMJ. 2011; 343: d3805. Continuous Glucose Monitoring for Patients with Diabetes – Ontario: Health Quality Ontario, 2011. Continuous glucose monitoring: consensus statement on the use of glucose sensing in outpatient clinical diabetes care - British Society for Paediatric Endocrinology and Diabetes, 2009. Liebl A, Henrichs HR, Heinemann L, Freckmann G, Biermann E, Thomas A et al. Continuous glucose monitoring: evidence and consensus statement for clinical use. *Journal of Diabetes Science & Technology* 2013;	PH Continuous Glucose Monitors.doc Continuous Glucose Monitors Addendum.c

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
		significant response after 6 months. All cases will be subject to individual approval by the IFR Team.	**7**(2):500-519. Larson NS, Pinsker JE. The role of continuous glucose monitoring in the care of children with type 1 diabetes. *International Journal of Pediatric Endocrinology* 2013; **2013**(1). DeSalvo D, Buckingham B. Continuous glucose monitoring: current use and future directions. *Current Diabetes Reports* 2013; **13**(5):657-662. Chinese DS. Chinese clinical guideline for continuous glucose monitoring (2012). *Chinese Medical Journal* 2012; **125**(23):4167-4174. Hammond PJ, Amiel SA, Dyan CM, Kerr D, Pickup JC. ABCD position statement on continuous glucose monitoring: use of glucose sensing in outpatient clinical diabetes care. *Pract Diab Int* 2010; **27**(2):66-68. Gifford R. Continuous glucose monitoring: 40 years, what we've learned and what's next. *Chemphyschem* 2013; **14**(10):2032-2044. Langendam M, Luijf YM, Hooft L, DeVries JH, Mudde AH, Scholten RJ. Continuous glucose monitoring systems for type 1 diabetes mellitus. *Cochrane Database of Systematic Reviews* 2012; **1**. Kasapkara CS, Cinasal G, Hasanoglu A, Tumer L. Continuous glucose monitoring in children with glycogen storage disease type I. *European Journal of Clinical Nutrition* 2014; **68**(1):101-105. Freckmann G, Pleus S, Link M, Zschornack E, Klotzer HM,	

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
			Haug C. Performance evaluation of three continuous glucose monitoring systems: comparison of six sensors per subject in parallel. *Journal of Diabetes Science & Technology* 2013; **7**(4):842-853. Pleus S, Schmid C, Link M, Zschornack E, Klotzer HM, Haug C et al. Performance evaluation of a continuous glucose monitoring system under conditions similar to daily life. *Journal of Diabetes Science & Technology* 2013; **7**(4):833-841. Leelarathna L, Nodale M, Allen JM, Elleri D, Kumareswaran K, Haidar A et al. Evaluating the accuracy and large inaccuracy of two continuous glucose monitoring systems. *Diabetes Technology & Therapeutics* 2013; **15**(2):143-149. Luijf YM, Avogaro A, Benesch C, Bruttomesso D, Cobelli C, Ellmerer M et al. Continuous glucose monitoring accuracy results vary between assessment at home and assessment at the clinical research center. *Journal of Diabetes Science & Technology* 2012; **6**(5):1103-1106. Mensh BD, Wisniewski NA, Neil BM, Burnett DR. Susceptibility of interstitial continuous glucose monitor performance to sleeping position. *Journal of Diabetes Science & Technology* 2013; **7**(4):863-870. Luijf YM, Mader JK, Doll W, Pieber T, Farret A, Place J et al. Accuracy and reliability of continuous glucose monitoring systems: a head-to-head comparison. *Diabetes Technology & Therapeutics* 2013; **15**(8):722-727. Damiano ER, El-Khatib FH, Zheng H, Nathan DM, Russell SJ. A comparative effectiveness analysis of three continuous glucose monitors. *Diabetes Care* 2013;	

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
			36(2):251-259. Sato J, Hirose T, Watada H. Continuous glucose monitoring system: Is it really accurate, safe and clinically useful? *Journal of Diabetes Investigation* 2012; **3**(3):225-230. Zhou J, Lv X, Mu Y, Wang X, Li J, Zhang X et al. The accuracy and efficacy of real-time continuous glucose monitoring sensor in Chinese diabetes patients: a multicenter study. *Diabetes Technology & Therapeutics* 2012; **14**(8):710-718. Barry D, Mastrototaro JJ, Weinzimer SA, Steil GM. Interstitial fluid glucose time-lag correction for real-time continuous glucose monitoring. *Biomedical Signal Processing and Control* 2013; **8**(1):81-89. Heinemann L, DeVries JH. Evidence for continuous glucose monitoring: sufficient for reimbursement ? *Diabetic Medicine* 2014; **31**:122-125. Choudhary P, Ramasamy S, Green L, Gallen G, Pender S, Brackenridge A et al. Real-time continuous glucose monitoring significantly reduces severe hypoglycemia in hypoglycemia-unaware patients with type 1 diabetes. *Diabetes Care* 2013; **36**(12):4160-4162. Moreno-Fernandez J, Gomez FJ, Gazquez M, Pedroche M, Garcia-Manzanares A, Tenias JM et al. Real-time continuous glucose monitoring or continuous subcutaneous insulin infusion, what goes first?: results of a pilot study. *Diabetes Technology & Therapeutics* 2013; **15**(7):596-600. Langeland LBL, Salvesen O, Selle H, Carlsen SM, Fougner	

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
			KJ. Short-term continuous glucose monitoring: Effects on glucose and treatment satisfaction in patients with type 1 diabetes mellitus; A randomized controlled trial. *International Journal of Clinical Practice* 2012; **66**(8):741-747. Effect of sensor-augmented insulin pump therapy and automated insulin suspension vs standard insulin pump therapy on hypoglycemia in patients with type 1 diabetes: a randomized clinical trial. *JAMA* 2013; **310**(12):1240-1247. Norgaard K, Scaramuzza A, Bratina N, Lalic NM. Routine sensor-augmented pump therapy in type I diabetes: The INTERPRET study. *Diabetes Technology & Therapeutics* 2013; **15**(4):273-280. Leinung M, Nardacci E, Patel N, Bettadahalli S, Paika K, Thompson S. Benefits of short-Term professional continuous glucose monitoring in clinical practice. *Diabetes Technology and Therapeutics* 2013; **15**(9):744-747. Bay C, Kristensen PL, Pedersen-Bjergaard U, Tarnow L, Thorsteinsson B. Nocturnal continuous glucose monitoring: accuracy and reliability of hypoglycemia detection in patients with type 1 diabetes at high risk of severe hypoglycemia. *Diabetes Technology & Therapeutics* 2013; **15**(5):371-377. Zijlstra E, Heise T, Nosek L, Heinemann L, Heckermann S. Continuous glucose monitoring: quality of hypoglycaemia detection. *Diabetes, Obesity & Metabolism* 2013; **15**(2):130-135. Choudhary P, Lonnen K, Emery CJ, Freeman JV, McLeod KM, Heller SR. Relationship between interstitial and blood	

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
			glucose during hypoglycemia in subjects with type 2 diabetes. *Diabetes Technology & Therapeutics* 2011; **13**(11):1121-1127. Renard E. Application of continuous glucose monitoring to identify nocturnal hypoglycemia in people with type 1 diabetes. *Diabetic Hypoglycemia* 2012; **5**(1):12-14. Phillip M, Danne T, Shalitin S, Buckingham B, Laffel L, Tamborlane W et al. Consensus statement: Use of continuous glucose monitoring in children and adolescents. *Pediatric Diabetes* 2012; **13**(3):215-228. Polonsky WH, Hessler D. What are the quality of life-related benefits and losses associated with real-time continuous glucose monitoring? A survey of current users. *Diabetes Technology and Therapeutics* 2013; **15**(4):295-301. Poolsup N, Suksomboon N, Kyaw AM. Systematic review and meta-analysis of the effectiveness of continuous glucose monitoring (CGM) on glucose control in diabetes. *Diabetology and Metabolic Syndrome* 2013; **5**(1). Voormolen DN, DeVries JH, Evers IM, Mol BW, Franx A. The efficacy and effectiveness of continuous glucose monitoring during pregnancy: a systematic review. *Obstetrical & Gynecological Survey* 2013; **68**(11):753-763. Diabetes in pregnancy: Management of diabetes and its complications from pre-conception to the postnatal period. 63, 1-42. 2008. London, National Institute for Health and Care Excellence. Clincal Guideline. Meade LT. The use of continuous glucose monitoring in	

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
			patients with type 2 diabetes. *Diabetes Technology & Therapeutics* 2012; **14**(2):190-195. Schmidt S, Duun-Henriksen AK, Norgaard K. Psychosocial factors and adherence to continuous glucose monitoring in type 1 diabetes. *Journal of Diabetes Science & Technology* 2012; **6**(4):986-987. McQueen RB, Ellis SL, Campbell JD, Nair KV, Sullivan PW. Cost-effectiveness of continuous glucose monitoring and intensive insulin therapy for type 1 diabetes. *Cost Effectiveness & Resource Allocation* 2011; **9**. Lane JE, Shivers JP, Zisser H. Continuous glucose monitors: current status and future developments. *Current Opinion in Endocrinology, Diabetes & Obesity* 2013; **20**(2):106-111. Mauras N, Fox L, Englert K, Beck RW. Continuous glucose monitoring in type 1 diabetes. *Endocrine* 2013; **43**(1):41-50. Szypowska A, Ramotowska A, Dzygalo K, Golicki D. Beneficial effect of real-time continuous glucose monitoring system on glycemic control in type 1 diabetic patients: systematic review and meta-analysis of randomized trials. *European Journal of Endocrinology* 2012; **166**(4):567-574. Formosa N, Matyka K. Continuous glucose monitoring in children and adolescents with type 1 diabetes mellitus: A literature review. *Archives of Disease in Childhood* 2012; **97**. Yeh HC, Brown TT, Maruthur N. Comparative effectiveness and safety methods of insulin delivery and glucose monitoring for diabetes mellitus: A systematic review and	

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
			meta-analysis. *Annals of Internal Medicine* 2012; **157**:336-347. Bergenstal RM, Tamborlane WV, Ahmann A, Buse JB, Dailey G, Davis SN. Effectiveness of sensor-augmented insulin-pump therapy in type I diabetes. *N Engl J Med* 2010; **363**(4):311-320. Clinical policy bulletin: Diabetes tests, programs and supplies. http://www aetna com/cpb/medical/data/1_99/0070 html [2013 Corporate medical policy: Continuous monitoring of glucose in the interstial fluid. https://www bcbsnc com/assets/services/public/pdfs/medicalpolicy/continuous_monitoring_of_glucose_in_the_interstitial_fluid pdf [2013 :[1-8] Type 1 diabetes: diagnosis and management of type 1 diabetes in children, young people and adults. CG 115, 1-2. 2004. London, National Institute for Clinical Excellence. Clinical Guideline. Management of diabetes: A national clinical guideline. 116, 1-144. 2010. Edinburgh, Scottish Intercollegiate Guidelines Network. A national clinical guideline. American Diabetes Association. Position statement: Standards of medical care 2012. *Diabetes Care* 2012; **35**(Supp 1):s11-s 63. Continuous glucose monitoring: An endocrine society clinical practice guideline. *J Clin Endocrinol Metab* 2011; **96**(10):2968-2979.	
4.	**ENT**			

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
4.1 NEW	Adenoidectomy	Commissioned only in either of the following clinical situations. In Children For the treatment of obstructive sleep apnoea or upper airways resistance syndrome in combination with tonsillectomy. In conjunction with grommet insertion where there are significant nasal symptoms, in order to prevent repeat grommet insertion for the treatment of glue ear or recurrent otitis media. See 5.3 Adenoidectomy is not routinely commissioned as an isolated procedure.	http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0010/98659/FullReport-hta18050.pdf Health Technology Assessment Volume: 18 Issue: 5 Tonsillectomy and Adenoidectomy in Children with Sleep Related Breathing Disorders – The Royal College of Anaesthetists - July 2010. Adenoidectomy for recurrent or chronic nasal symptoms in children The Cochrane Library 2010. Adenoidectomy for otitis media in children The Cochrane Library 2010. Updated systematic review of tonsillectomy and adenoidectomy for treatment of paediatric obstructive sleep apnoea/hypopnea syndrome (Structured abstract) Centre for Reviews and Dissemination 2013. NICE “Do not do” recommendation: “Once a decision has been taken to offer surgical intervention for otitis media with effusion (OME) in children, insertion of ventilation tubes is recommended. Adjuvant adenoidectomy is not recommended in the absence of persistent and/or frequent upper respiratory tract symptoms.” http://www.journalslibrary.nihr.ac.uk/__data/assets/pdf_file/0004/98869/FullReport-hta18050.pdf Boonacker CW, Rovers MM, Browning GG, Hoes AW, Schilder AG, Burton MJ.Adenoidectomy with or without grommets for children with otitis media: an individual patient data meta-analysis. Health Technology Assessment 2014;18(5)	

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Evidence	Comments
4.2	Pinnaplasty – for Correction of Prominent Ears	May be commissioned in the following circumstances: To surgical "correction" of prominent ear(s) only when all of the following criteria are met: 1. Referral only for children aged 5 to 18 years at the time of referral AND 2. With very significant ear deformity or asymmetry Patients not meeting these criteria should not be routinely referred for surgery. Incisionless otoplasty is not commissioned.	Pinnaplasty Department of Health (2007). Local PCT consensus - review conducted 2007. Modernisation Agency's Action on Plastic Surgery 2005. IPG 422: Incisionless otoplasty NICE 2012. http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/pinnaplasty Royal College of Surgeons (2013).	Children under the age of five are usually oblivious and referrals may reflect concerns expressed by the parents rather than the child.

4.3	Insertion of Grommets for Glue Ear (otitis media with effusion)	**a. Children** The CCG will commission treatment with grommets / Myringotomy for children with otitis media with effusion (OME) where: There is also a history of recurrent acute otitis media (RAOM) defined as 3 or more acute infections in 6 months or at least 4 in a year. OR There has been a period of at least three months watchful waiting from the date of diagnosis of OME (by a GP/primary care referrer/ audiologist/ENT surgeon). AND • OME persists after three months AND • the child (who must be over three years of age) suffers from persistent bilateral OME with a hearing level in the better ear of 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) or worse confirmed over 3 months. OR Persistent bilateral OME with hearing loss Less than 25-30 dBHL (averaged at 0.5, 1, 2 and 4kHz) and with significant impact on the child's developmental, social or educational status. Children with Downs Syndrome are normally fitted with Hearing Aids. Management of children with cleft palate is under specialist supervision. Do Not perform adenoidectomy at the same time unless evidence of significant upper respiratory tract symptoms see Section 5.1 Adenoidectomy. **b. Adults** will fund grommets in adults with OME only in the following circumstances: Significant negative middle ear pressure measured on two sequential appointments AND significant ongoing associated pain. OR Unilateral middle ear effusion where a post nasal space biopsy is required to exclude an underlying malignancy.	http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome Royal College of Surgeons (2013). NICE Pathway – Surgical management of Otitis Media with effusion in children (2012). CG60 Surgical management of children with otitis media with effusion (OME) (February 2008). The advice in the NICE guideline covers: •the surgical management of OME in children younger than 12 years. •guidance for managing OME in children with Down's syndrome and in children with all types of cleft palate. It does not specifically look at the management of OME in: •children with other syndromes (for example, craniofacial dysmorphism or polysaccharide storage disease). •children with multiple complex needs. *Grommets (ventilation tubes) for hearing loss associated with otitis media with effusion in children* - Cochrane Ear, Nose and Throat Disorders Group 2010. http://pathways.nice.org.uk/pathways/surgical-management-of-otitis-media-with-effusion-in-children - path=view%3A/pathways/surgical-management-of-otitis-media-with-effusion-in-children/assessment-and-treatment-for-children-with-otitis-media-with-effusion-without-downs-syndrome-or-cleft-palate.xml&content=view-node%3Anodes-surgical-interventions	Page **20** of **104**

4.4	Tonsillectomy for Recurrent Tonsillitis (excluding peri-tonsillar abscess) Adults and Children	Tonsillectomy will only be commissioned where: • Seven or more well documented clinically significant adequately treated sore throats in the preceding year; or • Five or more such episodes in each of the previous two years; or • Three or more such episodes in each of the preceding three years. Is commissioned if appropriate following peri-tonsillar abscess. Tonsillectomy is not commissioned for tonsil stones or halitosis. Tonsillectomy may be appropriate for significant hypertrophy causing OSA. Tonsillectomy is recommended for severe recurrent sore throats in adults.	Scottish intercollegiate guidelines network. Management of sore throat and indications for tonsillectomy (April 2010) Guideline 117. Tonsillectomy or adeno-tonsillectomy versus non-surgical treatment for chronic/recurrent acute tonsillitis - Cochrane Ear, Nose and Throat Disorders Group (2008). Evidence note 23: Tonsillectomy for recurrent bacterial tonsillitis – Health Improvement Scotland (2008). Tonsillectomy or adeno-tonsillectomy effective for chronic and recurrent acute tonsillitis – Cochrane Pearls 2009. http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/tonsillectomy Royal College of Surgeons (2013)	Watchful waiting is more appropriate than tonsillectomy for children with mild sore throats.
4.5	Surgical Remodelling of External Ear Lobe.	This is not routinely commissioned.	Modernisation Agency's Action on Plastic Surgery 2005.	Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.
4.6 NEW	Use of Sinus X-ray	X-rays of sinuses are not routinely commissioned.	BSACI guidelines for the management of rhinosinusitis and nasal polyposis Clinical & Experimental Allergy Volume 38, Issue 2, Article first published online: 20 DEC 2007. NHS Choices Sinusitis http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rhinosinusitus Royal College of Surgeons (2013).	

4.7	Rhinoplasty - Surgery to Reshape the Nose.	This procedure is NOT available under the NHS on cosmetic grounds. Only commissioned in any of the following circumstances: • Objective nasal deformity caused by trauma. • Problems caused by obstruction of nasal airway. • Correction of complex congenital conditions e.g. cleft lip and palate. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Patients with isolated airway problems (in the absence of visible nasal deformity) may be referred initially to an Ear Nose and Throat (ENT) consultant for assessment and treatment.
4.8 NEW	Surgery of Laser Treatment of Rhinophyma	Not routinely commissioned.	Nuances in the management of rhinophyma Facial Plastic Surgery, 2012 Apr;28(2):231-7. http://www.patient.co.uk/doctor/Rosacea-and-Rhinophyma.htm Information for Commissioners of Plastic Surgery Services: Referrals and Guidelines in Plastic Surgery NHS Modernisation Agency 2009 (page 17).	The first-line treatment of this condition of the nasal skin is medical. However response is poor. Severe cases that do not respond to medical treatment may be considered for surgery or laser treatment in exceptional circumstances.
5.	**Equipment**			
5.1 NEW	Use of Lycra Suits	Lycra Suits are not normally commissioned for postural management of cerebral palsy. Evidence does not support routine commissioning of	What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy? Health Improvement Scotland, May 2013. Blackmore AM, Garbellini SA, Buttigieg P & Wells J. (2006)	Any application for exceptional funding should include a comprehensive

		Lycra suits in the management of Cerebral Palsy.	A systematic review of the effects of soft splinting on upper limb function in people with cerebral palsy. *An AACPDM Evidence Report* Coghill JE & Simkiss DE. (2010) Do Lycra garments improve function and movement in children with cerebral palsy. *Archives of Disease in Childhood* 95: 393-396. Corn K, Imms C, Timewell G, Carter C, Collins L, Dubbeld S, Schubiger S & Froude E. (2009) Impact of second skin Lycra splinting on the quality of upper limb movement in children. *British Journal of Occupational Therapy*, October 2003, vol.66/10(464-472), 0308-0226 Eddison N & Chockalingam N. (2013) The effect of tuning ankle foot orthoses-footwear combination on the gait parameters of children with cerebral palsy. *Prosthetics and Orthotics International*, vol.37/2(95-107), 0309-3646;1746-1553 Elliott CM, Reid SL, Alderson JA & Elliott BC. (2011) Lycra arm splints in conjunction with goal-directed training can improve movement in children with cerebral palsy. *NeuroRehabilitation*. vol.28/1(47-54), 1053-8135;1878-6448 Figueiredo EM, Ferreira GB, Maia Moreira RC, Kirkwood RN & Fetters L. (2008) Efficacy of ankle-foot orthoses on gait of children with cerebral palsy: systematic review of literature. *Pediatric physical therapy : the official publication of the Section on Pediatrics of the American Physical Therapy Association*, vol.20/3(207-223), 1538-005X Flanagan A, Krzak J, Peer M, Johnson P & Urban M. (2009) Evaluation of short-term intensive orthotic garment use in children who have cerebral palsy *Pediatric Physical Therapy*, 21: 201-4. Health Improvement Scotland (2013). *What is the clinical and cost effectiveness of dynamic elastomeric fabric*	assessment of the child's postural management needs with clear outcome goals and time frames. Public Health Recommendations: Current evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy. Lycra suit orthoses for cerebral palsy should be assigned low priority.  PH Lycra Suits Review.doc

			orthoses (DEFOs) for cerebral palsy? Knox V. (2003) The use of Lycra garments in children with cerebral palsy: A report of a descriptive clinical trial. *British Journal of Occupational Therapy*, vol.66/2(71-77), 0308-0226. Matthews MJ, Watson M & Richardson B. (2009) Effects of dynamic elastomeric fabric orthoses on children with cerebral palsy. *Prosthetics and Orthotics International* 33 (4): 339-347. Mol EM, Monbaliu E, Ven M, Vergote M & Prinzie P. (2012) The use of night orthoses in cerebral palsy treatment: sleep disturbance in children and parental burden or not?. *Research in Developmental Disabilities* 33: 341-9. Morris C, Bowers R, Ross K, Stevens P & Phillips D. (2011) Orthotic management of cerebral palsy: recommendations from a consensus conference. *Neurorehabilitation*, 28 :37-46. Nicholson JH, Morton RE, Attfield S & Rennie D. (2001) Assessment of upper-limb function and movement in children with cerebral palsy wearing Lycra garments. *Developmental Medicine & Child Neurology* 43: 384-91. Raper J, Horridge K.A, Prudhoe S, Morrison A & Thorley A. (2011) Dynamic Lycra splints for children and young people with cerebral palsy: Do parents and professionals think they make a positive difference?. *Developmental Medicine and Child Neurology*, vol.53/(37), 0012-1622 Williamson EM, Mobley J, Kidd K. (2009) The effect of orthotic devices on gait symmetry of children with spasticity in the lower extremities. *Developmental Medicine and Child Neurology* 51/(64), 0012-1622**.** Do lycra garments improve function and movement in	

			children with cerebral palsy? BestBets, 2010.	
6.	**Fertility**			
6.1	Infertility Treatment for Subfertility e.g. medicines, surgical procedures and assisted conception. This also includes reversal of vasectomy or female sterilisation	See individual CCG policy.	CG156 Fertility: Assessment and treatment for people with fertility problems – NICE 2013. Contraception – sterilization – NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/#azTab	
7.	**General Surgery**			
7.1	Haemorrhoidectomy - Rectal Surgery: & Removal of Haemorrhoidal Skin Tags	Surgery commissioned for symptomatic : • Grade III and IV haemorrhoids. • Grade I or II haemorrhoids if they are large, symptomatic, and have not responded to the following non-surgical or out-patient treatments – - Diet modification to relieve constipation. - Topical applications. - Stool softeners and laxatives. - Rubber band ligation. - Sclerosant injections. - Infrared coagulation. Surgical treatment options include: • Surgical excision (haemorrhoidectomy). • Stapled haemorrhoidopexy. • Haemorrhoidal artery ligation. Removal of Skin tags should is not routinely commissioned.	Haemorrhoidal artery ligation NICE 2010. TAG128: Stapled haemorrhoidopexy for the treatment of haemorrhoids NICE 2007. BMJ2008. Clinical Review: Management of Haemorrhoids. Austin G Acheson, John H Scholefield, BMJ 2008; 336:380. Stapled versus conventional surgery for haemorrhoids – Cochrane Colorectal Cancer Group 2008. Long-term Outcomes of Stapled Hemorrhoidopexy vs Conventional HemorrhoidectomyA Meta-analysis of Randomized Controlled Trials – JAMA Surgery March 16, 2009, Vol 144, No. 3. Practice parameters for the management of hemorrhoids – Agency for Health Care Research and Quality (2010) US. Management of haemorrhoids BMJ 2008;336:380. Haemorrhoids NICE Clinical Knowledge Summaries 2012 http://cks.nice.org.uk/#azTab	There is some evidence of longer term efficacy of conventional haemorrhoidectomy over stapled procedure. Short term efficacy and cost effectiveness is similar.

			http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/rectal-bleeding Royal College of Surgeons (2013).	
7.2	Surgery for Treatment of Asymptomatic Incisional and Ventral Hernias. Surgical correction of Diastasis of the Recti	Surgery: not commissioned if no symptoms, easily reducible (i.e. can be 'pushed back in') and not at significant risk of complications. Surgical repair is not routinely commissioned.	Commissioning Policy for Procedures of Limited Clinical Value NHS Derby City and NHS Derbyshire County (April 2011). http://www.derbyshire.nhs.uk/pathways/PLCV-Doc-Dec-2012.pdf NHS Derby City and NHS Derbyshire County (December 2012). A systematic review on the outcomes of correction of diastasis of the recti Hernia, December 2011, Volume 15, Issue 6, pages 607-614, Hickey et al.	Diastasis of the recti are unsightly but do not carry a risk of complications and surgical results can be imperfect.
7.3 NEW	Surgery for Asymptomatic Gallstones Lithotripsy for Gallstones	This procedure is not routinely commissioned. Lithotripsy not routinely commissioned.	http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/gallstones Royal College of Surgeons (2013).	This procedure is considered a Low clinical priority for asymptomatic gallstones. Asymptomatic gallstones are usually diagnosed incidentally when they are seen on imaging which is done for some unrelated reasons. Lithotripsy rarely performed as rate recurrence high.

8.	**Gynaecology**			
8.1	Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding Hysterectomy D&C (dilatation and curettage)	Hysterectomy not commissioned unless all of the following requirements have been met: • An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) unless medically contra-indicated or the woman has made an informed choice not to use this treatment. • The following treatments have failed, are not appropriate or are contra-indicated in line with NICE guidance. - Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives. - Norethisterone (15mg) daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens. - Endometrial ablation has been tried (unless patient has fibroids >3cm). Dilatation and curettage not commissioned as a diagnostic or therapeutic procedure.	CG44 Heavy menstrual bleeding: full guideline NICE 2007. QS47 Heavy Menstrual Bleeding *NICE 2013.*	
9.	**Mental Health**			
9.1 NEW	Inpatient Care for Treatment of Chronic Fatigue Syndrome (CFS).	In patient care for Chronic Fatigue Syndrome is not routinely commissioned. If in-patient treatment is recommended an IFR referral will be required.	*Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children* – NICE 2007, CG53. *Cognitive behaviour therapy for chronic fatigue syndrome in adults* - Cochrane Depression, Anxiety and Neurosis Group 2008. *Adaptive pacing, cognitive behaviour therapy, Graded exercise, and specialist medical care for chronic fatigue syndrome: A cost-effectiveness analysis* - . PLoS ONE 7(8): e40808. doi:10.137. *Cost-effectiveness of counselling, graded-exercise and usual care for chronic fatigue: evidence from a randomised trial in primary care* - BMC Health Services Research 2012,	Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary. NICE section 1.915 states: Most people with CFS will not need hospital admission. However, there may be circumstances when a planned

			12:264.	admission should be considered. The decision to admit should be made with the person with CFS and their family, and be based on an informed consideration of the benefits and disadvantages. For example, a planned admission may be useful if assessment of a management plan and investigations would require frequent visits to the hospital.
9.2	Treatment of Gender Dysphoria	Patients with Gender Dysphoria issues should be referred to the Gender Identity Clinic (GIC) at either Charring Cross, Leeds, Nottingham or Sheffield. It is no longer necessary to access local services for assessment. Core surgery is commissioned by NHS England but there are a number of non- core treatments which will need consideration for funding by the CCG. These requests should be made by the GIC only and considered on an individual basis.	NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.	Where the provision of ''non-core surgery'' is appropriate the GIC should apply for treatment funding through the CCG. Liverpool, Sefton and Knowsley have a local support service in place at LCH.
9.3 NEW	Non-NHS Drug and Alcohol Rehabilitation (non-NHS commissioned services)	This is not routinely commissioned.	Interventions to reduce substance misuse among vulnerable young people – NICE Public Health Guidance 4 (2007) Drug misuse: psychosocial interventions – NICE Clinical Guideline 51 (2007). Alcohol-use disorders: diagnosis, assessment and	

			management of harmful drinking and alcohol dependence – NICE Clinical Guideline 115 (2011).	
9.4 NEW	Private Mental Health (MH) Care - Non-NHS Commissioned Services including psychotherapy adult eating disorders general in-patient care post-traumatic stress adolescent mental health	This will not normally be funded. Most Mental health conditions can be managed in the community with input from Community Mental Health Teams. NHS England Specialist Commissioning provides specialist services for various conditions including PTSD, eating disorders and severe OCD. There is also a specialist NHS MH service provided for affective disorders. A request for private MH care should be initiated by a consultant psychiatrist and give full explanation as to why NHS care is inappropriate or unavailable.	Veterans' post traumatic stress disorder programme (Adult) Service Specification NHS England Specialised Commissioning 2013. Post –traumatic stress disorder (PTSD):The management of PTSD in adults and children in primary and secondary care NICE Clinical Guideline 26 (2005). Severe OCD and body dysmorphic disorder service (Adults and Adolescents) Service Specification NHS England Specialised Commissioning (2013) The use of motivational interviewing in eating disorders: a systematic review. Psychiatry Research, 2012 Nov 30;200(1):1-11. Depression in children and young people: Identification and management in primary, community and secondary care. NICE Clinical Guideline 2005. Psychosis and schizophrenia in children and young people: Recognition and management. NICE Clinical Guideline 2013.	
10.	**Neurology**			
10.1 NEW	Bobath Therapy	Bobath Therapy is not routinely commissioned by the NHS. The evidence base is poor for both children and adults.	The Effectiveness of the Bobath Concept in Stroke Rehabilitation: What is the Evidence? Stroke, 2009; 40:e89-e97. Can physiotherapy after stroke based on the Bobath Concept result in improved quality of movement compared to the motor relearning programme Physiotherapy Research International Volume 16, Issue 2, pages 69–80, June 2011. Bobath Concept versus constraint-induced movement therapy to improve arm functional recovery in stroke patients: a randomized controlled trial Clinical Rehabilitation, 2012 Aug;26(8):705-15.	

			Bobath Therapy for Cerebral palsy Cambridge CCG (2013). A rapid review of the evidence for the effectiveness of Bobath therapy for children and adolescents with cerebral palsy National Public Health Service for Wales (2008).	
10.2 NEW	Trophic Electrical Stimulation for Facial/Bells Palsy	Not routinely commissioned.	Physical therapy for Bell's palsy (idiopathic facial paralysis). Cochrane Database of Systematic Reviews. Issue 12 (2011).	
10.3 NEW	Functional Electrical Stimulation (FES)	Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury. It is not routinely commissioned for lower motor neurone lesions. It is under review by NICE for dysphagia and muscle recovery chronic disease. Patients must have receptive cognitive abilities **Exclusion Criteria** • Fixed contractures of joints associated with muscles to be stimulated Broken or poor condition of skin. • Chronic oedema at site of stimulation. • Diagnosis of deep vein thrombosis. • Receptive dysphasia (unable to understand instructions). • Complete peripheral nerve damage. • Pacemaker in situ. • Pregnancy or intention to become pregnant. • Active cancer. • Uncontrolled epilepsy. • Metal in region of stimulation e.g.: pin and plate. • Ataxic and polio patients are generally poor responders although there are exceptions.	Functional Electric Stimulation (FES) for Children with Cerebral Palsy: Clinical Effectiveness – CADTH Rapid Response Service, 2011. Children with cerebral palsy: a systematic review and meta-analysis on gait and electrical stimulation. Clinical Rehabilitation. 2010 Nov; 24(11):963-78. Interventions for dysphagia and nutritional support in acute and subacute stroke Cochrane Database of Systematic Reviews 2012, Issue 10. Functional electrical stimulation for drop foot of central neurological origin NICE, 2009. Functional electrical stimulation for rehabilitation following spinal cord injury Centre for Reviews and Dissemination, NIHR, 2011.	

11.	Ophthalmology			
11.1	Upper Lid Blepharoplasty - Surgery on the Upper Eyelid.	Only commissioned in the following circumstances: • Eyelid function interferes with visual field.	Eyelid Surgery *The British Association of Aesthetic Plastic Surgeons 2011.* Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base London Health Observatory 2010.	Excess skin in the upper eyelids can accumulate due to the ageing and is thus normal. Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment. Impairment to visual field to be documented.
11.2	Lower Lid Blepharoplasty - Surgery on the Lower Eyelid.	Only commissioned in any of the following circumstances: • Correction of ectropion or entropion which threatens the health of the affected eye. • Removal of lesions of eyelid skin or lid margin. • Rehabilitative surgery for patients with thyroid eye disease.	*Eyelid Surgery* The British Association of Aesthetic Plastic Surgeons 2011. Local PCT consensus –review conducted 2007. Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.	Excessive skin in the lower lid may cause "eye bags" but does not affect function of the eyelid or vision and therefore does not need correction.
11.3	Surgical Treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids).	Only commissioned for: Larger legions which satisfy all of the following: 1. Not responded to treatment for underlying familial lipoprotein lipase deficiency 2. Failed topical treatment 3. Causing significant disfigurement 4. Causing functional impairment. Topical treatments may be available in a Primary care or Community setting.	Local PCT consensus – review conducted 2007. DermNet NZ information resources updated Jan 2013. Commissioning Criteria – Plastic Surgery Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Health Commission Wales (2008). http://www.patient.co.uk/doctor/xanthelasma	The following treatments should be considered for patients with xanthelasma: Many Xanthelasma may be treated with topical trichloroacetic acid (TCA) or

				cryotherapy. Xanthelasma may be associated with abnormally high cholesterol levels and this should be tested for before referral to a specialist. Patients with xanthelasma should always have their lipid profile checked before referral to a specialist. Investigation for underlying lipid abnormalities should be undertaken in the first instance. Lesions are harmless. Many Xanthelasma may be treated with topical trichloroacetic acid (TCA) or cryotherapy.
11.4 NEW	Surgery or Laser Treatment for Short Sightedness (myopia) or Long	Surgery or Laser Treatment for Short Sightedness or long sightedness is routinely not commissioned.		

	Sightedness (hypermetropia)			
11.5 NEW	Cataract Surgery	See appendix 1 for details of Referral Guidance template. Referral for cataract surgery should be based on symptomatic deterioration of vision e.g. difficulty reading, seeing TV, driving or visual disturbance e.g. glare/dazzle with bright sunlight or oncoming headlights. An example of a referral template for use by optometrists is given in appendix 1. There is good evidence that bilateral cataract replacement is beneficial.	Thresholds for cataract surgery – Shropshire and Telford Hospital NHS Trust, 2012. Shropshire CCG POLICY ON LOW PRIORITY TREATMENTS Version 13 – June 2013 Based on OPCS 4.6 and ICD 10 8.2 Cataract surgery pg38. PLCVv13June13.pdf http://www.hullccg.nhs.uk/uploads/policy/file/6/cataracts-hull-ccg.pdf Hull CCG, 2012. NHS Atlas of Variation, (cataract spend, cataract admissions) Don't turn back the clock: Cataract surgery - the need for patient centred care. RNIB / Royal College of Ophthalmologists (2011). Cataract surgery guidelines The Royal College of Ophthalmologists (RCOphth) 2010. Action on cataracts good practice guidance Department of Health (2000). Cataract care pathway Map of Medicine (2013). NHS UK - http://www.nhs.uk/conditions/Cataracts-age related/Pages/Introduction.aspx (Riaz Y, Mehta JS, Wormald R, Evans JR, Foster A, Ravilla	PH Evidence Review Cataracts.docx

			T et al. Surgical interventions for age-related cataract (Review). Cochrane Database of Systematic Reviews [2006 (Fedorowicz Z, Lawrence D, Gutierrez P. Day care versus in-patient surgery for age-related cataract (Review). Cochrane Database of Systematic Reviews [2005 NHS Executive. Action on cataracts: Good practice guidance. 1-60. 2000. London, Department of Health. Cataract surgery guidelines. 4, 1-106. 2010. London, Royal College of Ophthalmologists. Laidlaw, D. A. H., Harrad, R. A., Hopper, C. D., and Whitaker, A. Randomised trial of effectiveness of second eye surgery. *Lancet* 1998; **352**:925-929. National eyecare services steering group: First report. 1-17. 2004. London, Department of Health. Sampietro-Colom L, Espallargues M, Reina MD, Marso E, Valderas JM, Estrada MD. Citizens opinions, experiences and perceptions about waiting lists for elective cataract surgery and hip and knee replacement [Spanish] Opiniones, vivencias y percepciones de los ciudadanos en torno a las listas de espera para cirugia electiva de catarata y artroplastia de cadera y rodilla. *Atencion primaria / Sociedad Espanola de Medicina de Familia y Comunitaria* 2004; **33**(2):86-94. Sparrow, J. M. Cataract surgical rates: is there overprovision in certain areas? *British Journal of Ophthalmology* 2007; **91**:852-853.	

			Black, N., Browne, J., and van der Meulen, J. Is there overutilisation of cataract surgery in England? *British Journal of Ophthalmology* 2009; **93**:13-17. Mennemeyer ST, Owsley C, McGwin G. Reducing older driver motor vehicle collisions via earlier cataract surgery. *Accident Analysis and Prevention* 2013; **61**:203-211. Meuleners LB, Hendrie D, Lee AH, Ng JQ, Morlet N. The effectiveness of cataract surgery in reducing motor vehicle crashes: a whole population study using linked data. *Ophthalmic Epidemiology* 2012; **19**(1):23-28. Sach TH, Foss AJ, Gregson RM, Zaman A, Osborn F, Masud T. Second eye cataract surgery in elderly women: a cost utility analysis conducted alongside a randomised controlled trial. *Eye* 2010; **24**(2):276-283. Sach TH, Foss AJ, Gregson RM, Zaman A, Osborn F, Masud T. Falls and health status in elderly women following first eye cataract surgery: An economic evaluation conducted alongside a randomised controlled trial. *British Journal of Ophthalmology* 2007; **91**(12):1675-1679. Naeim A, Keeler EB, Gutierrez P, Wilson MR, Reuben D, Mangione CM. Is cataract surgery cost effective among older patients with a low predicted probability for improvement in reported visual functioning? *Medical CAre* 2006; **44**(11):982-989. Rasanen P, Krootila K, Sintonen H, Leivo T. Cost utility of routine cataract surgery. *Health & Quality of Life Outcomes* 2006; **4**. Brown GC, Brown MM, Menezes A, Bushbee BG. Cataract	

			surgery cost utility revisited in 2012: a new economic paradigm. *Ophthalmology* 2013; **120**(12):2367-2376. Gutierrez SG, Bilbao A, Beguiristain JM, Navarro G, Tapias JM, Blasco JA et al. Variability in the prioritization of patients for cataract extraction. *International Journal for Quality in Health Care* 2010; **22**(2):107-114. Ma QJ, Escobar A, Bilbao A, IRYSS-Appropriateness Cataract Group. Explicit criteria for prioritization of cataract surgery. *BMC health services research* 2006; **6**. Sampietro-Colom L, Espallargues M, Comas M, Rodriguez E, Castells X, Pinto JL. Prioritizing patients on waiting list for cataract surgery: preference differences among citizens [Spanish] Priorizacion de pacientes en lista de espera para cirugia de cataratas: diferencias en las preferencias entre ciudadanos. *Gaceta sanitaria / S E S P A S* 2006; **20**(5):342-351. Lamoureux EL, Fenwick E, Pesudovs K, Tan D. The impact of cataract surgery on quality of life. *Current Opinion in Ophthalmology* 2011; **22**(1):19-27. Cataracts:Management and Referral. NHS Clinical Knowledge Summaries [2010 [cited 2010 Dec. 7]; Management of diabetes. 116. 2010. Edinburgh, Scottish Intercollegiate Guideline Network. Yamaguchi T, Negishi K, Tsubota K. Functional visual acuity measurement in cataract and intraocular lens implantation. *Current Opinion in Ophthalmology* 2011; **22**(1):31-36.	

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			Mildon D, McGurran JJ, Noseworthy TW. The prioritization of patients on waiting lists for cataract surgery: Validation of the Western Canada waiting list project cataract priority criteria tool. *Ophthalmic Epidemiology* 2005; **12**(2):81-90. Gutierrez SG, Quintana JM, Bilbao A, Escobar A, Milla EP, Elizalde B et al. Validation of priority criteria for cataract extraction. *Journal of Evaluation in Clinical Practice* 2009; **15**(4):675-684.	
11.6 NEW	Coloured (irlens) Filters for Treatment of Dyslexia	There is insufficient evidence of efficacy on this treatment. It is not routinely commissioned until such time when there is robust evidence.	Coloured filters for reading disability:A systematic review WMHTAC 2008	
11.7 NEW	Intra Ocular Telescope for Advanced Age-Related Macular Degeneration	This is not routinely commissioned as there is limited published evidence of effectiveness.	Implantation of miniature lens systems for advanced age-related macular degeneration NICE, 2008. Intraocular telescope by Vision Care ™ for age-related macular degeneration North East Treatment Advisory Group (2012).	
11.8	Surgical Removal of Chalazion or Meibomian Cysts	Referral to secondary care will only be considered when all of the following are met: • Present for six months or more. • Conservative treatment has failed. • Sited on upper eyelid. AND Causes blurring or interference with vision. OR Has required treatment with antibiotics due to infection at least twice in the preceding six months. In Children under 10 this is commissioned as visual development may be at risk.	Guidance for the management of referrals for Meibomian Cysts NHS Cornwall & Isles of Scilly Devon, Plymouth and Torbay (January 2013). http://www.kernowccg.nhs.uk/media/136633/chalazion__meibomian_cyst__guidance_16.01.2013.pdf NHS Cornwall & Isles of Scilly, Devon, Plymouth and Torbay	
12.	**Oral Surgery**			
12.1	Surgical Replacement	Only commissioned in the following circumstances:	Surgical Replacement of the Temporo-mandibular Joint:	*Discussions ongoing*

NEW	of the Temporo-Mandibular Joint Temporo-Mandibular Joint Dysfunction Syndrome & Joint Replacement	Any or a combination of the following symptoms are present: - Restricted mouth opening <35mm). - Dietary score of< 5/10 (liquid scores 0, full diet scores 10). - Occlusal collapse (anterior open bite or retrusion). - Excessive condylar resorption and loss of height of vertical ramus. - Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms). - Other significant quality of life issues. AND Evidence that conservative treatments have been attempted and failed to adequately resolve symptoms and other TMJ modification surgery (if appropriate) has also been attempted and failed to resolve symptoms.	Interim guidance for Merseyside and Wirral/Cheshire Commissioners when considering funding requests.  TMJ replacement guidance 20130806.c Total prosthetic replacement of the Temporomandibular joint (IPG329) NICE 2009 http://www.patient.co.uk/doctor/temporomandibular-joint-dysfunction-and-pain-syndromes	*to confirm which organisation is the responsible commissioner for this service.*
13.	**Paediatrics**			
13.1 NEW	Cranial Banding for Positional Plagiocephaly	Not routinely commissioned.	Nonsurgical treatment of deformational plagiocephaly: a systematic review Archives of Pediatrics and Adolescent Medicine, Volume 162, Issue 8, 2008, p 719-27. What is the role of helmet therapy in positional plagiocephaly? BestBETS 2008.	This treatment is considered low priority. Most children's head shapes will improve naturally in their own time.

14.	Plastic & Cosmetic Surgery			
14.1	Reduction Mammoplasty - Female Breast Reduction	Commissioned only if all of the following circumstances are met: Musculo-skeletal symptoms are not due to other causes. AND There is at least a two year history of attending the GP with the problem. AND Other approaches such as analgesia and physiotherapy have been tried. AND The patient is suffering from functional symptoms as a result of the size of her breasts (e.g. candidal intertrigo; backache). AND The wearing of a professionally fitted brassiere has not helped. AND Patients BMI is <25 and stable for at least twelve months. AND The patients breast is a cup size H or larger AND	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base London Health Observatory 2010. Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Health Commission Wales (2008). Modernisation Agency's Action on Plastic Surgery 2005. Greenbaum, a. R., Heslop, T., Morris, J., & Dunn, K. W. (2003). An investigation of the suitability of bra fit in women referred for reduction mammaplasty. *British Journal of Plastic Surgery*, *56*(3), 230–236. Wood, K., Cameron, M., & Fitzgerald, K. (2008). Breast size, bra fit and thoracic pain in young women: a correlational study. *Chiropractic & Osteopathy*, *16*(1), 1–7. An investigation into the relationship between breast size, bra size and mechanical back pain British School of Osteopathy (2010). Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Best not performed on young teenagers and delayed until any planned family is complete. Unilateral reduction is preferable to unilateral augmentation.

		There is a proposed reduction of at least a three cup size reduction AND Aged over 18 years old AND It is envisaged there are no future planned pregnancies. Unilateral breast reduction is considered for asymmetric breasts of three or more cup size difference as measured by a specialist. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.		
14.2	Augmentation Mammoplasty - Breast Enlargement	Only commissioned in the following circumstance: In all cases: The BMI is <25 and stable for at least twelve months. AND There is congenital absence of breast tissue unilaterally of three or more cup size difference as measured by a specialist. OR Congenital absence i.e. no obvious breast tissue. In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality. All non-surgical options must have been explored e.g. padded bra.	Dixon, J, et al, 1994, ABC of breast diseases: congenital problems and aberrations of normal breast development and involution, Br Med J, 309, 24 September, 797-800 Freitas, R, et al, 2007, Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases, Aesthet Plast Surg, 31, 140-46. Heimberg, D, et al, 1996, The tuberous breast deformity: classification and treatment, Br J Plast Surg, 49, 339-45. Pacifico, M, et al, 2007, The tuberous breast revisited, J Plast Reconstruct Aesthet Surg, 60, 455-64. North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures", 5-7. Sadove, C, et al, 2005, Congenital and acquired pediatric breast anomalies: a review of 20 years experience, Plast Reconstruct Surg, April, 115(4), 1039-1050.	Patients should be made aware that; 1 in 5 implants need replacing within 10 years regardless of make. Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future policy may differ from current policy.

		Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.	Vale of Glamorgan Local Health Board, 2006, Policy on the commissioning of procedures of low priority or limited clinical effectiveness not normally funded, Annex A, 3.36. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant. Not all patients demonstrate improvement in psychosocial outcome measures following breast augmentation.
14.3	Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation	Revisional surgery will ONLY be considered if the NHS commissioned the original surgery and complications arise which necessitates surgical intervention. If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them will be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Modernisation Agency's Action on Plastic Surgery 2005. Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group Department of Health (June 2012).	1 in 5 implants need replacing within 10 years regardless of make. Prior to implant insertion all patients explicitly be made aware of the possibilities of complications, implant life span, the need for possible removal of the implant at a future date and that future

		Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013). Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.	policy may differ from current policy. Patients should be made aware that implant removal in the future might not be automatically followed by replacement of the implant.
14.4	Mastopexy - Breast Lift	Not routinely commissioned May be considered as part of other breast surgery to achieve an appropriate cosmetic result subject to prior approval. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol	

14.5	Surgical Correction of Nipple Inversion	This is not routinely commissioned. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. .	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol	Exclude malignancy as a cause - any recent nipple inversion might be suggestive of breast cancer and will require referral to the breast service under the rapid access two-week rule. This condition responds well to non-invasive suction device e.g. Nipplette device, for up to three months.
14.6	Male Breast Reduction Surgery for Gynaecomastia.	Not routinely commissioned except on an exceptional basis where all of the following criteria are met: True gynaecomastia not just adipose tissue. AND Underlying endocrine or liver abnormality excluded. AND Not due to recreational use of drugs such as steroids or cannabis or other supplements known to cause this. AND Not due to prescribed drug use. AND	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service* Modernisation Agency's Action on Plastic Surgery 2005. Dickson, G. (2012). Gynecomastia. *American Family Physician*, *85*(7), 716–722. Retrieved from: http://www.aafp.org/afp/2012/0401/p716.pdf Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol	Ensure breast cancer has been excluded as a possible cause especially if there is a family history of breast cancer.

		Has not responded to medical management for at least three months e.g. tamoxifen. AND Post pubertal. AND BMI <25kg/m2 and stable for at least 12 months. AND Patient experiences persistent pain. AND Experiences significant functional impairment. AND In cases of idiopathic gynaecomastia in men under the age of 25 then a period of at least 2 years has been allowed for natural resolution. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.		
14.7	Hair Removal Treatments including Depilation Laser Treatment or Electrolysis –for Hirsutism –	Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence. In other circumstances only commissioned if all of the following clinical circumstances are met;	Epidemiology, diagnosis and management of hirsutism: a consensus statement by the Androgen Excess and Polycystic Ovary Syndrome Society. Escobar et al. Human Reproduction Update, 03-04 2012, vol./is. 18/2(146-70). Hirsutism - NICE: Clinical Knowledge Summaries 2010.	The method of depilation (hair removal) considered will be the most appropriate form usually diathermy,

		• Abnormally located hair-bearing skin following reconstructive surgery located on face and neck. • There is an existing endocrine medical condition and severe facial hirsutism. 1. Ferryman Gallwey (*A method of evaluating and quantifying hirsutism in women*) Score 3 or more per area to be treated. 2. Medical treatments have been tried for at least one year and failed. 3. Patients with a BMI of>30 should be in a weight reduction programme and should have lost at least 5% body weight. All cases will be subject to individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e. endocrinologist). Photographs will also be required to allow the PCTs to visibly asses the severity equitably. Funded for 6 treatments only at an NHS commissioned premises. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Laser and photoepilation for unwanted hair growth – Cochrane Library 2009. Management of hirsutism – Koulouri et al BMJ 2009; 338:b847. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol	electrolysis performed by a registered electrologist, or laser centre.
14.8 NEW	Surgical Treatment for Pigeon Chest	This procedure is not routinely commissioned by the NHS on cosmetic grounds.	IPG310 Minimally invasive placement of pectus bar: guidance NICE (2009).	

14.9	Surgical Revision of Scars.	Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol	
14.10	Laser Tattoo Removal	Only commissioned in any of the following circumstances: • Tattoo is result of trauma inflicted against the patient's will. • The patient was a child and not responsible for his/her actions at the time of tattooing. • Inflicted under duress. • During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function). An individual funding request will be required.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005.	
14.11	Apronectomy or Abdominoplasty (Tummy Tuck).	Not routinely commissioned other than if all of the following criteria are met: The flap hangs at or below the level of the symphysis pubis. Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction). Bariatric surgery (if performed) was performed at least 3 years previously.	Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service A systematic review of outcomes of abdominoplasty. Staalesen et al. Journal of Plastic Surgery and Hand Surgery, 09 2012, vol./is. 46/3-4(139-44).	Maintenance of a stable weight is important so that the risks of recurrent obesity are reduced. Poor level of evidence of positive outcomes.

		AND any of the following: Causes significant problems with activities of daily life (e.g. ambulatory restrictions). Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. Poorly-fitting stoma bag. (If the patient does not fulfil all of the required criteria, an IFR should be submitted detailing why exception should be made) IFR information ***must*** contain the following information; • Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates. • Series of weight and BMI readings demonstrating weight loss and stability achieved. • Date stable weight and BMI achieved. • Current weight BMI. • Patient compliance with continuing nutritional supervision and management (if applicable). • Details of functional problems. • Details of associated medical problems.		
14.12	Other Skin Excisions/ Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty)	Not routinely commissioned. If an IFR request for exceptionality is made, the patient must fulfil all of the following criteria before being considered. Patients BMI is <25 and stable for at least 12 months.	Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service http://www.rcseng.ac.uk/healthcare-bodies/docs/massive-weight-loss-body-contouring Royal College of Surgeons (2013).	The functional disturbance of skin excess in these sites tends to be less than that in excessive abdominal skin folds and so surgery is

		(Some allowance may be made for redundant tissue not amenable to further weight reduction). Bariatric surgery (if performed) was performed at least 3 years previously. AND any of the following: Causes significant problems with activities of daily life (e.g. ambulatory restrictions). Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. IFR information ***must*** contain the following information; • Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates. • Series of weight and BMI readings demonstrating weight loss and stability achieved. • Date stable weight and BMI achieved. • Current weight BMI. • Patient compliance with continuing nutritional supervision and management(if applicable). • Details of functional problems. • Details of associated medical problems. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.	Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol	less likely to be indicated except for appearance. Therefore it will not be available on the NHS.

		Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.		
14.13	Treatments to Correct Hair Loss for Alopecia.	Only commissioned in either of the following circumstances: • Result of previous surgery • Result of trauma, including burns Hair Intralace System is not commissioned. Dermatography is not commissioned. NHS wigs will be available according to NHS policy. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	British Association of Dermatologists' guidelines for the management of alopecia areata 2012 Interventions for alopecia areata – Cochrane Library 2008. http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf Only one study which compared two topical corticosteroids showed significant short-term benefits. No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment. No evidence of effective treatments for alopecia – Cochrane Pearls 2008. Alopecia areata – NICE Clinical Knowledge Summaries 2008. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 (further evidence provided within this document by Islington PCT to support funding). Modernisation Agency's Action on Plastic Surgery 2005.	

			Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol	
14.14	Hair Transplantation	Commissioned only in exceptional circumstance, e.g. reconstruction of the eyebrow following cancer or trauma. Dermatography may be an acceptable alternative in eyebrow reconstruction. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	*A trial on subcutaneous pedicle island flap for eyebrow reconstruction* – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010 (further evidence provided within this document by Islington PCT to support funding). Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol	
14.15	Treatments to Correct Male Pattern Baldness	This is not routinely commissioned.	Modernisation Agency's Action on Plastic Surgery 2005.	
14.16	Labiaplasty, Vaginoplasty and Hymenorrhaphy	This is not routinely commissioned.	Bramwell R, Morland C, Garden A. (2007). Expectations and experience of labial reduction: a qualitative study. *BJOG* 2007; 114:1493-1499. Department for Education and Skills. (2004). *Local Authority Social Services Letter*. *LASSAL (2004)4,* London, DfES. Goodman, M. P. (2009). Female Cosmetic Genital Surgery. *Obstetrics and Gynaecology; 113: 154-159.* Liao, L-M; Michala, L; Creighton, SM. (2010). Labial Surgery for Well Women; a review of the literature. *BJOG: An International Journal of Obstetrics & Gynaecology; Volume 117: 20-25.* *Labiaplasty for labia minora hypertrophy - Centre for*	

			Reviews and Dissemination 2013. Clinical characteristics of well women seeking labial reduction surgery: a prospective study. BJOG; 2011 Nov;118(12):1507-10. Hymenoplasty and Labial Surgery (RCOG Statement 6). http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf	
14.17	Liposuction	Liposuction is sometimes an adjunct to other surgical procedures e.g. thinning of a transplanted flap. Not commissioned simply to correct fat distribution. May be commissioned as part of the management of true lipodystrophias or non-excisable clinical significant lipomata. An individual funding request will be required. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.	Liposuction for chronic lymphoedema NICE 2008. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Modernisation Agency's Action on Plastic Surgery 2005. Interim Gender Dysphoria Protocol &service guidelines 2013/14. NHS England interim protocol	
14.18	Rhytidectomy - Face or Brow Lift	This procedure is not available under the NHS on cosmetic grounds. Routinely commissioned in the following circumstances: • Congenital facial abnormalities. • Facial palsy. • Treatment of specific conditions affecting the facial skin, e.g. cutis, laxa, pseudoxanthoma elasticum, neurofibromatosis.	Modernisation Agency's Action on Plastic Surgery 2005. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol	Changes to the face and brow result due to normal ageing; however, there are a number of specific conditions for which these procedures may form part of the treatment to restore

		• To correct consequences of trauma. • To correct deformity following surgery. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.		appearance and function.
15.	**Respiratory**			
15.1	Treatments for Snoring. Soft Palate Implants and Radiofrequency Ablation of the Soft Palate Sodium Tetradecyl Sulfate (STS) Injection or 'snoreplasty' Uvulopalatoplasty and Uvulopalatopharyngoplasy	Not Routinely Commissioned.	Soft-palate implants for simple snoring. NICE interventional procedure guidance 240 (2007). Radiofrequency ablation of the soft palate for snoring. NICE interventional procedure guidance 124 (2005). Clinical Guideline 73: Management of obstructive sleep apnoea/ hypopnoea syndrome in Adults SIGN (2003). Surgery for obstructive sleep apnoea in adults Cochrane Database of Systematic Reviews (2005). Surgical procedures and non-surgical devices for the management of non-apnoeic snoring: a systematic review of clinical effects and associated treatment costs – Health Technology Assessment (2009). Effects and side-effects of surgery for snoring and obstructive sleep apnea : A systematic review – Sleep 2009 v.32(1) 27-36. The British Snoring & Sleep Apnoea Association	NICE concludes that soft palate implants for snoring can only be recommended in the context of research, and radiofrequency ablation should only be used providing special arrangements are in place for audit, consent and research. For both, there are no major safety concerns, but the evidence on efficacy and outcomes is uncertain. UPPP may compromise the patient's subsequent ability to use nasal CPAP.

				Research to date is exploratory and studies small and not randomised or blinded. The method of injecting a chemical into the soft palate known as 'Snoreplasty' is not well recognised in the UK as an effective method of treating snoring. This method has.
16.	**Trauma & Orthopaedics**			
16.1 NEW	Diagnostic, Interventions and Treatments for Early Management of Back Pain Persistent *non-specific* low back pain of duration 6 weeks to 12 months. Excluding spinal pathology, radiculopathy, and children.	X Rays and MRI scans should not be offered unless in a context of referral for surgery. Management should consist of a structured exercise programme, manual therapy or acupuncture. The following treatments should not be offered for the early management of persistent non-specific low back pain. • Selective serotonin re-uptake inhibitors (SSRIs) for treating pain. • Injections of therapeutic substances into the back. • Laser therapy. • Interferential therapy. • Therapeutic ultrasound. • Transcutaneous electrical nerve stimulation (TENS). • Lumbar supports. • Traction.	CG88 Low back pain: full guideline NICE 2009. Review of Clinical Guideline (CG88) – Low back pain: early management of persistent non-specific low back pain NICE 2012. IPG 319: Percutaneous intradiscal electrothermal therapy	

	Radiofrequency Facet Joint Denervation Intra Discal Electro Thermal Annuloplasty (IDET percutaneous intradiscal radiofrequency thermocoagulation PIRFT),	The following referrals should not be offered for the early management of persistent non-specific low back pain. • Radiofrequency facet joint denervation • Intra Discal Electro Thermal Annuloplasty (IDET) • Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT),	for low back pain NICE 2009. IPG83: Percutaneous intradiscal radiofrequency thermocoagulation NICE 2004.	
	TAMARS (technology assisted micromobilisation and reflex stimulation)	Not routinely commissioned. There is limited data on effectiveness and no data on superiority over other treatments.	http://tamars.co.uk/wp/wp-content/uploads/2012/10/21stCenturyBackCare.pdf Final_TAMARS_report[1].pdf	TAMARS (Technology Assisted Micromobilisation and Reflex Stimulation)
	Fusion	Fusion not commissioned unless the patient has completed an high intensity package of care, including a combined physical and psychological treatment programme. AND • Still has severe non-specific low back pain for which they would consider surgery.	*RCS commissioning guidance on LBP due out November. Gives guidance and tools. Will also give guidance on facet joints.*	
16.2	Facet Joint - Non Specific Back Pain Over 12 Months including radio	Non Specific back pain over 12 months – Not routinely commissioned. May have a role as a diagnostic procedure when	http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf	

	frequency degeneration Epidural Injection	considering Radio frequency ablation. This would require an individual funding request' Radicular Pain – Single injection may be of benefit to enable normal activity to resume in prolapsed disc & spinal stenosis where surgery is not desirable.' 'Non Specific Back Pain – Not routinely commissioned.'	http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf	
16.3	Endoscopic Laser Foraminoplasty	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence of the safety and efficacy of endoscopic laser foraminoplasty does not appear adequate to support the use of this procedure without special arrangements for consent and for audit or research.	IPG31 Endoscopic laser foraminoplasty: guidance NICE 2003 (confirmed 2009) Reviewed October 2011.	
16.4 NEW	Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the efficacy of peripheral nerve-field stimulation (PNFS) for chronic low back pain is limited in both quantity and quality, and duration of follow-up is limited. Evidence on safety is also limited and there is a risk of complications from any implanted device.	IPG 451: Peripheral nerve-field stimulation (PNFS) for chronic low back pain NICE 2013.	

16.5 NEW	Endoscopic Lumbar Decompression	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the safety and efficacy of percutaneous endoscopic laser lumbar discectomy is inadequate in quantity and quality.	IPG300: Percutaneous endoscopic laser lumbar discectomy NICE, 2009	
16.6 NEW	Percutaneous Disc Decompression using Coblation for Lower Back Pain.	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence suggests that there are no major safety concerns associated with the use of percutaneous disc decompression using coblation for lower back pain. There is some evidence of short-term efficacy; however, this is not sufficient to support the use of this procedure without special arrangements for consent and for audit or research.	IPG 173: Percutaneous disc decompression using coblation for lower back pain. NICE 2006	
16.7 NEW	Non-Rigid Stabilisation Techniques	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the efficacy of non-rigid stabilisation techniques for the treatment of low back pain shows that these procedures are efficacious for a proportion of patients with intractable back pain.	IPG 366: Non-rigid stabilisation techniques NICE 2010	

16.8 NEW	Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the safety and efficacy of lateral (including extreme, extra and direct lateral) interbody fusion in the lumbar spine is inadequate in quantity and quality. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research.	IPG 321: Lateral (including extreme, extra and direct lateral) interbody fusion in the lumbar spine is inadequate in quantity and quality. NICE 2009.	
16.9 NEW	Percutaneous Intradiscal Laser Ablation in the Lumbar Spine	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the safety and efficacy of percutaneous intradiscal laser ablation in the lumbar spine is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit.	IPG 357: Percutaneous intradiscal laser ablation in the lumbar spine NICE 2010.	
16.10 NEW	Transaxial Interbody Lumbosacral Fusion	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the efficacy of transaxial interbody lumbosacral fusion is limited in quantity but shows symptom relief in the short term in some patients. Evidence on safety shows that there is a risk of rectal perforation. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research.	IPG 387: Transaxial interbody lumbosacral fusion NICE 2011.	

16.11 NEW	Therapeutic Endoscopic Division of Epidural Adhesions	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on therapeutic endoscopic division of epidural adhesions is limited to some evidence of short-term efficacy, and there are significant safety concerns. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research.	IPG 333: Therapeutic endoscopic division of epidural adhesions NICE 2010	
16.12 NEW	Automated Percutaneous Mechanical Lumbar Discectomy.	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence suggests that there are no major safety concerns associated with automated percutaneous mechanical lumbar discectomy. There is limited evidence of efficacy based on uncontrolled case series of heterogeneous groups of patients, but evidence from small randomised controlled trials shows conflicting results. In view of the uncertainties about the efficacy of the procedure, it should not be used without special arrangements for consent and for audit or research.	IPG 141: Automated percutaneous mechanical lumbar discectomy. Nov 2005.	
16.13 NEW	Prosthetic Intervertebral Disc Replacement in the Lumbar Spine	This procedure is NOT routinely commissioned. Individual funding requests will need to be made for exceptional circumstances. Current evidence on the safety and efficacy of prosthetic intervertebral disc replacement in the lumbar spine is adequate to support the use of this procedure provided that normal arrangements are in place for clinical governance, consent and audit.	IPG 306: Prosthetic intervertebral disc replacement in the lumbar spine NICE 2009. Commissioning Guide – Low Back Pain. Royal College of Surgeons (2013). Total disc replacement for chronic back pain in the presence of disc degeneration The Cochrane Database of Systematic Reviews, Issue 9 (2012).	As effective as discectomy in the short term 2-3 yrs. but after that outcomes are similar. Long term follow-up data on efficacy and safety is lacking.

16.14 NEW	Bone Morphogenetic Proteins Dibotermin Alfa Eptotermin Alpha	Dibotermin alfa is commissioned in the following situation: The treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation. Eptotermin alfa is commissioned in line with its licensed indication: Treatment of non-union of tibia of at least 9 month duration, secondary to trauma, in skeletally mature patients, in cases where previous treatment with autograft has failed or use of autograft is unfeasible.	Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review Health Technology Assessment NHS R&D HTA Programme, 2007. Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI Annals of Internal Medicine | Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data June 2013 BMPs: Options, indications, and effectiveness – Journal of Orthopaedic Trauma. 2010 Mar;24 Suppl 1:S9-16.	
16.15	Surgery for Trigger Finger	Conservative management (including splinting, steroid injections, NSAIDS) is adequate in the majority of cases. Local steroid injections should be the first line treatment unless the patient is diabetic (where surgery preferred). Surgery not commissioned unless conservative treatments, (including at least 1 corticosteroid injections) have failed or are contraindicated AND Fixed flexion deformity that cannot be corrected easily is present.	Nimigan AS, Ross DC, Bing SG. Steroid injections in the management of trigger fingers. American Journal of Physical Medicine and Rehabilitation 2006; 85(1):36-43. BMJ review: Akhtar S, Bradley MJ, Quinton DN, Burke FD. Management and referral for trigger finder/thumb. BMJ 2005; 331(7507):30-33. NHS Oxfordshire, Interim Treatment Threshold Statement: Surgery for trigger finger (stenosing tenovaginosis) Corticosteroid injection for trigger finger in adults Cochrane Database of Systematic Reviews (2008). Trigger Finger Assessment Map of Medicine (2012) – for North Mersey Surgery versus ultrasound-guided steroid injections for trigger finger disease: protocol of a randomized controlled trial Danish Medical Journal 2013;60(5):A4633.	

16.16 NEW	Hyaluronic Acid and Derivatives Injections for Peripheral Joint Pain Secondary Care Administered Steroid Joint Injections.	Hyaluronic Acid and Derivatives Injections are not commissioned for joint injection. Provision of joint injections for pain should only be undertaken in a primary care setting, unless ultrasound guidance is needed or as part of another procedure being undertaken in theatre.	http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English Ultrasound-guided injections of joints of the extremities – University of York Centre for Research and Dissemination 2012.	
16.17 NEW	Palmar Fasciectomy/Needle Faciotomy for Dupuytren's Disease. Radiotherapy Collagenase Injections	Requests for treatment will be considered when: • Metacarpophalangeal joint contracture of 30o or more, (inability to place hand flat on table OR • Any degree of proximal interphalangeal joint contracture, OR • Patients under 45 years of age with disease affecting 2 or more digits and loss of extension exceeding 100 or more. There should be significant functional impairment. These procedures are not commissioned.	IPG043 Needle fasciotomy for Dupuyren's contracture - guidance – NICE 2004. Dupuytrens disease NICE Clinical Knowledge Summaries (2010). British society hand surgeons New guidelines awaited. NHS North West London commissioning policy – Dupuytren's Disease April 2013. Common Hand Conditions NHS Dorset Clinical Commissioning Group (2011). IPG368: Radiation therapy for early Dupuytren's disease NICE 2010.	
16.18	Hip and Knee Replacement Surgery & Hip Resurfacing	Referral is based on local referral pathways. **Funding for total or partial knee replacement**	NHS North West London commissioning policy – Hip Replacement (Total) April 2013.	A hip and knee score threshold can form part of a demand management

		<u>surgery</u> is available if the following criteria are met 1. Patients with BMI <40 AND 2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. AND 3. Has radiological features of severe disease; OR 4. Has radiological features of moderate disease with limited mobility or instability of the knee joint Patients not meeting the above criteria can be referred via the IFR route where there are exceptional circumstances present. **Referral criteria for <u>Total Hip Replacements (THR)</u>** should be based on the level of pain and functional impairment suffered by the patient. NHS NWL CCGs will fund THR for patients who fulfil the following criteria; 1. Patient complains of severe joint pain AND functional limitation, despite the use of non-surgical treatments such as adequate doses	NHS North West London commissioning policy – Knee Replacement (Total) April 2013. Clinical thresholds knee replacement York & Humber Health Intelligence (2011). Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013). http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English Relevant NICE Guidance (TA44) as referred to above http://publications.nice.org.uk/guidance-on-the-use-of-metal-on-metal-hip-resurfacing-arthroplasty-ta44	approach. NICE ID 540 (in development – expected publication date Feb 2014). Suggests the following; 1 Appraisal Committee's preliminary recommendations. 1.1 Total hip replacement and resurfacing arthroplasty prostheses are recommended as treatment options for people with end-stage arthritis of the hip only if the prosthesis has a rate (or projected rate) of revision of less than 5% at 10 years. 1.2 If more than one type of prosthesis meeting the above criteria is suitable for a patient, the prosthesis with the

		of NSAID analgesia, weight control treatments and physical therapies. OR 2. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44)		lowest acquisition costs should be chosen.

16.19	Diagnostic Arthroscopy for Arthritis of the Knee	Routinely commissioned where there is strong clinical suspicion of a meniscal cartilage tear/s, ACL injuries, or other specific conditions, the benefits of knee arthroscopy is considered wholly appropriate. However it is not routinely commissioned for any of the following indications: • Investigation of knee pain. • Treatment of Osteo-Arthritis including Arthroscopic washout. • If there is diagnostic uncertainty despite a competent examination or if there are ''red flag'' symptoms then a Magnetic resonance imaging (MRI) scan may be indicated. If patients have had an inconclusive MRI scan and physiotherapy the procedure may be considered.	CG59 Osteoarthritis. Section 3.1 NICE 2008 Arthroscopic knee washout, with or without debridement, for the treatment of osteoarthritis NICE 2007. Knee replacement: A guide to good practice British Orthopaedic Association, 2000. Commissioning Guide: Painful osteoarthritis of the knee Royal College of Surgeons (2013). http://guidance.nice.org.uk/CG177 CG177Osteoarthritis (NICE 2014)	
	Arthroscopic Lavage and Debridement for Osteoarthritis of the Knee	Arthroscopic lavage and debridement for knee osteoarthritis will not be commissioned, unless there is a clear history of mechanical locking (not gelling, 'giving way' or X-ray evidence of loose bodies).		
	Patient Specific Unicompartmental Knee Replacement Patient Specific Total Knee Replacement	This is not commissioned.	IPG317 Individually magnetic resonance imaging- designed unicompartmental interpositional implant insertion for osteoarthritis of the knee: guidance NICE, 2009 EMERGING TECHNOLOGY Total Knee Replacement Using Patient-specific Templates ECRI Institute (2012) IPG 345: Mini-incision surgery for total knee replacement NICE 2010	Referral should be made to specialist centres only.

16.20	Surgical Treatment for Carpal Tunnel Syndrome	Conservative treatment in the community (local corticosteroid injection and splinting) may be appropriate for mild to moderate cases. Surgery for mild to moderate cases is not commissioned unless all of the following criteria are satisfied: • Patients have not responded to 3 months of conservative treatments, including: ➢ >6 weeks of night-time use of wrist splints. ➢ Corticosteroid injection in appropriate patients. • Conservative treatments contraindicated. Severe cases: Carpal tunnel surgery (open or endoscopic) for severe symptoms (constant pins and needles, numbness and muscle wasting) will be commissioned following assessment. The following treatments are not commissioned for carpal tunnel syndrome: • Diuretics. • NSAIDS. • Vitamin B6. • Activity modification. • Heat treatment. • Botulinum toxin.	Local corticosteroid injection for carpal tunnel syndrome Cochrane Database of Systematic Reviews, 2007. Clinical practice guideline on treatment of Carpal Tunnel Syndrome American Academy of Orthopaedic Surgeons, 2008. Interim Treatment Threshold Statement: Surgery for Carpal Tunnel Syndrome NHS Oxfordshire, 2009. Non-surgical treatment (other than steroid injection) for carpal tunnel syndrome - Cochrane Database of Systematic Reviews 2002. Surgical treatment options for carpal tunnel syndrome Cochrane Database of Systematic Reviews 2007. Surgical versus non-surgical treatment for carpal tunnel syndrome Cochrane Database of Systematic Reviews 2008. Is surgical intervention more effective than non-surgical treatment for carpal tunnel syndrome? a systematic review Journal of Orthopaedic Surgery & Research 2011, 6:17. Median Nerve Lesions and Carpal Tunnel Syndrome Patient.co.uk. Commissioning Guide: Painful tingling fingers Royal College of Surgeons (2013).	Mild cases often resolve spontaneously after 6 months.

16.21	Surgical Removal of Mucoid Cysts at Distal Inter Phalangeal Joint (DIP). Surgical Removal of Ganglions	Only commissioned for mucoid cycsts under the following circumstance: Failure of conservative treatments including watchful waiting. AND any of the following • Nail growth disturbed • Discharging, ulcerated or infected. • Size interferes with normal hand function. Aspiration and Surgery for ganglion (open or arthroscopic) are not routinely commissioned.. Reassurance that no treatment is required should be given to the patient.	Digital Mucous Cyst Overview of condition – Medscape. Ganglions of the hand and wrist: determinants of treatment choice – Journal of Hand Surgery 2013 Feb. v.38(2) p151-7. http://www.fundingrequestscentralsouthern.co.uk/wp-content/uploads/2013/10/BPC-policy-152-Ganglions.pdf Berkshire PCT, 2009.	
16.22 NEW	Hip Arthroscopy for Femoro–Acetabular Impingement.	CCGs routinely commissions hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL of the following criteria: A definite diagnosis of hip impingement syndrome / femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans. An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal	IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance – NICE, 2011. http://www.hullccg.nhs.uk/uploads/policy/file/22/hip-arthroscopy-hull-ccg.pdf NHS Hull Clinical Commissioning Group 2012. Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. British Journal of Sports Medicine, 2007;41:64–68. Macfarlane RJ, Haddad FS The diagnosis and management of femoro-acetabular impingement. Annals of the Royal College of Surgeons of England, July 2010, vol/iss 92/5(363-7).	Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term. With regard to safety, there are well-recognised complications. Therefore this

		radiologist. The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.	Ng V Y et al.. Efficacy of Surgery for Femoro-acetabular Impingement: A Systematic Review. American Journal of Sports Medicine, November 2010,38 2337-2345. Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013). IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance NICE, 2011	procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.
16.23 NEW	Surgical Removal of Bunions/Surgery for Lesser Toe Deformity	Requests for the removal of bunions will only be considered where; conservative methods of management* have failed. AND the patient suffers significant functional impairment** as a result of the bunions. AND radiographic evidence of joint damage (at point of referral). *Conservative measures include: Avoiding high heel shoes and wearing wide fitting leather shoes. Non surgical treatments such as bunion pads, splints, insoles or shields or exercise where appropriate. **Significant functional impairment is defined as: The patient complains of moderate to severe joint pain not relieved by extended non-surgical management AND has severe impact on their ability to undertake activities of daily living. Treatment will not be commissioned for cosmetic	Bunions NICE Clinical Knowledge Summaries (2012) IPG 332: Surgical correction of hallux valgus using minimal access techniques NICE (2010) Commissioning Guide: Painful deformed great toe in adults Royal College of Surgeons (2013)	

		appearance only.		
16.24 NEW	Surgical Treatment of Morton's Neuroma	Surgical Treatment is not routinely commissioned unless the patient has documented evidence that they are not responding to conservative treatments and the patient is experiencing significant pain or it is having a serious impact on their daily life and completed the following pathway. 1. The patient should have had 3 months of conservative treatment in primary care such as footwear modification and metatarsal pads. 2. Been referred to an orthotist or podiatrist for an assessment. 3. Had a trial of local corticosteroid injection.	Therapeutic massage provides pain relief to a client with Morton's Neuroma: A case report - International Journal of Therapeutic Massage and Bodywork—Volume 5(2), June 2012. Clinical Inquiry. What is the best way to treat Morton's neuroma? - Journal of Family Practice 2011 v.60(3), p157-9. Morton's neuroma NICE Clinical Knowledge Summaries (2010).	
16.25 NEW	Surgical Treatment of Plantar Fasciitis	Surgical Treatment is not routinely commissioned unless the following pathway has been followed: 1. patient has documented evidence that they are not responding to conservative treatments 2. patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following 3. Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss. 4. Been referred to a podiatrist or physiotherapist. 5. Not responded to corticosteroid injections.	Heel pain--plantar fasciitis: clinical practice guidelines linked to the international classification of function, disability, and health from the orthopaedic section of the American Physical Therapy Association - Journal of Orthopaedic & Sports Physical Therapy. 2008:38(4):A1-A18. Plantar fasciitis NICE Clinical Knowledge Summaries (2009). Plantar fasciitis BMJ 2012;345:e6603.	
16.26 NEW	Treatment of Tendinopathies	These treatments are not routinely commissioned for plantar fasciitis, achilles tendinopathy, refractory tennis elbow.	IPG 311: Extracorporeal shockwave therapy for refractory plantar fasciitis NICE 2009.	

	Extracorporeal Shock Wave Therapy Autologous Blood or Platelet Injection.	***(Need to confirm if commissioned locally)***	IPG 312: Extracorporeal shockwave therapy for refractory Achilles NICE 2009. IPG 313: Extracorporeal shockwave therapy for refractory tennis elbow NICE 2009. IPG 437: Autologous blood injection for plantar fasciitis NICE 2013. IPG 438: Autologous blood injection for tendinopathy NICE 2013.	
17.	**Urology**			
17.1 NEW	Circumcision	This not offered for social, cultural or religious reasons. However certain CCGs may have individual policies. Indicated for the following condition; ➢ balantis xerotica obliterans. ➢ traumatic foreskin injury/scarring where it cannot be salvaged. ➢ 3 or more episodes of balanitis/balanoposthis. ➢ Pathological phimosis. ➢ Irreducible paraphimosis. ➢ Recurrent proven Urinary Tract Infections (UTIs) with an abnormal urinary tract.	Male Circumcision: Guidance for Healthcare Practitioners Royal College of Surgeons, 2002. 2008 UK National Guideline on the Management of Balanoposthitis – Clinical Effectiveness Group British Association for Sexual Health and HIV (2008). Balanitis NICE Clinical Knowledge Summaries 2009. I don't know, let's try some canestan: an audit of non-specific balanitis treatment and outcomes Sexually Transmitted Infections 2012;88:A55-A56. Balanitis Patient.co.uk. http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskin-conditions Royal College of Surgeons guidance (2013).	Race/cultural implications.

17.2	Penile Implant: A Surgical Procedure to Implant a Device into the Penis.	Penile prostheses for erectile dysfunction are not routinely commissioned. In rare circumstances, funding will be available for men (where clinically appropriate). An IFR will need to be submitted.	1. Penile implants NHS NWL policy 2012. 2. Telford and Wrekin CCG Penile Implants 2012. 3. Guidelines Male Sexual Dysfunction European Association Urology (2010). 4. Guidelines on the Management of ED British Society for Sexual Medicine(2007). 5. CG175: Prostate Cancer NICE 2008. 6. http://guidance.nice.org.uk/CG175 NICE 2014. 7. REFERENCES 8. Munser, A., Kalsi, J., Nazareth, I., and Arya, M. Clinical Review: Erectile dysfunction. BMJ 2014; 348. 9. Bettocchi C, Palumbo F, Spilotros M, Palazzo S, Saracino GA, Martino P et al. Penile prostheses. Therapeutic Advances in Urology 2010; 2(1):35-40. 10. Paranhos M, Andrade E, Antunes AA. Penile prosthesis implantation in an academic institution in Latin America. International Braz J 2010; 36(5):591-601. 11. Megas G, Papadopoulos G, Stathouros G, Moschonas D, Gkialas I, Ntoumas K. Comparison of efficacy and satisfaction profile, between penile prosthesis implantation and oral PDE5 inhibitor tadalafil therapy, in men with nerve-sparing radical prostatectomy erectile dysfunction. BJU International 2013; 112(2):E169-E176. 12. Wespes E, Eardley F, Guiliano F, Hatzichristou D, Hatzimouratidis K, Moncada I et al. Guidelines on male sexual dysfunction: Erectile dysfunction and premature ejaculation. 1-53. 2013. European Association of Urology. 13. Porena M, Mearini L, Marzi M, Zucchi A. Penile prosthesis implantation and couple's satisfaction. Urologia Internationalis 1999; 63(3):185-187. 14. Mulhall JP, Ahmed A, Branch J, Parker M. Serial assessment of efficacy and satisfaction profiles following penile prosthesis surgery. Journal of Urology 2003; 169(4):1429-1433. 15. Song WD, Yuan YM, Cui WS, Wu AK. Penile prosthesis implantation in Chinese patients with severe erectile dysfunction: 10 year experience. Asian Journal of	Requests for inflatable devices are received occasionally from various CCG areas. There is good evidence of high efficacy 80-100% low failure rate < 5 % after five yrs and low infection rate 2-3%. All guidelines put devices third line behind PG5 inhibitors and mechanical devices/injections etc NICE considered penile implants but did not think them high priority for review. Public Health Recommendations: 1. Penile prostheses for erectile dysfunction should be assigned low priority. 2. In rare circumstances, funding will be available for men who have failed to respond to the

			Andrology 2013; 15(5):658-661. 16. Mittmann N, Craven BC, Gordon M. Erectile dysfunction and spinal cord injury: A cost utility analysis. J Rehabil Med 2005; 37:358-364. 17. Henry, G. D., Donatucci, C. F., and Conners, W. An outcome analysis of over 200 revision surgeries for penile prosthesis implantation: a multicenter study. J Sex Med 2012; 9:309-315. 18. Hackett G, Dean J, Kell P, Price D, Ralph D, Speakman M et al. British Society for Sexual Medicine Guielines on the Management of Erectile Dysfunction. 1-34. 2007. Staffordshire, British Society for Sexual Medicine. 19. Kendirci M, Tanriverdi O, Trost L, Hellstrom WJ. Management of sildenafil treatment failures. Current Opinion in Urology 2006; 16(6):449-459. 20. Prostate cancer: diagnosis and management. 175, 1-45. 2014. London, National Institute for Health and Care Excellence. Clinical Guideline. 21. Treatment for impotence. 148, 1-7. 1999. London, Department of Health. Health Service Circular. 22. Ateia AH, Voinescu O, Geavlete R. Penile prosthesis in the surgical treatment of Peyronie's disease. Journal of Medicine & Life 2012; 5(3):280-282.	British Society for Sexual Medicine guidelines first and second line recommended treatments and who have one of the following conditions:- • Peyronie's disease. • Post – priapism. • Malformation of the penis.  Evidence Briefing Penile Prosthesis.doc
17.3 NEW	Reversal of Male Sterilisation	The NHS does not commission this service. Patients consenting to vasectomy should be made fully aware of this policy. Reversal will be only considered in exceptional circumstances such as the loss of a child.		Cross reference to fertility policy.
17.4 NEW	ESWT (extracorporeal shockwave therapy) for Prostadynia or Pelvic Floor Syndrome	This is not commissioned as there is limited clinical evidence of effectiveness.	Guidelines on chronic pelvic pain European Association of Urology (2012).	
17.5 NEW	Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome	This is not commissioned as there is limited evidence of effectiveness.	Guidelines on chronic pelvic pain European Association of Urology (2012).	
17.6	Surgery for Prostatism	Only commissioned where there are sound clinical	CG97: Lower urinary tract symptoms: The management of	No references to

NEW		reasons and after failure of conservative treatments and in any of the following circumstances: ➢ International prostate symptom score >7; ➢ dysuria; ➢ post voided residual volume >150ml; ➢ recurrent proven Urinary Tract Infections (UTI); ➢ deranged renal function; ➢ Prostate-specific antigen (PSA) > age adjusted normal values.	lower urinary tract symptoms in men NICE 2010. LUTS in men, age-related (prostatism) NICE Clinical Knowledge Summaries (2010). http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/luts Royal College of Surgeons (2013).	treatment thresholds found.
18.	**Vascular**			
18.1 NEW	Surgery for Extreme Sweating Hyperhydrosis – all areas surgical resection endoscopic thoracic sympathectomy	Treatment is medical. Treatment of hyperhidrosis with surgery is not routinely commissioned. Risk of compensatory hyperhidrosis elsewhere is very high.	Hyperhidrosis – NICE Clinical Knowledge Summaries (2013). Hyperhidrosis Patient.co.uk.	
18.2 NEW	Chelation Therapy for Vascular Occlusions	This is not commissioned.	Diagnosis and management of Peripheral arterial disease: A national clinical guideline -SIGN, 2006. Effect of Disodium EDTA Chelation Regimen on Cardiovascular Events in Patients With Previous Myocardial Infarction The TACT Randomized Trial JAMA. 2013;309(12):1241-1250.	A recent trial has been published showing some modest benefit post MI but concluded evidence was not sufficient to support routine use post MI.
18.3	Interventional Treatments e.g. endothermal ablation, foam sclerotherapy and surgery for varicose veins.	Treatment of varicose veins is not commissioned except in the following circumstances: • Ulcers/history of ulcers secondary to superficial venous disease. • Liposclerosis. • Varicose eczema. • History of phlebitis.	CG168: Varicose Veins in the legs NICE 2013. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base	Position unchanged - It is recommended that further consultation is held on this aspect of the Cheshire and Merseyside PLCP and that the current guidance is maintained in the

			- London Health Observatory 2010. A systematic review and meta-analysis of treatments for varicose veins – Centre for Reviews and Dissemination 2011 Ultrasound-guided foam sclerotherapy for varicose veins – NICE IPG 440 2013 A systematic review and meta-analysis of randomised controlled trials comparing endovenous ablation and surgical intervention in patients with varicose vein – Centre for Review and Dissemination 2013 CG 168: Varicose veins NICE 2013 http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/varicose-veins Royal College of Surgeons (2013)	interim period. Varicose Veins Summary.docx
19.	**Other**			
19.1	Botulinum Toxin A & B Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migrane.	The use of botulinum toxin type A is commissioned in the following indications: • Anal fissures only following a minimum of two months with standard treatment (lifestyle and topical pharmaceutical products) for chronic anal fissures that have not resulted in fissure healing; and only a maximum of 2 courses of injections. • Blepharospasm and hemifacial spasm. • Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities (i.e. in line with NICE Clinical Guideline 8). http://guidance.nice.org.uk/CG8 • Focal dystonia, where other measures are inappropriate or ineffective. • Focal spasticity in patients with upper motor	NICE TA260 June 2012 –Migraine (chronic) botulinum toxin type A http://guidance.nice.org.uk/TA260 Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171 and only one course of injections. **Diagnosis and management of hyperhidrosis** British Medical Journal	

		neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries and neurodegenerative disease, where other measures are inappropriate or ineffective. • Idiopathic cervical dystonia (spasmodic torticollis). • Prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) that has not responded to at least three prior pharmacological prophylaxis therapies, and whose condition is appropriately managed for medication overuse (i.e. in line with NICE Technology Appraisal 260). http://guidance.nice.org.uk/TA260 • Refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women) http://guidance.nice.org.uk/CG171 and Clinical Guideline 97 (men) http://guidance.nice.org.uk/CG97 where conservative therapy and conventional drug treatment has failed to control symptoms. • Sialorrhoea (excessive salivary drooling), when all other treatments have failed. Botulinum toxin type A is not routinely commissioned in the following indications: • Canthal lines (crow's feet) and glabellar (frown) lines. • Hyperhidrosis. • Any other indication that is not listed above: The use of botulinum type B is not routinely commissioned. Where the use of botulinum toxin is used to treat an indication outside of the manufacturer's marketing		

		authorisation, clinicians and patients should be aware of the particular governance requirements, including consent (which must be documented) for using drugs outside of their licensed indications. For patients with conditions which are not routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Merseyside Clinical Commissioning Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Merseyside. Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG's defined processes. If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated.		

Appendix 1: Cataract Referral Guidance

Referrals for cataract should only be made in the following context:-

1) ASSESSMENT OF VISION AND QUALITY OF LIFE

Questions	Responses		
	A	**B**	**C**
1. How well can patient see objects in the distance?	without difficulty	with slight difficulty	with great difficulty
2. How well can patient read writing on the TV and/or road signs?	without difficulty	with slight difficulty	with great difficulty
3. How well can patient recognise people on the street?	without difficulty	with slight difficulty	with great difficulty
4. How well can patient read from newspapers/books?	without difficulty	with slight difficulty	with great difficulty
5. How often does patient suffer from glare at night?	without difficulty	with slight difficulty	with great difficulty

Interpretation

- If answer to question 4 is b or c, this is often an indication of macular problems rather than cataract. If this is the only problem, referral for cataract surgery is inappropriate. However, referral for an opinion on maculopathy might be required.
- If answers to questions 1 to 3 are mainly (c), this is probably cataract-related and referral may be appropriate.
- If glare is the ONLY problem (question 5), the referrer (after discussion with the patient) will need to make a judgement as to the potential impact of cataract removal before deciding whether surgery is appropriate.

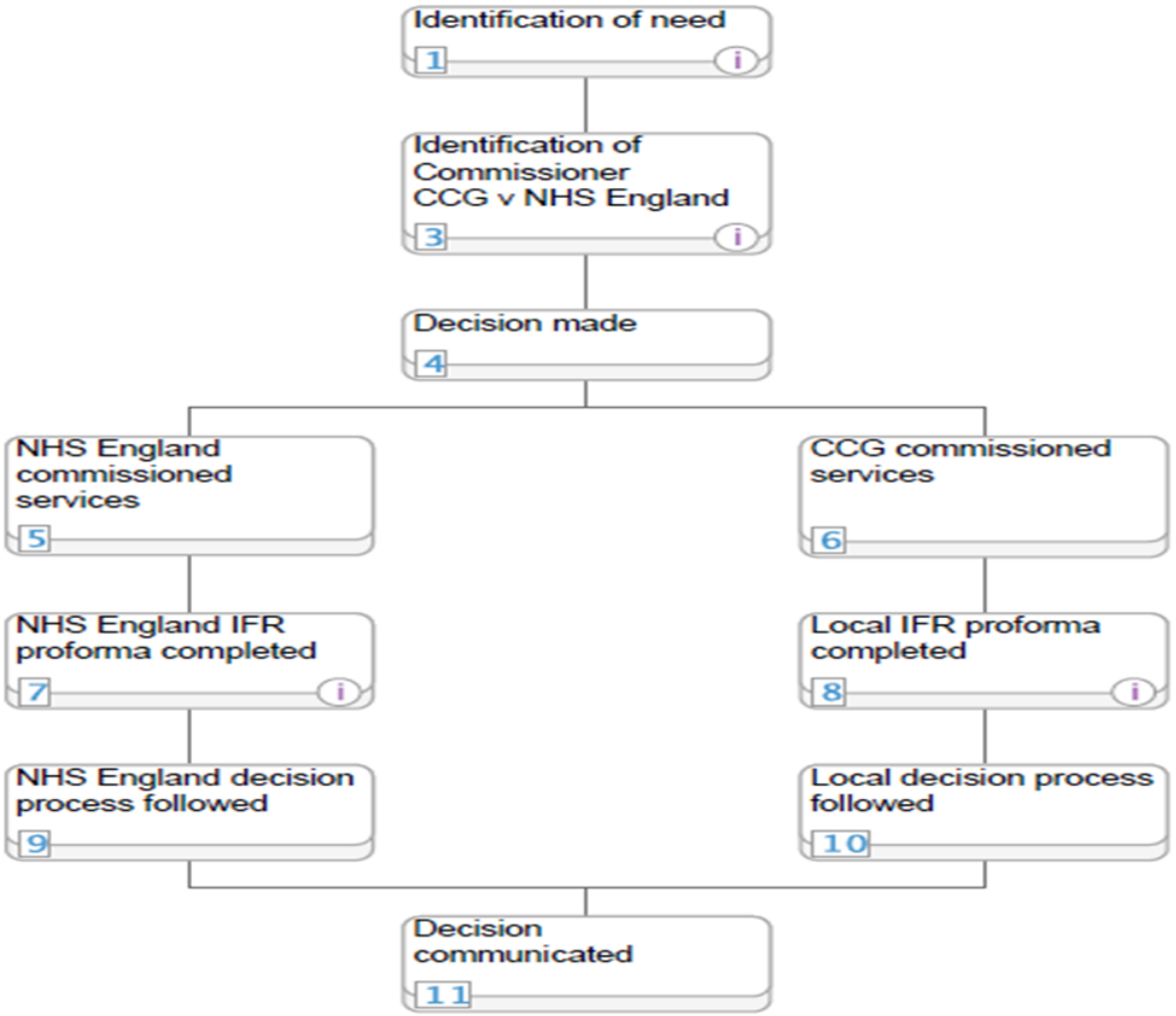
2) FITNESS FOR SURGERY

Is the patient medically fit for surgery?

3) RISKS AND CONSENT
Has the potential to benefit been explained?
Have details of the procedure and risks been explained to patient?
Is patient still willing to proceed?

The referrer should be satisfied that the criteria outlined in (1) to (3) have all been met before referring

Appendix 2 IFR Process



Appendix 3 - IFR Panel Contact Details

Telephone: 01244 650 305

Email:

CCG	Email Address
Wirral CCG	Wirralccg.IFR@nhs.net
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Eastern Cheshire CCG	Easterncheshireccg.IFR@nhs.net
South Cheshire CCG	Southcheshireccg.IFR@nhs.net
Vale Royal CCG	Valeroyalccg.IFR@nhs.net
Warrington CCG	Warringtonccg.IFR@nhs.net
Liverpool CCG	IFR.manager@nhs.net
Halton CCG	IFR.manager@nhs.net
Knowsley CCG	IFR.manager@nhs.net
Southport & Formby CCG	IFR.manager@nhs.net
South Sefton CCG	IFR.manager@nhs.net
St Helens CCG	IFR.manager@nhs.net

Version	Date	Author	Status	Comments
1.0	23.01.11	CISSU, Champs & Cheshire and Mersey PCTs	Review date 2012	This policy superseded all individual PCT policies.
Draft version 1.2	Oct 2013	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Draft Policy following review of evidence. Supporting documentation produced outlining changes and impact.
Draft Version 1.3	19th Dec 13	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Botulinum Toxin A & B section added (19.1). Duplicates numbers 18.8 same as 18.14 & 18.9 same as 18.15 removed. Childlessness definition amended in Infertility policy.
Draft Version 1.4	6th Jan 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Minor wording changes made following legal advice.
Draft version 1.5	27th Jan 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Amendments made to penile implants section following legal advice and during consultation. CG175 Prostate cancer: NICE guideline 2014 NICE 2014 evidence also added.
Draft 1.6	29th Jan 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Additional evidence added under Adenoidectomy. Health Technology Assessment Volume: 18 Issue: 5.
Draft 1.7	24th Feb 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section says do not give hyaluronic injections – added to section -Hyaluronic Acid and Derivatives Injections for Peripheral Joint Pain. http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Introduction: Psychological Distress. First paragraph. Minor wording change - Following words removed from the sentence 'an', intervention' and an 'a' added.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Introduction: Psychological Distress. Second paragraph. Following wording removed. 'and will need to be supported by a current psychological assessment, which specifically addresses current and prior engagement with appropriate psychological or psychiatric treatment.'. Wording revised as psychological distress effects a number of cases and psychological assessments may not be required for all.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Introduction: Personal data – photographs. Additional wording added. *'Information in Payment: Costs incurred for photographic evidence will be the responsibility of the referrer. Photographic evidence is often required in cases which are being considered on exceptionality. They are reviewed by clinical member/s of*

				the IFR team only.'
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Introduction: Evidence section added. New wording added and states *'At the time of publication the evidence presented was the lost current available. Where reference is made to publications over five years old, this still represents the most up to date view.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Introduction: Red, amber green table outlining changes in draft document removed and the following accompany wording –' *For the purposes of engagement process only, this policy includes under the comments the following key to assist readers in understanding the proposed change.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Red, amber, green, and blue (new) colour coding removed from the numbered and comments section.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	1.1. Bariatric Surgery: Following wording removed '*Please see local policies and pathways for criteria.*' And replaced with the following wording. *'Please see latest guidance from NHS England re guidance on commissioning bariatric surgery pathways'.*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	2.1 Complimentary therapies: Following wording removed '*including Homeopathy'.* Additional evidence added: http://www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/inquiries/homeopathy-/
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	3.2 Surgical treatment for removal of Lipoma in Secondary Care. Following wording removed from comments section. ' *There is argument to remove lipomas when they are smaller as this is easier and could be done in a community setting.'.*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	3.3. Treatment for hypo- pigmentation. Details for a local Wirral provider added. Following worded added to the comments section; *'Access available for Wirral patients via Dermatology Dept'.*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	4.1 Continuous Glucose Monitoring: The following wording has been removed from the comment section. '*There is some evidence that CGM may be beneficial for a narrow group of young children on insulin pump therapy who despite optimal conventional monitoring are difficult to control and experience severe hypoglycaemic episodes, that they do not have awareness of and severely interfere with daily routines and activities*. The situation is less clear in adults. There is on-going public health review in this area.'

				The following wording has been removed from the exceptionality section: *'Evidence to support the use of Continuous Glucose Monitors (CGM) is limited. CGM will not be routinely commissioned.'* The following new wording has been added under the exceptionality section: Not routinely commissioned and only considered if all of the following criteria are met. • Type I diabetes. • AND currently on a sensor augmented continuous subcutaneous insulin pump in strict accordance with NICE appraisal TAG 151. • AND HbA_{1c} ≥ 8.5% OR experiencing severe hypoglycaemic attacks which require intervention by a carer. • AND selected to use an approved sensor augmented pump system of high specification with a low Mean Absolute Relative Difference (MARD) value. • AND managed by a recognised centre of excellence in diabetes (currently using a minimum of 20 continuous infusion pumps per annum). • AND motivated to comply with the requirements.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	5.1 Adenoidectomy: Following words have been added to the exceptionality statement. 'See 5.3' & Adenoidectomy is not 'routinely' commissioned as an isolated procedure.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	5.2. Pinnaplasty: Changes made to reflect NHS England position. Following wording removed from the comments section: *'Ear prominence is very common and can lead to low self-esteem, bullying and significant psychological morbidity particularly in childhood and adolescence.'.* Following wording removed from the exceptionality section: • *'The patient should be between 5 and 19 years of age.* • *Patient assessed by plastic or ENT surgeon who has the option to refer, when appropriate to a specialist paediatric psychologist.* *If there is evidence of psychological distress likely to be alleviated by surgery, prior approval is not required'.*

				The following wording has been added to the exceptionality section: *"To surgical "correction" of prominent ear(s) only when all of the following criteria are met:* *1. Referral only for children aged 5 to 18 years at the time of referral* *AND* *2. With very significant ear deformity or asymmetry* *Patients not meeting these criteria should not be routinely referred for surgery."*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	5.3 Grommets: Changes made to reflect NHS England & adult position. Adults and Children' sections defined. The eligibility criteria divided into A & B sections to define Children and Adult criteria. The following wording has also been added to the exceptionality section: *'B. Adults* *will fund grommets in adults with OME only in the following circumstances:* *Significant negative middle ear pressure measured on two sequential appointments AND significant ongoing associated pain.'* Following wording added to the exceptionality section.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	5.2 Tonsillectomy: Following wording removed: *'Sore throats are due to acute tonsillitis.* *The episodes of sore throat are disabling and prevent normal function.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	6.1 Lycra suits: Wording changes to reflect public health feedback: *Following wording added to the criteria* • *Evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy.*

				• *Lycra suit orthoses for cerebral palsy should be assigned low priority.* Embedded document giving additional information removed.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	9.1. Haemorrhoidectomy: Following wording changed from '*Removal of Skin tags should not ordinarily be performed.'* To *"Removal of Skin tags should is not routinely commissioned."*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	9.2 Hernias: Following wording moved from exceptionality section to comments section. *'Diastasis of the recti are unsightly but do not carry a risk of complications and surgical results can be imperfect.'.* Following wording added. *'Surgical repair is not routinely commissioned.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	11.1 Counseling services for hearing impaired Following wording changes made *INSERT TEXT HERE*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	11.3 Gender Dysphoria: The following wording added to the comments section: *'Liverpool, Sefton and Knowsley have a local support service in place at LCH.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	11.4 Non NHS Drug & Alcohol Rehabilitation: The following wording has been removed from the exceptionality section; *'These treatments will only be funded on the advice of the Community Alcohol and Drugs Teams of the Cheshire and Wirral Partnership Foundation Trust.'.* The following wording has been added under the exceptionality section:

				'This is not routinely commissioned.'
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	12.3 FES: the following wording added to the exceptionality section; *Patients must have receptive cognitive abilities.* ***Exclusion Criteria*** • *Fixed contractures of joints associated with muscles to be stimulated Broken or poor condition of skin.* • *Chronic oedema at site of stimulation.* • *Diagnosis of deep vein thrombosis.* • *Receptive dysphasia (unable to understand instructions).* • *Complete peripheral nerve damage.* • *Pacemaker in situ.* • *Pregnancy or intention to become pregnant.* • *Active cancer.* • *Uncontrolled epilepsy.* • *Metal in region of stimulation e.g.: pin and plate.* • *Ataxic and polio patients are generally poor responders although there are exceptions.*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	13.4 Short sightedness: The following wording has been added; *'routinely'* And the following wording has been removed from the exceptionality criteria. *'Glasses are lower risk and more cost effective.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	13.5 Cataract Surgery: The following wording has been added to the exceptionality section following public health feedback: *'Listing for cataract surgery should be based on symptomatic deterioration of vision e.g. difficulty reading, seeing TV, driving or visual disturbance e.g. glare/dazzle with bright sunlight or oncoming headlights.* *'All referrals should be made using the attached referral template (See appendix 1).'* Following wording from the comments section removed;

				'Further public health work in this area is being undertaken.' The following wording in the exceptionality section has been removed; *'CCGs currently have agreed clinical pathways with Optometrists'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	14.1 Wisdom teeth: Whole section removed as confirmed that this is the commissioning responsibility of NHS England.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	14.2 TMJ now numbered 14.1: Following wording added to the comments section; *'Discussions on going to confirm who is the responsible commissioner for this service.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	14.3 Orthodontics: Whole section removed as confirmed that this is the commissioning responsibility of NHS England.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	16.1 Breast Reduction: The following wording has been added to the exceptionality section. *'And* *The patients breast is a cup size H or larger.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	16.2 Breast Enlargement: The following wording has been added to the exceptionality criteria: *'In all cases:'* *'There is congenital absence of breast tissue unilaterally* *'Or'* *'All non-surgical options must have been explored e.g. padded bra.'* The following wording has been removed from the exceptionality criteria; *'any of the following: Unilateral breast enlargement is considered for breasts'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	16.3 Silicone Implants: The following wording has been removed from the exceptionality criteria: *'such as:* *Capsule contraction causing significant deformity*

				or *Implant rupture.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	16.6. Male breast reduction: The following wording has been added to the exceptionality criteria: *'e.g. tamoxifen'* *'persistent'* *'And in cases of idiopathic gynaecomastia in men under the age of 25 then a period of at least 2 years has been allowed for natural resolution'.*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	16.7 Hair Removal: Ferryman Gallwey Score definition added. *'A method of evaluating and quantifying hirsutism in women.'* The following words has also been removed from the criteria; *'Dermatologist or'* The following paper has also been removed; *'NHS North West London CCGs policy.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	16.16 Labial Reduction Surgery: The treatment section has been changed from; *'Labial Reduction Surgery'* To *'Labiaplasty, Vaginoplasty and Hymenorrhaphy'* And new evidence added; http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf
Draft	12th April	Cheshire and Merseyside	DRAFT	17.1 Treatments for Obstructive Sleep apnoea/hypopnoea syndrome in Adults (OSAHS): **Section removed.**

1.8	14	CSU on behalf of CCGs		
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	17.2 Snoring: Re-numbered to 17.1.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.1 Back Pain: The following wording has been removed from the comments section: *RCS commissioning guidance on LBP due out November.* *Gives guidance and tools.* *Will also give guidance on facet joints.* https://www.boa.ac.uk/LIB/LIBPUB/Documents/CCG_Low%20Back%20pain_draft.pdf **Fusion:** The word '*optimal'* has been removed from the criteria and replaced with the following wording under the exceptionality criteria. *'High intensity;'* The following wording has also been removed from the criteria: ' *over a period likely to be more than 12 months'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Facett Joints: Following wording removed from the criteria. '*Referral to a pain intervention service may be appropriate for consideration of therapeutic injection of facet joints or epidural injection in patients with non-specific back pain of over 12 months duration or radicular pain failing to respond to conservative treatment as per the policy attached.'* Additional wording added to the criteria *'Non Specific back pain over 12 months – Not routinely commissioned. May have a role as a diagnostic procedure when considering Radio frequency ablation. This would require an individual funding request'* Additional wording added to the title. *'Non Specific Back pain over 12 months including Radio Frequency Degeneration'*

				Additional evidence added. http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf Attachment – *'pathways for patients with low back pain'* has been removed. **Epidural Injection**: Removed and described in a section on its own. New wording added to the criteria *'Radicular Pain – Single injection may be of benefit to enable normal activity to resume in prolapsed disc & spinal stenosis where surgery is not desirable.'* *'Non Specific Back Pain – Not routinely commissioned.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.3 Endoscopic Laser Foraminoplasty **- Statement removed**
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.4. Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain **- Statement removed**
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.5 Endoscopic Lumbar Decompression **- Statement removed**
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.6 Percutaneous Disc Decompression using Coblation for Lower Back Pain **- Statement removed**
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.7 Non-rigid Stabilisation Techniques **- Statement removed**
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.8 Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine **- Statement removed**
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.9 Percutaneous Intradiscal Laser Ablation in the Lumbar Spine **- Statement removed**
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.10 Transaxial Interbody Lumbosacral Fusion **- Statement removed**
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.11 Therapeutic Endoscopic Division of Epidural Adhesions **- Statement removed**
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.12 Automated Percutaneous Mechanical Lumbar Discectomy **- Statement removed**
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.13 Prosthetic Intervertebral Disc Replacement in the Lumbar Spine**- Statement removed**
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.14 Now renumbered to 18.3.

Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.15 Trigger Finger: Now renumbered to 18.4. Following wording changed in exceptionality section; *'(including at least 2 corticosteroid injections)'* *changed to* '(including at least 1 corticosteroid injections)' And additional evidence added to support the change.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.16 Hyaluronic acid and derivatives injections for peripheral joint & secondary care administered steroid joint injections. Now renumbered to 18.5
				18.17 – Now renumbered to 18.6
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.18 Hip and Knee replacement & Hip Resurfacing Now renumbered to 18.7 Additional evidence added CG177 & TA44 NICE guidance. Following wording added: *'Funding for total or <u>partial knee replacement surgery</u> is available if the following criteria are met* *1. Patients with BMI <40* *AND* *2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.* *AND* *3. Has radiological features of severe disease;*

				OR *4. Has radiological features of moderate disease with limited mobility or instability of the knee joint* *Patients not meeting the above criteria can be referred via the IFR route where there are exceptional circumstances present.* *Referral criteria for Total Hip Replacements (THR) should be based on the level of pain and functional impairment suffered by the patient. NHS NWL CCGs will fund THR for patients who fulfil the following criteria;* *1.Patient complains of severe joint pain AND functional limitation, despite the use of non- surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.* *Or* *2. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies.'* North West London embedded documents removed.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.19 Diagnostic Arthroscopy and lavage/debridement for OA Knee Now renumbered to 18.8 Patient specific unicompartmental knee replacement patient specific total
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.20 Surgical treatment for carpel tunnel syndrome Now renumbered to 18.9 Criteria changed from *'Patients have not responded to 3 months of conservative treatments, including:* ➢ *>8 weeks of night-time use of wrist splints.'* To

				'Patients have not responded to 3 months of conservative treatments, including: ➢ >6 weeks of night-time use of wrist splints
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.21 Surgical removal of ganglion & mucoid cysts. – Now renumbered to 18.10 This section has been subdivided into two sections and the evidence for ganglions has been moved to the section on surgical removal of ganglions. The following wording in the comments section has been removed; *'50% may resolve.* *High risk of recurrence after any treatment. More radical surgery carries higher risks of complications.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.22 – Now renumbered to 18.11
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.23 – Now renumbered to 18.12
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.24 Surgical treatment of mortons neuroma. Now renumbered to 18.13 The following wording has been added to point 2 within the exceptionality criteria; 'or podiatrist'.
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.25 Surgical treatment of Plantar Fasciitis: Now renumbered to 18.14. The following wording has been changed in point 5 within the exceptionality criteria. From *'5. Been offered up to 3 corticosteroid injections 6 weeks apart.'*

				to '5. Not responded to corticosteroid injections.'
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.26 – Now renumbered to 18.15
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	19.2 Penile Implants: The following criteria wording has been removed; *'Penile Implants are not routinely commissioned.* *They may be commissioned as third line treatment in the following circumstances:* • *Peyronie's disease* • *Post priapism* • *Complex malformations* • *Post trauma '* The following wording has been added to the criteria following public health feedback; *"Penile prostheses for erectile dysfunction should be assigned low priority.* *In rare circumstances, funding will be available for men who have failed to respond to the British Society for Sexual Medicine guidelines first and second line recommended treatments* ***and*** *who have one of the following conditions;* • *Peyronie's disease* • *Post – priapism* • *Malformation of the penis'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	20.1 Surgery for Hyperhydrosis: The following word has been added to the criteria section. *'Routinely'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	20.3 Varicose Veins: The following criteria statement has been removed as the position requires additional analysis. *'Treatment is in line with NICE CG168.* *For patients with symptomatic varicose veins having a significant impact on their activities of daily living the following pathway applies.*

				Refer people to a vascular service[1] if they have any of the following. • *Symptomatic[2] primary or symptomatic recurrent varicose veins.* • *Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency.* • *Superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence.* • *A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks).* • *A healed venous leg ulcer.* *1. A team of healthcare professionals who have the skills to undertake a full clinical and duplex ultrasound assessment and provide a full range of treatment.* *2. Veins found in association with troublesome lower limb symptoms (typically pain, aching, discomfort, swelling, heaviness and itching).* *Compression hosiery is not recommended unless patients are not willing or are unfit for surgery.'* The current criteria/commissioning statement has been continued i.e. 'Treatment of varicose veins is not commissioned except in the following circumstances: - *Ulcers/history of ulcers secondary to superficial venous disease.* - *Liposclerosis.* - *Varicose eczema.* - *History of phlebitis.'*
Draft 1.8	12th April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	General: Numbering reordered following the removal of a number of sections.
Draft 1.9	25th April 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	6.1 Use of Lycra Suits: Removed *"Lycra suit orthoses for cerebral palsy should be assigned low priority."*

Draft 1.9	25th April 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	13.5 Cataract Surgery: Removed *"symptomatic deterioration of vision e.g. difficulty reading, seeing TV, driving or visual disturbance e.g. glare/dazzle with bright sunlight or oncoming headlights."* Added: *"the quality of vision and impact on daily life e.g. difficulty with reading, driving etc."*
Draft 1.9	25th April 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	19.2 Penile Implants: Removed *"should be assigned low priority"* Added *"are not routinely commissioned".* Removed *"who have failed to respond to the British Society for Sexual Medicine guidelines first and second line recommended treatments* ***and*** *who have one of the following conditions;* • *Peyronie's disease* • *Post – priapism* • *Malformation of the penis* • *Prostate Cancer. NICE CG58 2008"* Added *"(where clinically appropriate)"* *Removed* *"CG58"*

				Added *"CG175"*
Draft 1.9	25th April 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.5 Hyaluronic Acid and Derivatives Injections for Peripheral Joint Pain Removed *"http://guidance.nice.org.uk/CG177/NICEGuidance/pdf/English"*
Draft 1.9	25th April 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	11:1 Counselling Services for Hearing Impaired Adults with Mental Health Problems Removed *"sign language) and who need specialist counselling and support will be considered on a case by case basis.* *Some CCGs commission the service from non NHS providers"* Added " *(British Sign Language) BSL should have access to IAPT services that use therapists with training in BSL"*
Draft 1.9	28th April 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	3.3 Tile changed from *' Treatments for Hypo-pigmentation'* to *'Treatments for Skin Pigment Disorders'*
Draft 1.9	28th April 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	16.1: Reduction Mammoplasty - Female Breast Reduction Reference to 500g reduction changed to three cup size reduction. And

				The following additional criteria has been added; '*Aged over 18 years old'*
Draft 1.10	5th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.1 Back Pain: The following wording was reinserted in the comments section: *RCS commissioning guidance on LBP due out November.* *Gives guidance and tools.* *Will also give guidance on facet joints.* https://www.boa.ac.uk/LIB/LIBPUB/Documents/CCG_Low%20Back%20pain_draft.pdf **Fusion:** The word *'High intensity'* has been removed from the criteria and replaced with the following wording under the exceptionality criteria. '*optimal'* The following wording has also been reinserted into the criteria: ' *over a period likely to be more than 12 months'*
Draft 1.10	5th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Facett Joints: Following wording reinserted into the criteria. '*Referral to a pain intervention service may be appropriate for consideration of therapeutic injection of facet joints or epidural injection in patients with non-specific back pain of over 12 months duration or radicular pain failing to respond to conservative treatment as per the policy attached.'* Attachment – *'pathways for patients with low back pain'* has been reinserted.
Draft 1.10	5th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	'Peripheral Nerve-field Stimulation (PNFS) for Chronic Low Back Pain' – procedure reinserted.
Draft 1.10	5th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	'Endoscopic Lumbar Decompression' – procedure reinserted.
Draft	5th June	Cheshire and Merseyside	DRAFT	'Percutaneous Disc Decompression using Coblation for Lower Back Pain' - procedure reinserted.

1.10	2014	CSU on behalf of CCGs		
Draft 1.10	5th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	'Non-rigid Stabilisation Techniques' – procedure reinserted.
Draft 1.10	5th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	'Lateral (including extreme, extra and direct lateral) Interbody Fusion in the Lumbar Spine' - procedure reinserted.
Draft 1.10	5th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	'Percutaneous Intradiscal Laser Ablation in the Lumbar Spine' – procedure reinserted.
Draft 1.10	5th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	'Transaxial Interbody Lumbosacral Fusion' – procedure reinserted.
Draft 1.10	5th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	'Therapeutic Endoscopic Division of Epidural Adhesions' – procedure reinserted.
Draft 1.10	5th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	'Automated Percutaneous Mechanical Lumbar Discectomy' - procedure reinserted.
Draft 1.10	5th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	'Prosthetic Intervertebral Disc Replacement in the Lumbar Spine' - procedure reinserted.
Draft 1.11	9th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	1. Bariatric Manangement statement **removed.**
Draft 1.11	9th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	11.1 Counselling Services for Hearing Impaired Adults with Mental Health Problems statement **removed.**
Draft 1.11	9th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Whole policy renumbered.
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Paragraph removed re NW cancer prioritisation steering group as recommended by MM team and new note added stating funding for all solid and haemological cancers are now the responsibility of NHS England.
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Botox changed to Botulinum Toxin A & B.
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Amended; " Not routinely commissioned for the following conditions: ▪ Hyperhidrosis ▪ Chronic anal fissure ▪ Sphincter of Oddi dysfunction ▪ Carpal tunnel syndrome ▪ Cosmetic surgery procedures e.g. Glabellar lines/wrinkles ▪ Chronic migraine - only commissioned in accordance with NICE TA260 June 2012 –Migraine (chronic)

				botulinum toxin type A http://guidance.nice.org.uk/TA260 ▪ Idiopathic detrusor instability - only commissioned in accordance with NICE CG171 Sept 2013 - Urinary incontinence in women http://guidance.nice.org.uk/CG171 and only one course of injections." To " The use of botulinum toxin type A is commissioned in the following indications: • Anal fissures only following a minimum of two months with standard treatment (lifestyle and topical pharmaceutical products) for chronic anal fissures that have not resulted in fissure healing; and only a maximum of 2 courses of injections. • Blepharospasm and hemifacial spasm. • Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities (i.e. in line with NICE Clinical Guideline 8). http://guidance.nice.org.uk/CG8 • Focal dystonia, where other measures are inappropriate or ineffective. • Focal spasticity in patients with upper motor neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries and neurodegenerative disease, where other measures are inappropriate or ineffective. • Idiopathic cervical dystonia (spasmodic torticollis). • Prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) that has not responded to at least three prior pharmacological prophylaxis therapies, and whose condition is appropriately managed for medication overuse (i.e. in line with NICE Technology Appraisal 260). http://guidance.nice.org.uk/TA260 • Refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women) http://guidance.nice.org.uk/CG171 and Clinical Guideline 97 (men) http://guidance.nice.org.uk/CG97 where conservative therapy and conventional drug treatment has failed to control symptoms. • Sialorrhoea (excessive salivary drooling), when all other treatments have failed. Botulinum toxin type A is not routinely commissioned in the following indications: • Canthal lines (crow's feet) and glabellar (frown) lines. • Hyperhidrosis. • Any other indication that is not listed above: The use of botulinum type B is not routinely commissioned. Where the use of botulinum toxin is used to treat an indication outside of the manufacturer's marketing authorisation, clinicians and patients should be aware of the particular governance requirements, including consent (which must be documented) for using drugs outside of their licensed indications.

				For patients with conditions which are not routinely commissioned, as indicated above, requests will continue to be considered by Cheshire & Merseyside Clinical Commissioning Groups processes for individual funding requests, if there is evidence that the patient is considered to have clinically exceptional circumstances to any other patient experiencing the same condition within Cheshire & Merseyside. Requests to commission the use of botulinum toxin as an option to treat other indications, where a known cohort of patients can be identified, should be processed in accordance with the relevant CCG's defined processes. If a subsequent CCG approved policy supersedes the information above, this section will be reviewed and updated."
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 6 removed reference to Cheshire & Mersey Fertility policy and replaced with individual CCG policy.
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Varicose Veins: Removed "See below for discussion of issues."
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Varicose Veins: Removed "Currently there is no consensus amongst CCGs. There is ongoing work to facilitate this process and understand the potential impact if adopted. This section is subject to changes. Recommendations: It is recommended that the 12 CCGs in Cheshire and Merseyside commit to an extension of the review and consultation on this new guidance. This is because of the uncertainties identified above. Public Health further review required to properly test out the assumptions described, and allow a full discussion between stakeholders."
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 3.1 added "All cases will be subject to individual approval by the IFR Team".
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 3.1 Continuous Glucose Monitoring embedded Public Health papers.
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 3.1 Continuous Glucose Monitoring added " The device should be withdrawn from patients who fail to achieve clinically significant response after 6 months."
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 12.5 Cataract Surgery Removed: "Listing for cataract surgery should be based on the quality of vision and impact on daily life e.g. difficulty with reading, driving etc." Added: "Referral for cataract surgery should be based on symptomatic deterioration of vision e.g. difficulty reading, seeing TV, driving or visual disturbance e.g. glare/dazzle with bright sunlight or oncoming headlights. An example of a referral template for use by optometrists is given in appendix 1. There is good evidence that bilateral cataract replacement is beneficial." And embedded Public Health paper.

Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	5.1 Use of Lycra Suits: embedded Public Health paper.
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	18.1 Penile Implant: embedded Public Health paper.
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 19.3 Interventional treatments: embedded Public Health paper.
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Removed Section 7 Gastroenterology.
Draft 1.12	24th June 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Added proposed review date.
				3.1 Continuous Glucose Monitoring Removed " Public Health recommendations: There may be an extremely small cohort of patients who would benefit from this intervention, based on the best evidence available. These patients must fulfil the following criteria: Type I diabetes AND Currently on a sensor augmented continuous subcutaneous insulin pump in strict accordance with NICE appraisal TAG 151. AND $HbA_{1c} \geq 8.5\%$ OR Experiencing severe hypoglycaemic attacks which require intervention by a carer. AND Selected to use an approved sensor augmented pump system of high specification with a low Mean Absolute Relative Difference (MARD) value. AND Managed by a recognised centre of excellence in diabetes (currently using a minimum of 20 continuous infusion pumps per annum).

				All other requests will not be funded."
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 2.1 Skin Resurfacing: Added "Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities."
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 2.3 Skin Pigmentation: Added "Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities."
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 4.7 Rhinoplasty: Added "Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities."
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 9.2 Gender Dysphoria: Added "Patients with Gender Dysphoria issues should be referred to the Gender Identity Clinic (GIC) at either Charring Cross, Leeds, Nottingham or Sheffield. It is no longer necessary to access local services for assessment. Core surgery is commissioned by NHS England but there are a number of non-core treatments which will need consideration for funding by the CCG. These requests should be made by the GIC only and considered on an individual basis. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14"
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 14.2 Augmentation Mammoplasty - Breast Enlargement: Added "Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities."

Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 14.1 Reduction Mammoplasty - Female Breast Reduction: Added "Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities."
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 14.3 Removal and/or Replacement of Silicone Implants - Revision of Breast Augmentation: Added "Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol NHS England (2013) Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities."
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 14.4 Mastopexy - Breast Lift: Added "Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol"
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 14.5 Surgical Correction of Nipple Inversion: Added " Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol"
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 14.6 Male Breast Reduction Surgery for Gynaecomastia: Added " Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol"
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 14.7 Hair Removal Treatments including Depilation Laser Treatment or Electrolysis – for Hirsutism: Added "Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14

				NHS England interim protocol"
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 14.9 Surgical Revision of Scars: Added " Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol"
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 14.12 Other Skin Excisions/Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty): Added " Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol"
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 14.13 Treatments to Correct Hair Loss for Alopecia: Added "Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol"
Draft 1.13	2nd July 2014	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Section 14.14 Hair Transplantation: Added "Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14 NHS England interim protocol"

Appendix B

DRAFT

Version 1.5

Cheshire & Merseyside

NHS Funded Treatment for Subfertility

Policy

Table of Contents

1. INTRODUCTION

1.1 This policy describes circumstances in which the Clinical Commissioning Group (CCG) will fund treatment for subfertility as defined in section 3.

1.2 The objective of treatment for subfertility is to achieve a successful pregnancy quickly and safely with the least intervention required and the delivery of a healthy child.

1.3 The criteria set out in this policy apply irrespective of where the residents of the CCG have their treatment (local NHS hospitals, tertiary care centres or independent sector providers). A patient is defined as someone registered with a GP practice within the CCG boundary.

This policy has drawn on guidance issued by the Department of Health, Infertility Network UK and the NICE guidance (CG156) published in February 2013.

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_101068.pdf

http://www.infertilitynetworkuk.com/uploadedFiles/Standardising%20Access%20Criteria%20to%20NHS%20Fertility%20Treatment%2009%2006%2009.doc

http://guidance.nice.org.uk/CG156 (summary guidance)

http://www.nice.org.uk/nicemedia/live/14078/62770/62770.pdf (full guidance)

2. GENERAL PRINCIPLES

2.1 The CCG has had regard to the NICE guidance in the formulation of this policy.

2.2 The eligibility criteria set out below does not apply to clinical investigations for subfertility which are available to anyone with a fertility problem.

2.3 The eligibility criteria does not apply to the use of assisted conception techniques for reasons other than subfertility, for example in families with serious inherited diseases where in-vitro fertilization (IVF) is used to screen out embryos carrying the disease (see section 19), or to preserve fertility, for example for patients about to undergo chemotherapy, radiotherapy or other invasive treatments.

2.4 The CCG respects the right of patients to be treated according to the obligations set out in the NHS Constitution and the Human Rights Act specifically with regard to age and sex discrimination.

3. DEFINITION OF SUBFERTILITY, TIMING OF ACCESS TO TREATMENT AND AGE RANGE

3.1 Fertility problems are common in the UK and it is estimated that they affect one in seven couples. 84% of couples in the general population will conceive within one year if they do not use contraception and have regular sexual intercourse. Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate 92%). In 25% of infertility cases the cause can not be identified.

3.2 Where a woman is of reproductive age and having regular unprotected vaginal intercourse two to three times per week, failure to conceive within twelve months should be taken as an indication for further assessment and possible treatment. In the following circumstances an earlier assessment should be considered:

- If the woman is aged 36 or over then such assessment should be considered after 6 months of unprotected regular intercourse since her chances of successful conception are lower and the window of opportunity for intervention is less.
- If there is a known clinical cause of infertility or a history of predisposing factors for infertility.

3.3 Women should be offered access to investigations if they have subfertility of at least 1 year duration (6 months for women aged 36 and over) and offered IVF if they have subfertility of at least 2 years duration (12 months for women aged 36 and over). Additional criteria apply for IVF in women aged 40 – 42 (See paragraph 12.4).

3.4 If, as a result of investigations, a cause for the infertility is found, the patient should be referred for appropriate treatment without further delay.

The CCG will offer access to intra-uterine insemination (IUI) or donor insemination (DI) services where appropriate after subfertility of at least 12 months duration. See NICE guidance recommendations 117 – 119.

http://www.nice.org.uk/nicemedia/live/14078/62769/62769.pdf

This policy adopts the NICE guidance that access to high level treatments including IVF should be offered to women between the ages of 23 - 42. First treatment cycles must be commenced before the woman's 42nd birthday (See section 12.4 for further details).

Women will be offered treatment provided their hormonal profile is satisfactory i.e. in line with NICE CG156 section 6.3 guidance recommendations.

http://www.nice.org.uk/nicemedia/live/14078/62769/62769.pdf.

4. DEFINITION OF CHILDLESSNESS

4.1 Funding will be made available where a couple have no living children from a current or any previous relationship i.e. if previous living child from current or previous relationship then excluded from sub fertility treatment.

4.2 A child adopted by a patient or adopted in a previous relationship is considered to have the same status as a biological child.

4.3 Once a patient is accepted for sub fertility treatment they will no longer be eligible for further treatment if a pregnancy leading to a live birth occurs or the patient adopts a child.

5. SAME SEX COUPLES AND SINGLE WOMEN

5.1 This policy is intended, as per NICE guidance, for people who have a possible pathological problem (physical or psychological) to explain their infertility. The CCG will fund sub

fertility treatment for same sex couples and single women provided there is evidence of proven subfertility, defined as no live birth following artificial insemination (AI) of up to 6 cycles or proven by clinical investigation as per NICE guidance. AI must be undertaken in a clinical setting with an initial clinical assessment and appropriate investigations.

5.2 The CCG will not fund the AI cycles referred to in 5.1 but will fund access to a clinical consultation to discuss options for attempting conception, further assessment and appropriate treatment.

6. SURROGACY

6.1 The CCG will not commission any form of fertility treatment to those in surrogacy arrangements (i.e. the use of a third party to bear a child for another couple). This is due to the numerous legal and ethical issues involved.

7. REVERSAL OF STERILISATION AND TREATMENT FOLLOWING REVERSAL

7.1 Subfertility treatment will not normally be provided where this is the result of a sterilisation procedure in either partner.

7.2 The surgical reversal of either male or female sterilisation will not normally be funded.

7.3 Where sub fertility remains after a reversal of sterilisation, treatment will not normally be funded.

8. FEMALE BODY MASS INDEX (BMI)

8.1 Women will be required to achieve a BMI of 19-29.9 before sub fertility treatment begins. Women outside this range can still undergo investigations and be added to the 'watchful-waiting' list but sub fertility treatment will not commence until their BMI is within this range.

9. SMOKING

9.1 Patients should be confirmed non-smokers in order to access any sub fertility treatment and must continue to be non smoking throughout treatment. Providers should seek evidence from referrers and confirmation from patients. Providers should also include this undertaking on the consent form and ask patients to acknowledge that smoking could result in cessation of treatment.

10. DRUGS AND ALCOHOL

10.1 Patients will be asked to give an assurance that their alcohol intake is within Department of Health guidelines and they are not using recreational drugs. Any evidence to the contrary will result in the cessation of treatment.

https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence

https://www.gov.uk/government/policies/reducing-harmful-drinking

11. INTRA – UTERINE INSEMINATION (IUI) / DONOR INSEMINATION (DI)

11.1 Consider unstimulated intrauterine insemination as a treatment option in the following groups as an alternative to vaginal sexual intercourse:

- people who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychosexual problem who are using partner or donor sperm;

- people with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive);

- people in same -sex relationships.

For those people who have not conceived after six (6) cycles of donor or partner insemination, despite evidence of normal ovulation, tubal patency and semen analysis, offer a further six (6) cycles of un-stimulated intrauterine insemination before IVF is considered.

11.2 For people with unexplained infertility, mild endometriosis or 'mild male factor infertility', who are having regular unprotected sexual intercourse, do not routinely offer intrauterine insemination, either with or without ovarian stimulation. Advise them to try to conceive for a total period of time as per section 3.3 before IVF will be considered.

11.3 Donor insemination (with IUI) will be funded where clinically indicated.

11.4 Stimulated IUI will be funded where clinically indicated, due concern must be given to the risk of multiple births in this situation and insemination abandoned if this is felt to be a possibility.

11.5 Patients who are receiving IUI who have not conceived after 6 cycles of donor or partner insemination, despite evidence of normal ovulation, tubal patency and semenalysis, should be offered a further 6 cycles of unstimulated intrauterine insemination before IVF is considered.

11.6 Patients who fail to achieve a pregnancy using IUI/DI will be considered for IVF.

12. IVF DEFINITION AND NUMBER OF CYCLES

12.1 A cycle is the process whereby one course of IVF (or ICSI) commences with ovarian stimulation and is deemed to be complete when all viable fresh and frozen embryos resulting from that stimulation have been replaced.

12.2 For women aged 23-39 the CCG offers **1*, 2* or 3*** (*individual CCGs to confirm positions) full cycles.

12.3 All cycles must be commenced before 40th birthday.

12.4 For women aged 40 and up to 42 the CCG offers 1 full cycle provided:
They have never previously had IVF (including privately);

There is no evidence of low ovarian reserve; (see section 3.7 or NICE Guidance section 6.3).
There has been a discussion about the implications of IVF at this age.
The cycle must be commenced before the woman's 42nd birthday.

12.5 Access to additional cycles is not an automatic right – the outcome of any previous cycle will be taken into account.

12.6 The number of IVF cycles commissioned is unrelated to the number of IUI/DI cycles commissioned.

12.7 As IVF success rates decline significantly after 3 cycles the CCG will take into account the number of cycles received irrespective as to whether they were funded by the NHS or privately.

12.7.1 If patients have funded **3** or more IVF cycles privately they will not be entitled to any NHS funded cycles.

12.7.2 If patients have funded **2*** cycles privately they will be entitled to **1*** (individual CCGs to confirm positions) NHS cycle.

12.7.3. If patients have funded 1 cycle privately they will be entitled to **1*** or **2*** (individual CCGs to confirm positions) NHS cycles

13. NUMBER OF TRANSFERRED EMBRYOS

13.1 In keeping with the Human Fertilisation and Embryology Authority's (HFEA) multiple birth reduction strategy patients will be counselled about the risks associated with multiple pregnancies and advised that they will receive a single embryo transfer (whether fresh or frozen) unless there is a clear clinical justification for not doing so (e.g. a single top quality embryo is not available). In any event a maximum of 2 embryos will be transferred per procedure (either fresh or frozen).

13.2 Patients with a good prognosis should be advised that a single embryo transfer, involving fresh followed by frozen single embryo transfers, can virtually abolish the risk of a multiple pregnancy while maintaining a live birth rate which is the same as that achieved by transferring 2 fresh or frozen embryos.

13.3 The CCG will only contract with providers who make a public commitment to comply with the HFEA single embryo transfer policy and can demonstrate significant progress towards achieving the annual target set by the HFEA with performance that is not signicantly above the target.

13.4 Further information is available via the HFEA's 'One at a Time' website - http://www.oneatatime.org.uk.

13.5 Provider multiple-pregnancy data is available via the HFEA's website - http://www.hfea.gov.uk/6195.html

14. CANCELLED AND ABANDONED CYCLES

14.1 A cancelled cycle is defined by NICE as 'egg collection not undertaken'. This would not count as a cycle when considering eligible number of cycles.

14.2 An abandoned cycle is not defined by NICE but is defined by this policy as including IVF treatment leading to a failed embryo transfer. This would count as a cycle when considering eligible number of cycles.

15. HANDLING OF EXISTING FROZEN EMBRYOS FROM PREVIOUSLY FUNDED CYCLES

15.1 All stored and viable embryos should be replaced before a new cycle commences. This includes embryos stored by private providers.

16. SPERM RETREIVAL

16.1 Sperm retrieval for the management of male related fertility problems is a separate clinical procedure and will be charged at Payment by Results rates to the CCG.

16.2 Sperm retrieval for the management of male related fertility problems will be provided for men who, with their partner, will be eligible for NHS funded IVF treatment.

16.3 Couples will have to self-fund sperm retrieval for vasectomised men even if the female partner also requires subfertility treatment.

17. OVUM / EMBRYO DONATION

17.1 Ovum/Embryo donation and sub fertility treatment will be available for women with the following conditions;
premature ovarian failure, defined as amenenorrhea of at least 12 months duration with an hormonal profile in the menopausal–range, under the age of 40. The cause may be spontaneous, or as a result of other morbidity, or congenital abnormality or iatrogenic.

17.2 NHS funding would not normally be available for women outside these groups who do not respond to follicular stimulation.

18. EGG SHARING/DONATION AND SPERM DONATION

18.1 Egg sharing/donation and sperm donation will be available for couples requiring donated eggs/sperm.

18.2 Egg sharing/ donation for any 'commercial' consideration (i.e purchase of additional entitlements) will not be approved.

18.3 Egg and sperm donations will be sourced by providers and charged separately.

19. EMBRYO, EGG AND SPERM STORAGE

19.1 Embryo, egg and sperm storage will be funded for patients who are undergoing NHS subfertility treatment in line with The Human Fertilisation and Embryology Authority guidance. The storage standard period for sperm, egg and embryo storage is normally ten years.

20. PRE – IMPLANTATION GENETIC DIAGNOSIS

20.1 This is subject to a separate NHS England policy.

20.2 All applications must be made to the NHS England for approval and must be for conditions listed by the Human Fertilisation and Embryology Authority.

21. ANTI – VIRAL TRANSMISSION (e.g. HIV and HepC)

21.1 This is subject to separate guidance issued by the Greater Manchester Sexual Health Network. The policy can be accessed at the following site;
https://www.liv.ac.uk/hiv/HIV_Infertility_guidelines_(inc._access_to_SW)_(v.28)_21.02..pdf

22. CRYO – PRESERVATION

22.1 Cryo-presevation services will be offered to;
women with premature ovarian failure/ under the age of 40 (see previous definition- see section 17)
men and women with cancer or other illnesses which may impact on fertility may access tertiary care services to discuss fertility preservation (egg, embryo or sperm storage).

Storage will be in-line with section 19..

22.2 The eligibility criteria set out in this policy do not apply to cryo-preservation **but do apply to the use of the stored material.**

22.3 Storage of ovarian tissue will not be funded.

Version Control Sheet

Version	Date	Author	Status	Comments
1.	April 2006	Specialist Commissioning Team	Review date 2009	This policy superseded all individual PCT policies on fertility treatments prior to 1 April 2006.
Draft version 1.1	Oct 2013	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Policy in the process of review following issue of new NICE guidance and CCG formation.
Draft Version 1.2	Dec 13	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Current policy for Childlessness definition applied and cycles stated as between1 -3 as this reflects the current CCG commissioning differences across Cheshire and Merseyside.
Draft Version 1.3	April 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Policy revised following clinical and legal teams feedback.
Draft version 1.4	June 14	Cheshire and Merseyside CSU on behalf of CCGs	DRAFT	Following changes made as follows: 3.2 Bullet points added and following additional wording added *If there is a known clinical cause of infertility or a history of predisposing factors for infertility.* 3.3 Following wording added *Additional criteria apply for IVF in women aged 40 – 42 (See paragraph 12.4).* 3.5 Following wording added *See NICE guidance recommendations 117 – 119.* 3.6 Following wording added *(See section 12.4 for further details*). Following wording removed: *Second treatment cycles must be commenced before the woman's 40th birthday.* 3.7 Following wording added *i.e. in line with NICE CG156 section 6.3 guidance recommendations.* 4.1 Following wording added *Sub fertility & of* changed to *or* 4.3 Reference to exceptionality section removed. 4.4 changed to 4.3 Following wording removed *(i.e additional cycles if eligible – see section 12)*

				5.1 Following wording added *Sub fertility* *6.Surrogacy*- Following wording added *Current legal advice is for CCGs not to fund surrogacy arrangements. The rationale underpinning this is contained in the attached advice received from Hill Dickenson. (Appendix 1). This should be used by PCTs in conjunction with the existing points for consideration contained in the guidance on exceptional case consideration.* Following wording removed *For this reason NHS treatment is not available to male couples except when a pregnancy does not occur through surrogacy after an appropriate period of time (equivalent to the 12 months with vaginal intercourse or 6 cycles of AI for other people). In those circumstances the man whose sperm is used and the surrogate partner would be eligible to be referred for further clinical assessment and possible treatment of any underlying condition.* Hill Dickinson guidance - appendix 1 added to back of policy. 7.4 Section removed 8.1 BMI changed from 19 – 29 to 19 – 29.9. Following wording added Sub fertility Exceptionality wording removed. 9. Smoking - Wording adapted to *should be confirmed non smokers* Following wording changed *Will changed to could* Following wording added *Sub - fertility* Following wording removed. *Or treatment costs being applied.* 11 - Whole section reworded in line with NICE guidance and for clarification. 11.1 Exceptionality removed

				12.3 Reference to waiting 6 months between cycles removed. Following worded added *All cycles must be commenced before 40th birthday.* 12.4 Wording changed to includes *For women aged 40 and up to 42* 12.4.d Following wording added *The cycle must be commenced before the woman's 42nd birthday* 12.8 Section and wording removed 14.1 Following wording removed *Where IVF is charged by providers as a 'all in' price a cancelled cycle should not be charged.* Following wording added *This would not count as a cycle when considering eligible number of cycles* 14.2 Sentence referencing IVF funding removed and replaced with *This would count as a cycle when considering eligible number of cycles* 15.1Following wording removed *(but the CCG will consider any financial issues for the couple this may give rise to.)* 16.3 Section on funding removed 16.2 Wording changed from *Funding will be provided for men who, with their partner, will be eligible for NHS funded treatment.* to *Sperm retrieval for the management of male related fertility problems will be provided for men who, with their partner, will be eligible for NHS funded IVF treatment.* 16.4 Exceptionality reference removed and changed to 16.3. 17.1 Wording changed from *NHS funding will be available for women with premature menopause, defined as amenorrhea of at least 12 months duration with an hormonal profile in the menopausal range, under the age*

				of 42. The cause may be spontaneous, or as a result of other morbidity, or congenital abnormality or iatrogenic. To *Ovum/Embryo donation and sub fertility treatment will be available for women with the following conditions* • *premature ovarian failure , defined as amenenorrhea of at least 12 months duration with an hormonal profile in the menopausal range, under the age of 40. The cause may be spontaneous, or as a result of other morbidity, or congenital abnormality or iatrogenic.* 18.1 Wording changed from *NHS funding will be available for women requiring donated eggs/sperm. Due to a reduction in the availability of donated eggs and sperm this may result in couples having to wait. Due consideration will be given to those couples who would consequently be a risk of falling outside of the age criteria.* to *Egg sharing/donation and sperm donation will be available for couples requiring donated eggs/sperm.* 19. 'Egg' added to the sub heading 19.1 Wording changed from *Embryo and sperm storage will be funded for patients who are undergoing NHS fertility treatment. Storage will be funded for a maximum of 3 years or until 6 months post successful live birth, whichever is the shorter.* to *Embryo, egg and sperm storage will be funded for patients who are undergoing NHS subfertility treatment in line with The Human Fertilisation and Embryology authority guidance. The storage standard period for sperm, egg and embryo storage is normally ten years.* 19.2 Following wording removed *The CCG will not separately fund access to and the use of frozen embryos remaining after a live birth. Couples may be charged separately by providers for the use of these embryos.* 21. Sexual health network link added.

				22. 1 Bullet points added, early menopausal women reference removed, see previous definition – see section 17 added, storage in line with section 19.1 reference added. 22.2 section created for the eligibility criteria. End section changed to bold. 22.3 section created for detail on ovarian tissue storage.
Final Version 2.0		*Cheshire and Merseyside CSU on behalf of CCGs*	*To be confirmed*	Surrogacy: removed "Current legal advice is for CCGs not to fund surrogacy arrangements. The rationale underpinning this is contained in the attached advice received from Hill Dickenson. (Appendix 1)."

NHS
Cheshire and Merseyside
Commissioning Support Unit

Cheshire & Merseyside - Equality Analysis Report

– Commissioning of Low Clinical Value - Review

(Part One)

Table of Contents

1. Executive Summary

- The majority of consultees accept NICE's recommendations.
- NICE guidelines on commissioning low clinical value services can be adopted.
- Consultation has been conducted, responses have been received across the demographic spectrum and no appreciable discrimination has been discerned although authentic worries and risks have been identified that would have equality/ Human Rights implication.
- Accepting the following achievable recommendations would mitigate any Equality and Human Rights risk ensuring that negative impacts are mitigated in order to satisfy the Public Sector Equality Duty.

2. Recommendations:

- CCGs move to 3 cycles and raise age limit for IVF as part of meeting the PSED under advancing equality of opportunity (Gender Equality Act 2010 and Human Rights Article 16 (1)[1]).
- Better guidance on IVF for same sex couples and transgender applicants.
- Glucose monitoring (the continuous glucose meters in the management of diabetes); public views countered clinical evidence; caution is advised when following NICE guidance. (Disability- Equality act 2010).
- Lycra suites further evidence needs to be developed, but the suits can improve life chances for disabled children, practitioners to consider 'exemptions and Individual funding' (Disability- Equality act 2010).
- Training for key staff in relation to 'exemptions and Individual funding requests' for treatment on identifying equality and Human Rights implication (PSED Eliminate discrimination).
- Monitoring of decision making in relation to 'exemptions and individual funding' (PSED eliminate discrimination).
- Develop Policy Guidance for making decisions around 'exemption and individual funding' (PSED eliminate discrimination).
- Recognise that the Transgender community have a number of concerns and CCGs need to continue to work with the community. (Transgender, eliminating discrimination and advancing equality of opportunity – equality act 2010).
- Clinical specific comments made by the general public must be considered by the relevant decision makers and clinicians (annex 1).
- Develop Action plan to ensure recommendations cohere.

[1] Article 16. (1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

3. Background

The CCG's within Cheshire & Merseyside have inherited legacy documents, policies and procedures from the previous and now defunct PCTs.

The CCG's use NICE (National Institute for Health and Care Excellence) guidelines when deciding on how and what services to deliver. Nice have issued new guidance on the best technical application and appropriateness of some procedures deemed as 'low clinical value'. The aim of the 'low clinical value' guidance is to both update CCGs on new recommendation but also to give guidance to CCGs on what would be appropriate or not in terms of CCGs providing certain provisions.

As such the CCGs felt it was appropriate to ask interested parties for their views on the NICE update for their guidance.

Equality Impact Assessment:

The Law requires that any new service, significant change in service, reduction or removal of service has an Equality Impact Assessment to see if there are negative impacts, i.e. direct or indirect discrimination on particular people because of their protected characteristic, relating to the action. If there are negative impacts, then the CCG has to be cognisant of its Public Sector Equality Duty when making decisions with a view to mitigating the impact or in extenuating circumstances explaining why it cannot.

An Equality Impact Assessment is the document that:

I. Sets out the detail of the change in relation to the Equality legislation.

II. Analyzes the input from interested parties.

III. Identifies any concerns and worries related to equality issues.

IV. Proposes recommendations for Committee to consider.

4. Details of Change in Relation to Equality Legislation.

In order to identify potential equality impacts the full NICE guideline was reviewed, in the first instance to identify particular procedures that effect particular protected characteristics (see pre-EIA for full list). Once this was identified then a specialist team with clinicians looked at the detail of the change, many changes were simply procedural or 'better medicine' meaning there would be 'no clinical difference from the patients perspective' however, there were a number of changes that seemed significant enough that may have an 'equality impact' and of which interested parties may need to comment.

Speciality / Clinical Area
7.1. Infertility Services
20.3 Interventional treatments for Varicose Veins
19.2 Penile (Penis) Implants
21.1 BotulinumToxin
11.3 Mental Health
14.1 Oral Surgery – extraction of wisdom teeth
16.5 Plastic and Cosmetic Surgery
17.1, 17.2 - Respiratory Services
18.2, 18.3, 18.18, 18.19 Trauma and Orthopaedics
1.1 Weight Management (Bariatric) Surgery
2.1 Complementary Therapies (including Homeopathy)
3.1, 3.2, 3.4 Dermatology
5.2, 5.3, 5.4, 5.5. 5.7 Ear, Nose and Throat
8.1 Gastroenterology
9.1, 9.2 General Surgery
10.1 Gynaecology
13.1,13.2, 13.3, 13.8 Ophthalmology
16.1, 16.2, 16.3, 16.4, 16.6, 16.7, 16.8, 16.9, 16.10, 16.11, 16.12, 16.13, 16.14, 16.16, 16.17, 16.18 Plastic and Cosmetic Surgery
18.15, 18.17, 18.20, 18.21, 18.22, 18.23 - Trauma and Orthopaedics
4.1 Diabetes - Continuous Glucose Monitoring
3.3 Dermatology
6.1 Equipment (Lycra suits)
12.1, 12.2, 12.3 Neurology
13.5 Ophthalmology

14.3 Oral Surgery 16.8 Plastic and Cosmetic Surgery 18.1, 18.4, 18.5, 18.6, 18.7, 18.8, 18.9, 18.10, 18.11, 18.12, 18.13, 18.14, 18.16, 18.22 Trauma and Orthopaedics 19.1, 19.4, 19.5, 19.6 Urology 20.1, 20.2 Vascular Services
5.1, 5.6, 5.8 Ear, Nose and Throat 9.3 General Surgery 11.1,11.2, 11.4, 11.5 Mental Health 13.4, 13.6, 13.7 Ophthalmology 14.2 Oral Surgery 15.1 Paediatrics 18.23, 18.24, 18.25, 18.26 Trauma and Orthopaedics 19.3 Urology

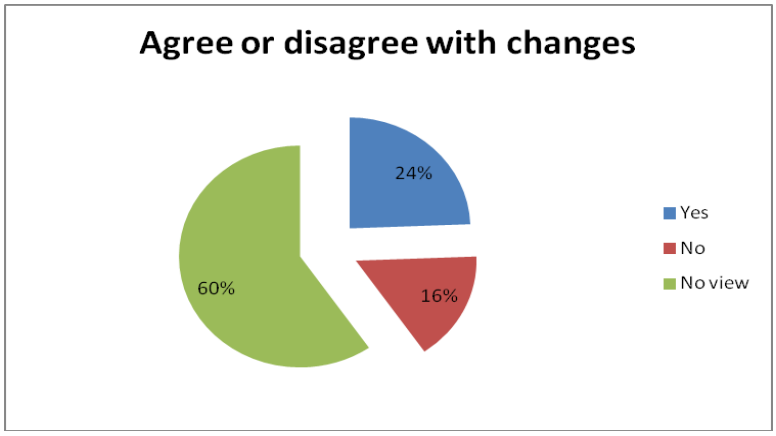
5. Analysis of Feedback from Interested Parties

The consultation reports show that extensive work was done in term of making interested parties aware of NICE's proposed changes and giving them opportunities to respond. Full methodology of the consultation are available in the individual CCG consultation report 'Commissioning Policy Review'.

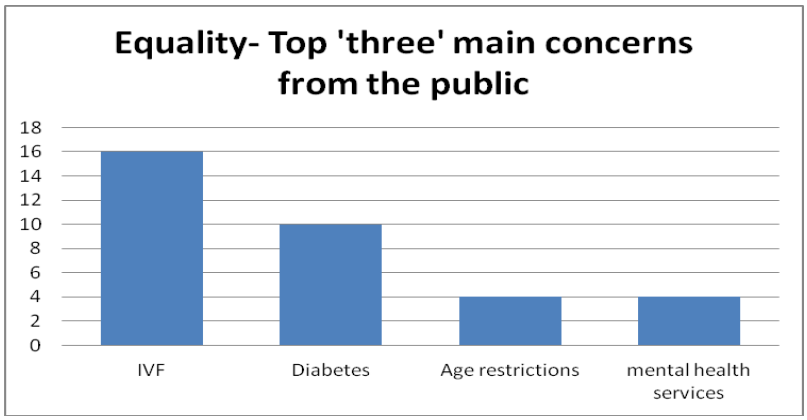
Online survey over view[2]

- 590 people entered online survey.
- Broad demographic mix of responders.
- Responders where in the majority female.
- Views aired by responders cut across the demographic.
- Of those that answered there was overwhelming support for NICE guidelines on commissioning low clinical value.

[2] Full online survey report is Part 2



- Clear concerns were raised, of which the top 'three' concerns linked to:



- IVF – overwhelming consensus that CCGs should offer 3 cycles and raise the age limit.
- Diabetes- In spite of clinical guidance suggesting that the continuous glucose monitoring was only beneficial to a narrow cohort of patients, public comments provided counter argument and evidence to this.
- Age Restrictions – concern was raised that to either not start a procedure or to curtail a procedure on the grounds of age was worrying – many provided contra evidence where the procedure as worked outside the age threshold.
- Mental health service – grave concern was raised over the diminishing mental health provision.

Focus Groups

Due to the difficulty in capturing opinions from the transgender community (due to its small size and dispersment) and because of the new specialist commission guidelines around 'gender dysphasia[3]' a focus group took place. A full report of this meeting and Transgender concern is in the annex 2 below, but the highlights are:

[3] Transgender dysphoria is the term used within the medical documents – its a term not necessarily supported by the transgender community. The Gender Dysphoria Protocol & Service Guidelines 2013/14

http://www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf

- 6 representative from various Transgender groups attended.
- They will continually disperse information and feed information back to CCGs.
- Commented on 29 Policy areas.
- Comments were rated into high, medium and low importance.
- The high importance areas where areas that could disadvantage transgender community in relation to local CCG commissioning include:
    - Rhino Plasty
    - Augmentation Mammoplasty
    - Hair removal treatments
    - Removal of surgical scars
    - Treatment for hair loss

Other Interested parties

- Businesses connected to health care were also encouraged to give feedback – none of the feedback received highlighted any equality implication.

6. Risks.

Where the NICE guidelines provide for additional provision (e.g. .IVF 3 cycles and a higher age range) it would be incumbent on CCGs to ensure that all CCGs within the group follow the same actions. Failure to do so may potentially leave the CCG that offers less open to appeal and litigation.

In addition, CCGs need to keep in mind that the NICE guidelines are recommendations and in some cases it may be clinically expedient to provide or continue a procedure – this can be done via the exceptions and individual funding routes.

Where discretion is used on whether or not to go beyond the guidelines then it would be extremely good practice to record/monitor the decisions. Where decisions trigger the individual funding request process, including appeals then CCGs would need to ensure that as part of this process, that they consider, alongside any clinical assessment, any Human Right or Equality Duty that may be being impinged.

7. Recommendations in Detail

- CCGs move to 3 cycles and raise age limit for IVF as part of meeting the PSED under advancing equality of opportunity (Gender Equality Act 2010 and Human Rights Article 16 (1)[4]).
- CCGs need to clarify guidance for same sex couples and the transgendered in relation to service over IVF and other concerns related to the focus group outcome.

[4] Article 16. (1) Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution.

(Transgender, eliminating discrimination, advancing equality of opportunity – Equality Act 2010).

- Glucose - In spite of clinical guidance suggesting that the continuous glucose meters in the management of diabetes was only beneficial to a narrow cohort of patients, public comments provided counter argument and evidence to this. From the comments it was clear that the treatment improved life chances for the members of public who responded. CCGs and health care practitioners need to keep in mind the 'exceptions funding route'. (Disability, Advancing equality of opportunity, – Equality Act 2010).
- Lycra suites – further clinical evidence is needed in relation to this subject (of whether they are workable) and has been requested by CCGs. There are some circumstances where they would clearly improve life chances and at such points CCGs should commission their use. This can be done through the exceptions funding route. (Disability, advancing equality of Opportunity- Equality Act 2010).
- Age bars. Concern was coming from the public at seeing age delineation in prescribing medication. Evidence was offered showing the success of the medication outside the restricted age. Caution needs to be advised. (Age, eliminating discrimination, Equality Act 2010).
- Clinical specific comments made by the general public must be considered by the relevant decision makers and clinicians. These comments fall outside the expertise and remit of this Equality Impact assessment but may be of significant interest.(annex 1)
- Transgender Recommendations- that high importance areas identified through the focus group are considered by local CCGs Individual Funding request decision makers under exceptional clinical needs, if the treatment is relevant to protected characteristic and life chances , then treatments should be approved. (Advance equality of Opportunity- Equality Act 2010- gender reassignment)
  Ensuring GPs and health professional understand the new interim guidance and pathway for gender dyphoria and how this interacts with the low clinical value policies
  Seek clarity from NHS England on any grey areas detected as a result of the feedback (Annex 2).
- Training & Briefings for all CCGs and people connected with individual funding request route on identifying equality and Human Rights implication (PSED Eliminate discrimination)
    - General briefings to help professional to be distributed by CCGs
    - Specific targeted Training to the individual funding request panel/s around Equality and Human Rights (especially considering the Bristol Judicial Review case)
    - Develop succinct guidance within the individual funding request policy
- Monitoring of decision making in relation to exemptions and individual funding requests (PSED - eliminate discrimination).
- Action plan for traction to ensure:
    - The above recommendation on clinical policy are formulated to ensure they are inculcated by all CCGs
    - The consultation process is reviewed under 'lessons learnt' to ensure the communities diverse voice is more fully heard and understood
    - Training, guidance and monitoring are embedded in to the individual funding practice.

Accepting the NICE guidance and consulting with interested parties incorporating their views in to decision making by following the above recommendations will ensure that Cheshire and Merseyside CCGs are compliant with the Public Sector Equality Duty.

End of Part One.

Part 2
Consultation Report:
Equality Data – Online Survey

1. Introduction

For full details of the consultation process and methodologies see report see individual consultation report on the commissioning policy review.

This section of the Equality Impact assessment will look in detail at:

1. Who replied
2. What was the general consensus
3. What issues were raised in relation to 'equality considerations'

2. Responders

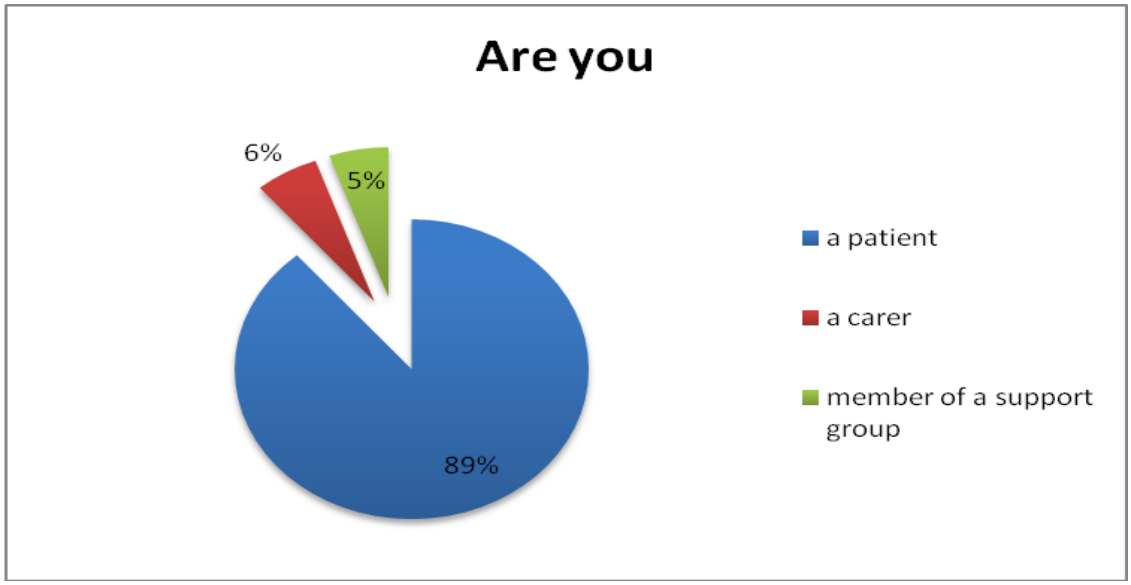
The online survey showed that 590 people entered the survey and gave answers to either all or some of the questions. The data below shows the number of respondents that give answers to particular equality questions. This is an important part of the survey to ensure that we can test whether there is a fair representation of the public and whether or not a particular view is coming from a particular group which would need to be specifically addressed. The survey was backed up by group meetings of particular groups, such as transgender to help identify issues that may be of concern to particular groups and identify any worries or concerns.

Cheshire & Merseyside = 291

Wirral = 255

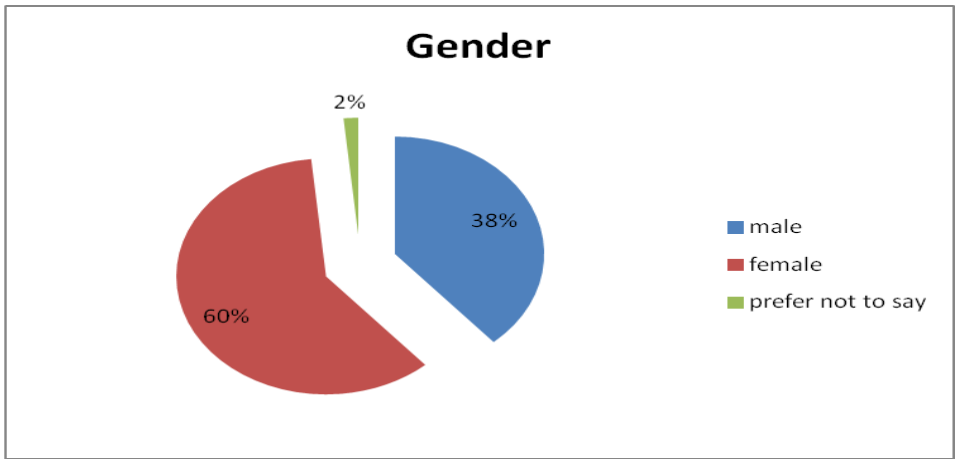
Liverpool = 44

The survey set up parameter in order to identify responders, the three broad areas where; patient, carer and member of support group of all the respondents, 516 selected one of the categories.



Of all responses, 439 give data identifying their gender:

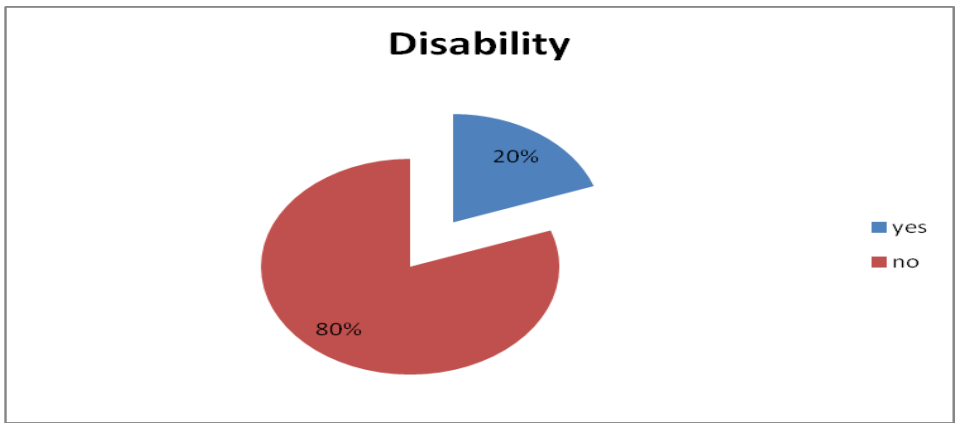
Gender[5]



There were no responders who identified as Transgender - however a focus group for Transgender was formed and reported in Part 1 of the EIA.

Disability[6];

We asked respondent whether they considered themselves to be disabled of all respondents, 430 selected either yes or no as follows:

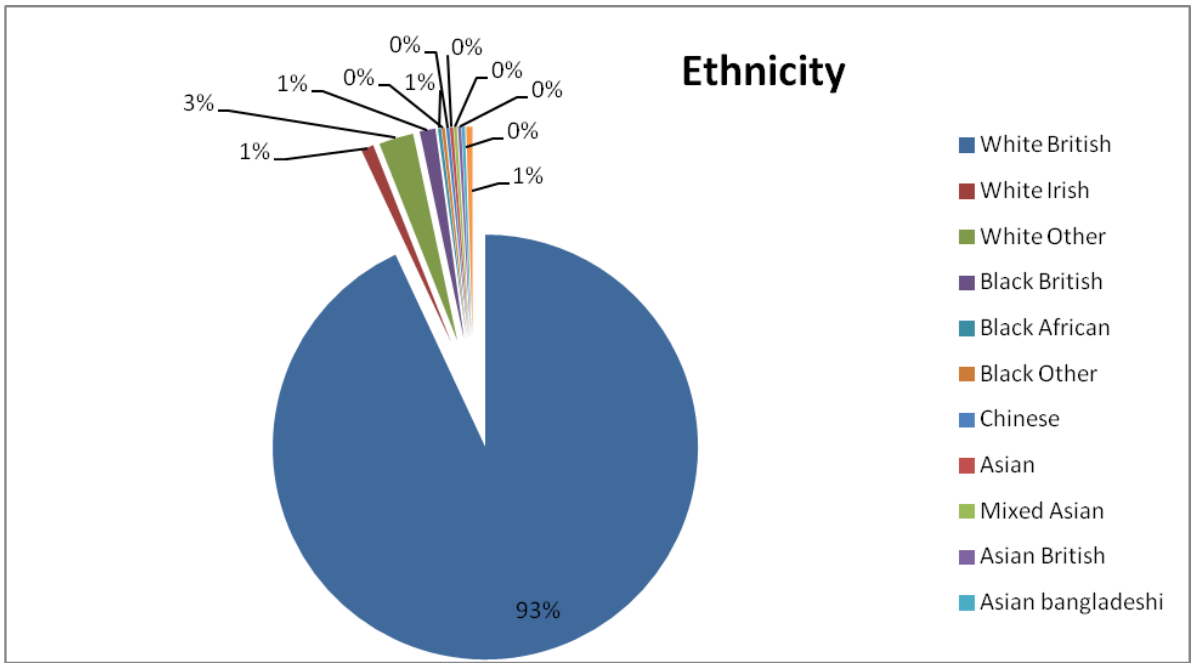


[5] The questionnaire did have facility to select male to female transgender and female to male transgender but none were selected

[6] The survey made it clear that we were using the definition of disability as defined in the Equality Act 2010

Ethnic Origin[7]

Of those who responded 417 ansered the questions on 'ethnic origin'. 'White British' was the largest group with which people identified (where the chart indicates 0%[8] the numeric value is 1).

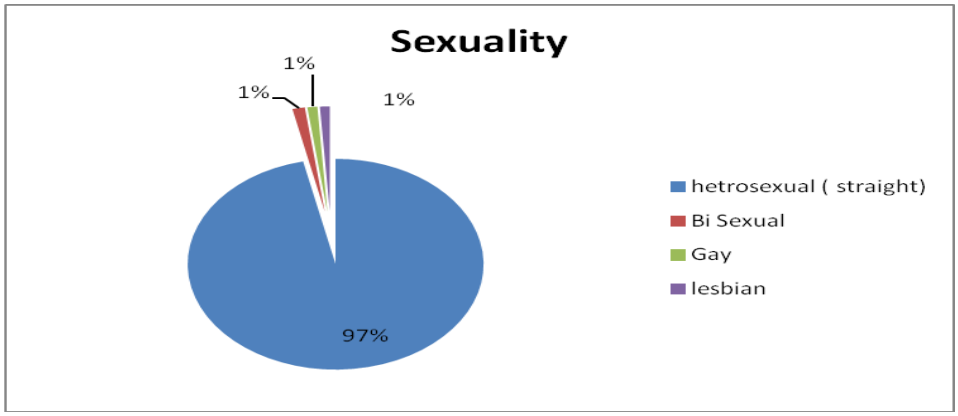


The data shows a particularly low response from BME . Given the survey was a random survey (anyone could respond) there is an under response from BME community.

Sexuality

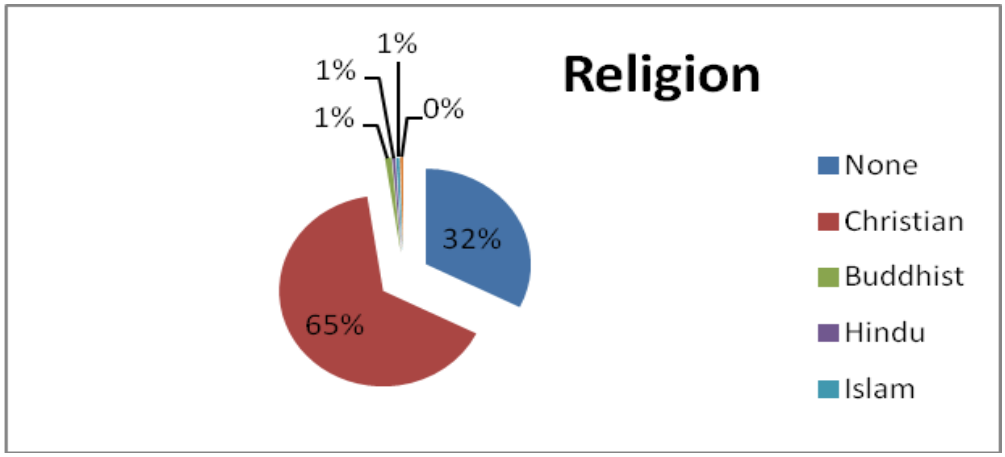
367 responders selected sexuality. Given the survey was a random survey (anyone could respond) there is an under response from the LGBT community.

[7] All ethnic origin categories where used in the survey – this chart shows those with a response 0% equals 1 for the purposes of this chart.



Religion[9]

408 responders selected a category under 'religion'

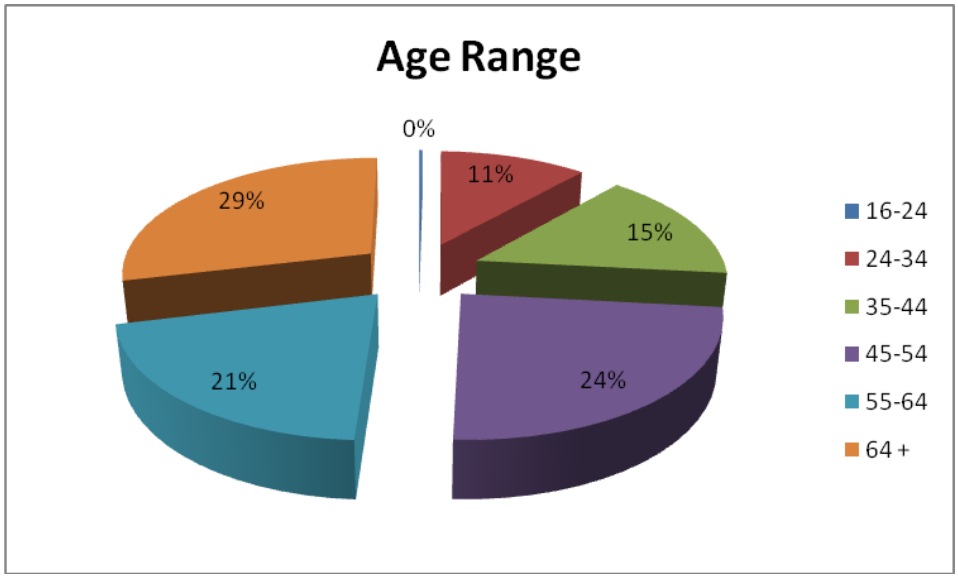


Similar to the under representation from BME, on the religious question there was little reporting of being 'Islam'.

[9] All religions were given as an option. The chart only shows those that were selected, including 'none religion' where the chart indicates 0% the actual number of respondents for this category was 1.

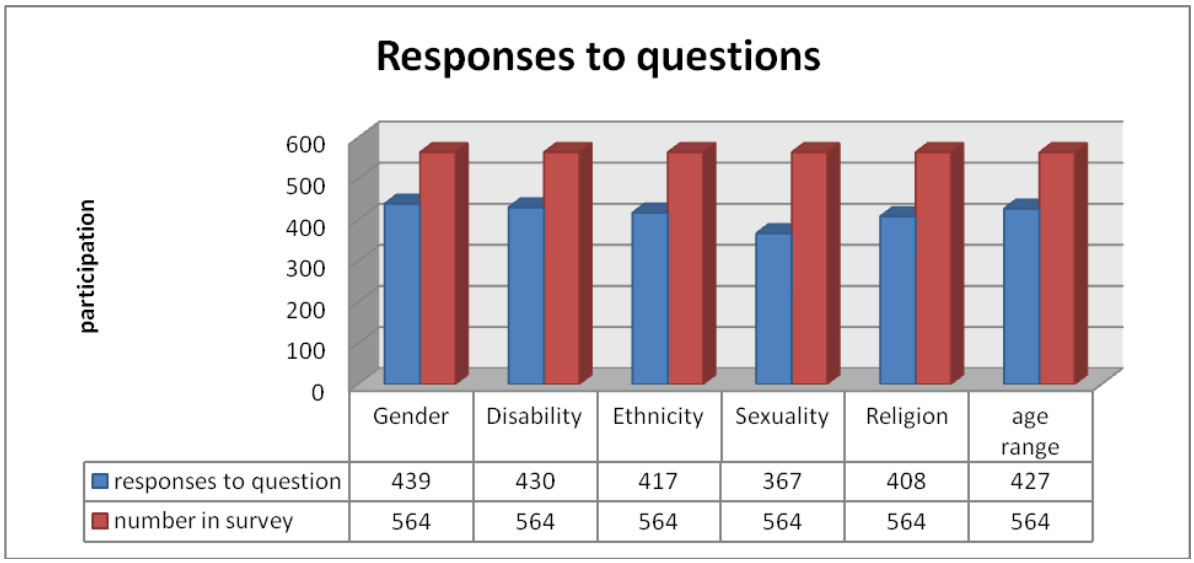
Age Range

427 responders indicated their age range. (0% equals 1 person). There is an under representation in 16 – 34 age range. The biggest age group responders were the 64+ Age range.



Rate of Response

Not all participants in the questionnaire responded to every question and non of the equality categories recieved a full response. The highest responses where given to age and gender (the most familiar and often asked questions), the lowest reponse was given to sexuality, however, even here there was a significant rate of response whihc shows people are willing to disclose information.



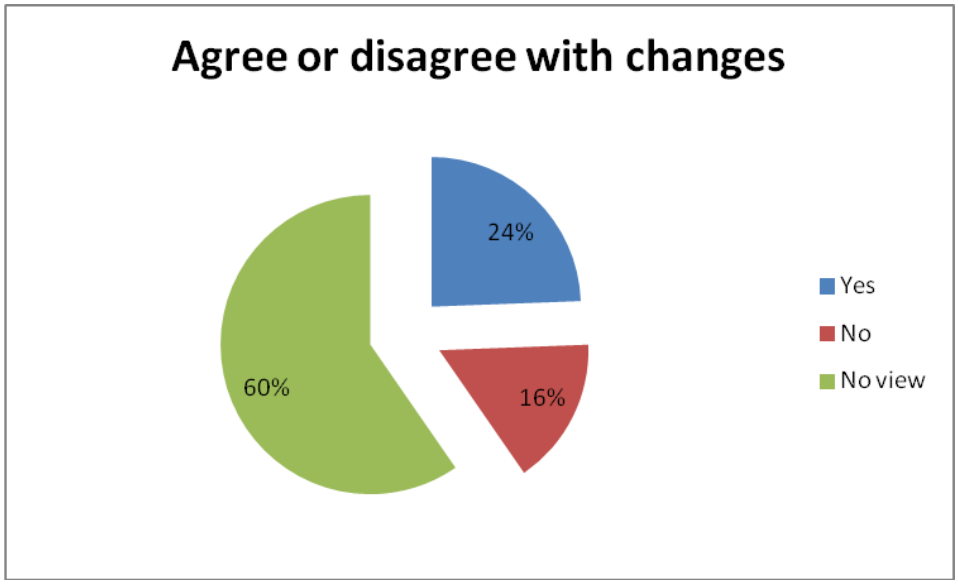
	Gender	Disability	Ethnicity	Sexuality	Religion	age range
responses to question	439	430	417	367	408	427
number in survey	564	564	564	564	564	564

End of section 1

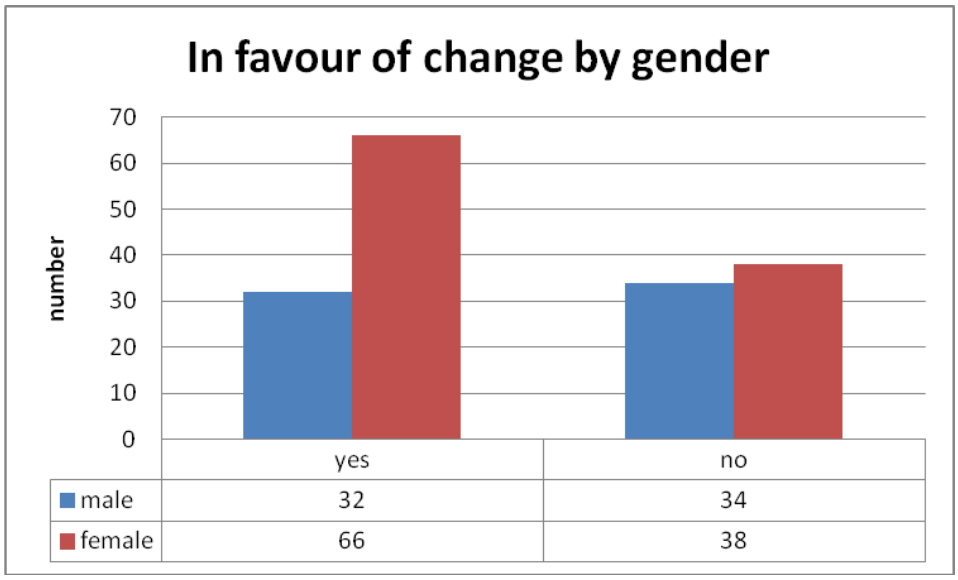
Section 2:

General Consensus

On the quesiton of whether or not respondents agreed with the need to adopt the changes recommended by NICE on the low clinical value there were 235 that expressed a definate view of either 'yes ' or 'no' and 347 (well over half the respondess) that did not answer the question one way or another. Out of those that answered there was a clear view to accept the changes.



When those that either siad 'yes' or 'no' where analysed by gender we could see that a larger proportion of women voted Yes than men.



Section 3 – Equality Issues

As part of the survey if responders didn't agree or wanted to comment on the changes then at 'question 12'[10] they were encourgaged to leave comments – its expected that only a small minority of respondents will leave comments.

The comments could be roughly broken down in to several types of response headings:

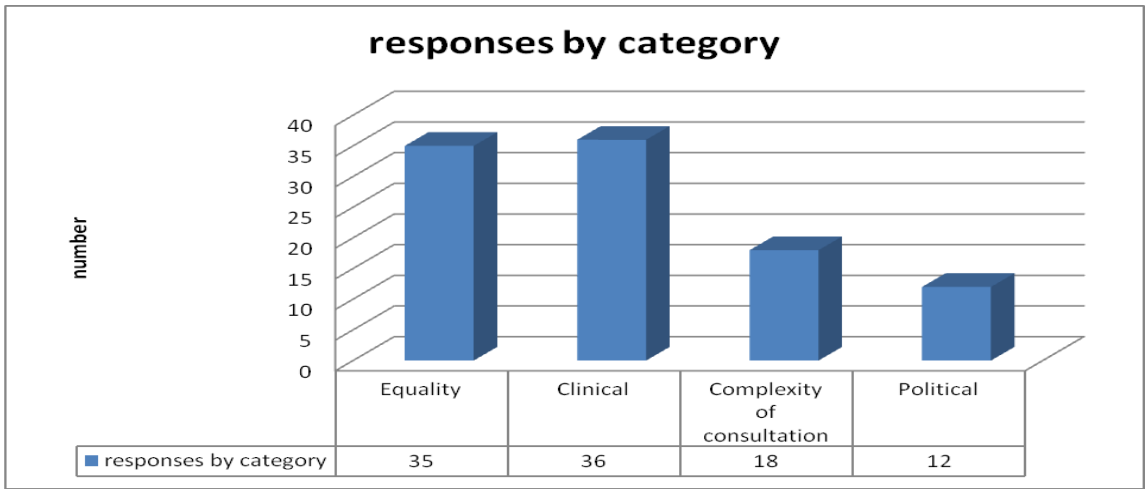
1. ***Political*** – comments clearly worrying about privatisation and rationing in the NHS.

2. ***Equality*** – Comments that clealry focus on equality issues (these are the main focus of this report).

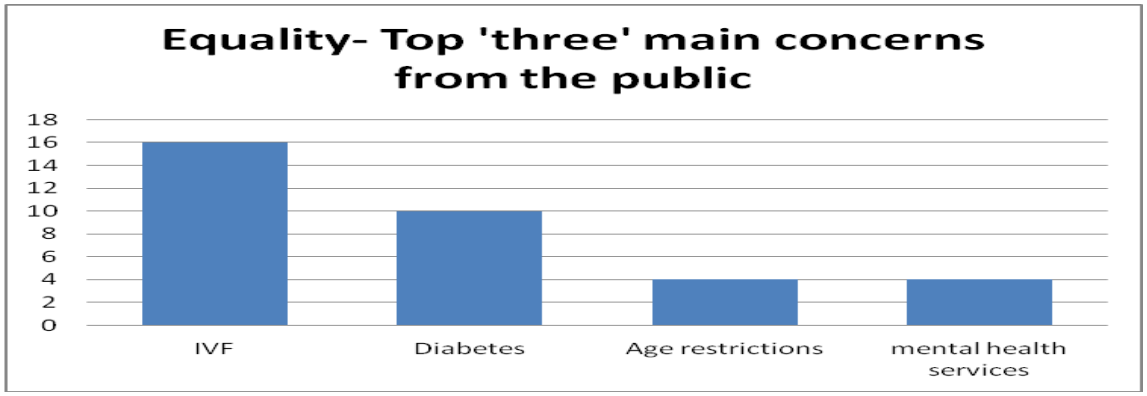
3. ***Consultation process*** – comments expressing concern over the amount of material and the complexity of the material.

4. ***Clinical Comment*** – comments that give their experiences of using serivces or advice on treatments- in some instances providing contra evidence to the NICE guidline.

There were 101 comments left by the responders:



In looking at the 'equality issues' there were clealry patters of concern:



[10] **Q12 If you do not agree with the planned changes to the draft policy please briefly tell us why? (250 word limit)**

Section 3 Written responses from the online survey concerning 'Equality Issues'

Response Text to Q12	Categories	Protected Characteristic	PSED	Issue for Consideration by CCG
Infertility treatment should be supported.	Equality Issue	Gender	Advance	*Support for three cycles*
Warrington CCG should fall in line with NICE guidance for the maximum number of cycles with respect to IVF (three). One funded cycle (despite increasing from 0) is not good enough considering success rates of treatment meaning follow on cycles are typically 'a given'. I feel the pressure of only being funded for 1 cycles is actually detrimental to the process as it places more stress and anxiety on to a patient pre and post ivf knowing that failure will not only be a tough situation to deal with but also have a massive financial impact following this that many struggle to afford. This also falls behind neighbouring CCG's who offer at least two cycles.	Equality Issue	Gender	Eliminate & Advance	*Support for 3 cycles but a clear request that ALL CCGs support the NICE recommendation*
? possible age discrimination rather than based on clinical or scientific evidence base	Equality Issue	Age	Eliminate	*CCGs note that there are funding routes based on individual needs via 'exceptions and individual funding requests' Age bars are for guidance only.*
I would assert that this is contrary to the Equality Act 2010, which you should know came into force in October 2012. There is no evidence to support that the withholding of Orthodontic Treatment to those aged 18 or over will any way benefit them positively and there is therefore no basis for managing their needs differently and hence discriminating against them.	Equality Issue	Age	Eliminate & Advance	This questions the bases for an age related cut off
I agree that the things proposed are useful, but I also think that Foot Care for older people needs to be included.	Equality Issue	Age	Eliminate	*For consideration*

I m not really clear as what is proposed by my ccg as whether those 40 plus qualify for Ivf however as someone whose life has been deeply affected by infertility I would strongly support the Ivf being available up to ages 42	Equality Issue	Gender/ Age	Advance	Wants to extend age range for IVF to 42
I do not support the changes to 7.1 or 20.3 considering that these do not constitute a significant impact on the quality of the health of the population and therefore are not priority for additional expenditure	Equality Issue	Gender	Advance	*This person disagrees that these treatments should be given at all.*
Equality across boroughs when it comes to awarding infertility cycles would save much heartache for childless couples who end up living in the 'wrong' area. Specifically, being eligible for three cycles consistently across commissioning areas would be much fairer and give childless couples a chance. Whilst I understand that budget is limited, equality is preferable to the current situation where depending on your post code some couples are only eligible for one cycle	Equality Issue	Gender	Eliminate & Advance	Support for IVF 3 cycles but wants all CCGs to support the NICE recommendation

I think CGM should be offered more widely, particularly where it's been proven to improve blood sugar control. As someone who has had type 1 diabetes for 36 years, it is not just about getting a good HBA1C reading, it is also about the day to day control and how you reach that end target. It's no good having a great HBA1C but having debilitating hypos constantly. Having temporarily used CGM last year, I found that not only did it improve my HBA1C overall but more importantly it helped me to get rid of some of the fluctuating glucose levels I was experiencing and helped me to have less hypos. The trend graphs on the CGM were invaluable in helping me to keep track on what my glucose levels were doing, and how my body reacts to different foods. It helped me to avert hypos or highs by looking at these trends. By downloading the data onto my PC I could pinpoint where I needed to make changes to my basal. The alarms on the CGM, particularly for low sugars, gave me greater confidence – so instead of going to bed with higher levels than I should for fear of a hypo during my sleep, I felt happier to have lower levels knowing that the alarm would wake me up if my sugars did dip too low. And seeing the trends throughout the night I was able to make adjustments to prevent highs and lows.	Equality Issue	Disability/Age	Advance	Offers evidence to suggest that CGM is a useful process especially for younger people.
Assisted Conception is expensive, not very successful, extremely stressful and more emotionally driven than clinically. It has also overreached the limits of ethics and the law. It must be tightly controlled both within and outside the NHS (where it is also highly profitable). Whilst hysterectomy has been the commonest operation on females, used far too liberally, there are now many alternatives and the clinicians should be allowed to judge when it is necessary and justified.	Equality Issue	Gender	Eliminate	*This person disagrees that these treatments should be given at all.*
Insufficient information on CCG decision re funding for CG monitors for adult T1 diabetics.	Equality Issue	Disability	Eliminate	

On reading the summary documents, it is difficult to understand what changes the CCG is planning to make. However, for infertility treatment for example, if the suggestion is that the access to this for couples will be restricted, this might be considered unfair. Also, for patients undergoing gender reassignment, it might be considered unfair if they could not access penile implants. The policy summary isn't specific on what the "circumstances" are when penile implants will be accessible and therefore it it difficult to judge whether the changes are appropriate.	Equality Issue	Transgender & Gender	Eliminate	*This person questions whether there is equality in treatment especially when the request comes from a transgender perosn/need – develop clear guidance/further information on same sex couples and AI*
19.1 - not sure that I fully understand the wording of the proposals, but I wanted to say that, as a 69 yr. old gay man with Type 2 diabetes, I still have/want an active sex life. Fortunately, medication helps me if I need it, but I would value the option of an implant if it became necessary, as I find my sex life impacts quite strongly on my emotional and mental state. (Gardening and house maintenance don't always fulfil my needs!) 19.2 - As someone who was circumcised at birth, I don't think that this should be offered on the NHS for social, cultural or religious reasons. (My only worry is that this might lead to unauthorised, poorly supervised circumcisions being carried out, with resultant risk of damage and/or infection, similar to the problems arising from Female Genital Mutilation.)	Equality Issue	Gender	Advance	

My son has used CGM on a couple of occasions supervised by the Paediatric Department at COCH. On one occasion we used it to identify glucose movements overnight and as a result I have programmed his insulin pump more effectively. On the second occasion he used it for his first overnight school trip away, the fact that the system sounds an alarm when his blood sugar goes high or low gives him, and his teachers, confidence that he wont die (his words!). (He had never spent a night away from his parents and is 12 years old). I very much support the use of CGM where there is a medical need and as part of the overall treatment plan. I don't think that frequent use of CGM by individual patients is necessary.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people*
I understand that funding is extremely limited with CCGs, LAs, etc but to continue with a policy that prevents couples where one or both partners have children from previous relationships from having free fertility treatment on the NHS is ridiculous. The CCG need to consider the amount of funding that is wasted in others areas of it's business then perhaps it may find extra savings. The majority of the population who need fertility treatment are unable to raise £5-6k for IVF treatment without getting into debt which in turn has negatives consequences and pressures on other resources in the NHS such as depression and anxiety.	Equality Issue	Gender	Advance	*This person disagrees with the criteria for being allowed IVF - especially if one of the partners already has children from a previous relationship*

CGM is a relatively new technology and there is not a great range of research yet to support use. In our case it has completely restored a sense of 'normality' to our family. our son's HBA1C is improved, his blood glucose control is much better (and within tighter margins) and lows greatly reduced. He is eating a wider range of foods, performing better at school and is happier (Bgs are within range, he feels better) and more independent. He participates confidently in a wider range of activities which previously have caused difficult blood sugars. We are getting better sleep as we are not constantly testing through the night due to highs/lows at bedtime/ in the night. We have been able to deal with teen growth spurts and consequent changes to insulin pump basals very confidently, quickly and pro-actively. We could not have done this for him without CGM.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people*
My daughter is waiting for CGM and the new changes may affect how long she has to wait or even if she can have one.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people*
I don't believe IVF treatment should be offered more than once on the NHS but agree with the BMI and smoking arrangements within the policy. Varicose Veins - Agree that the service should be extented to those in pain. Penile dysfunction - Agree that treatments should be extended for severe structural disease and malformations.	Equality Issue	Gender & Disability	Advance	*This person disagrees with three cycles for IVF*

We use the sensor on an occasional basis to help us to adjust basal rates when B**** has had a growth spurt or when her insulin needs change, the sensor information is much more accurate to help us to do this. We also use the sensor when she is ill or when we are away, for example at new year we stayed with friends and she therefore was staying up late and doing different activities than normal, the sensor allowed us to pick up on several hypos before she became too low and made it easily ear to put on temporary backgrounds and adjust the basals to maintain control, without this she would have had to be removed from the other children, or would have had severe hypos or severe hypers and then been unable to join in family activities the following day as she tends to take a good 24-48 hrs to recover when hypos or hypers are severe. When we last changed her pump, we stayed with Medtronic purely as there pump had a sensor which we did not want to loose despite it having some downsides such as not being waterproof, which is a problem with swimming water polo and kayaking which she does weekly.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people see recommendations*
I have read the basic version and the end comment "The impact for patients is that they may not receive a Botulinum toxin A treatment." I have seen very good result from the use of Botulinum toxin for spasticity post stroke and am concerned about patients not being able to get this treatment. It can make such a difference to someone's life and make them more able to care for themselves. This will enhance their self esteem and self image thus reducing depression and consequently medication in another area.	Equality Issue	Disability	Advance	

My son has type 1 diabetes and has an hb1ac that is at best 11.0+ he has ADHD but is unable to take methylphenidate medication as (along with other side effects) it interferes with his appetite causing more problems with his blood glucose levels. I have been unable to access CBG monitoring for him to date and believe the proposed changes will put this treatment even further out if reach. It is my belief that a short period of CBG monitoring would benefit him greatly as his sleeping patterns make it very difficult to monitor his BG effectively.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people*
I having been caring for my daughter who was diagnosed at age 2 with type 1 diabetes, she is now six years old. I am pleased she has the insulin pump as I know this is the best possible treatment for her condition. Despite the pump her diabetes is still very difficult to control. She can have several hypos in a day and she often has many high blood sugars. It is 24/7 with diabetes. When we have trialled the sensor we have been able to see her hypos coming and stopping them before she gets dangerously low, because L**** has so many hypos she can get really low before she feels the physical symptoms . This is particularly worrying especially as I have to leave her in school. The sensor also helped us intervene before her bloods get to high. Once the sensor was calibrated well it saved her having her finger pricked constantly, getting her down to just two tests a day. It was very valuable to us.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people see recommendation section*
Fertility services and varicose veins should still be readily available on the NHS without restrictions.	Equality Issue	Gender	Advance	
support new infertility policy and move in line with NICE	Equality Issue	Gender	Advance	*the comment supports the move for three cycles, see recommendations*

My daughter has type 1 Diabetes. Continuous Glucose Monitoring has been vital for my daughter especially to gather information about what is happening to her glucose levels during the night. My daughter has severe learning difficulties and severe communication difficulties so having access to this type of equipment has meant health professionals give better support and more person centred advice. I have friends too who struggle to understand their diabetes and how best to control their blood sugars and I know they too have valued the help and support that wearing a CGM system has given when they are at a loss to know how to control their erratic blood glucose levels. Diabetes is on the increase and those who have the condition especially young people like my daughter and her carers need as much support as they can possibly get. It would be detrimental to my daughter and friends if this piece of equipment was no longer funded for use by those who need it most.	Equality Issue	Disability/Age	Advance	*Offers evidence to suggest that CGM is a useful process especially for younger people*

ADHD and paediatric services need to be higher on the agenda, recent cuts to the number of clinicians and paediatricians available are significantly impacting on services and available support	Equality Issue	Age & Disability	Eliminate & Advance	Please note disability and children services are raising concerns of service users.
I believe the NICE guidance 156 should be adopted in full.	Equality Issue	Gender	Advance	*support for 3 cycles but a clear request that ALL CCGs support the NICE recommendation*

I would like to see the shift to 3 rounds as with each patient the reasons and problems for infertility are many. The drugs used may need to be tweaked from the first round as it is not predicted how the patient will react to them and so can be more of a trial run for many. The second round is not always likely to have a positive outcome as it is down to many variables, which can produce success in one area but failure still in another. Liverpool is still not set up to do tests for immune problem and other factors that can cause problems in fertility - this is offered in most private practices world wide. Also the choice to only put back one embryo also has a setback for those unable to afford more than 2 courses of treatment. I feel in the case for unexplained infertility in couples there is not a quick fix as there is no obvious reason for problems which can be looked into and therefore according to my embryologist at Liverpool - throw mud at a wall and it will eventually stick! in other words the more goes with fresh and frozen embryos the better.	Equality Issue	Gender	Advance	*support for 3 cycles but a clear request that ALL CCGs support the NICE recommendation*

Varicose veins have been the subject of a new NICE guideline and I do not believe that your proposals are compatible with the NICE guidelines. Having had my varicose veins operated on at Clatterbridge, it has had a major positive impact on my working life. They used to ache terribly and as I work on my feet all day I was unable to do a proper days work. I have never had an ulcer or phlebitis and the new NICE guidelines make it clear that there is benefit from varicose vein surgery in all symptomatic patients. You should apply the NICE guidelines in the same way that you expect hospitals to apply them.	Equality Issue	Age	Advance	*CCGs& health professionals may need to consider individual circumstances via individual funding request route*
I feel there is an necessary change to the bariatric service as currently there is n facility for CBT which is a qualifying need for bariatric surgery without this you can never qualify for surgery . Hence there is a blockage in the system where only people with a BMI over 50 will qualify I feel this is prejudices of people with a slightly lower BMI and denying them surgery. This I view as a major change requirement	Equality Issue	Disability	Eliminate & Advance	*In form relevant CCG of potential gap in service – health professionals may need to consider individual circumstance funding route.*

Backward policy with no regard for patients	Equality Issue		Eliminate	*monitor patient satisfaction levels with service*
I think IVF should be available to the older age group but think that two cycles on the NHS is more than a fair portion of the NHS funds available when there are still insufficient life saving kidney machines and life saving cancer drugs and treatments.	Equality Issue	Gender	Advance	*This person disagrees with three cycles for IVF*
It is not at all clear what NHS provision now exist in these areas ie exactly what routine NHS care is available for eating disorders etc- is in patient specialist care available?- if it is and is sufficient to meet need, then private provision should not be necessary and not used.	Equality Issue	Disability	Eliminate & Advance	*Funding provision is available for eating disorders i through specialist commissioning (NHS England) Local CCG funding should take account of this on individual basis.*
I agree in general to evidence based changes in treatments. I am not convicted that gender reassignment surgery, specifically penile implants have a medical justification, so should not be commissioned.	Equality Issue	Gender/ Transgender	Eliminate & Advance	*This individual doesn't support the NICE guidance*.
Please can it be considered that IVF treatment be available in order for family's to create a sibling?	Equality Issue	Gender	Advance	*request is currently outside NICE guidance*

END OF COMMENTS.

ANNEXES :

1. Responses by online users.
2. Transgender forum report and concerns from Transgender community.

Annex 1

Responses by online users.

These are the comments left by online survey responders to Q12 (tell us why you disagree with NICE guidelines) many of the comments answer this indirectly but none the less, in terms of transparency and completeness have merit and information **that needs to be viewed before 'committee decision making'** . **Whilst all comments need to be read, those highlighted need particular attention**.

The comments can be roughly broken down in to several types of response headings:

1. ***Clinical Comment*** – comments that give their experiences of using serivces or advice on treatments- in some instances providing contra evidence to the NICE guidline (page 1 -10 below)
2. ***Political*** – comments clearly worrying about privatisation and rationing in the NHS (page 11 – 12 below)
3. ***Consultation process*** – comments expressing concern over the amount of material and the complexity of the material being consulted upon (page 13 – 15 below)
4. ***Equality*** – Comments that clealry focus on equality issues (these are reported in Part 2 of the Equality Analysis report and not below)

Clinical Comments

Comments classed as 'Clinical comments' are comments with a clear view on what should and shouldn't be funded, comments that give medical back stories, comments that suggests alternative ways of working as clinicians/practitioners. (all personal identifiers, other than first names, have been removed in accordance with the Data Protection Act)

Comment	Type
Bariatric surgery is a waste of NHS resources. They should be referred to a gym or a boot camp style camp where they are given a strict diet and made to exercise. No fertility treatment should be given as this is NOT an illness. There are plenty of children waiting for adoption. No silicone implants should be carried out. No laser tattoo removal should be done.	clinical comment
I fully support the planned changes.	clinical comment

As diagnosis of lipoma is ultimately a histological one this guidance is potentially at variance with the NICE guidance on the early detection of Sarcoma's , my own mother died from a sarcoma misdiagnosed clinically as a lipoma and was in curable by the time the " criteria" for its removal was reached .	clinical comment
Most changes seem minor to say the least. In general I think money should be spent on serious physical and mental illness and not conditions like infertility and gender change. Regarding varicose veins I do believe that treatment should be available before ulcers develop, rather than waiting for things to get worse. (And I write as someone who has had Varicose veins for 30 years since pregnancy and has not yet gone to the GP requesting treatment because the severity is unchanged).	clinical comment
The whole process is disingenuous. How can we decide whether to implement a policy that redirects resources from existing budgets when we have no idea where the money will be spent, how disproportionate the cost may be to treat 1 patient, and how this may differ for the different treatments in question.	clinical comment
Anal Fissure- I believe that expert guidance and best practice involves the trial of use of Botox prior to surgical 'anal stretch' which can result in degrees of more permanent faecal incontinence. It would appear preferable to have a Policy that allowed the use at a particular stage in treatment or am I misinformed and there is evidence to the contrary that I am not aware of? Hyperhidrosis- What are the alternative treatment strategies, after the routine therapies, the Committee propose to offer this cohort of patient for whom this is a considerable psychological and social impediment. Isn't surgical intervention associated with irreversible complications and time limited response? Again- isn't a tightly considered 'position in treatment' preferable?	clinical comment

Cataract surgery should be rationed simply by a visual acuity test. Patients should be offered it if: Cataract is adversely affecting their daily living. They fully understand the risks and benefits of surgery and They want to have, and are fit enough for surgery. Some people can pass the visual acuity test but some effects of a cataract can make their life very difficult e.g. Lorry drivers affected by bright light.	clinical comment
I'm undiagnosed for this, but I regularly get multiple "red flag" symptoms of cauda equina, the treatment of which is generally recommended to include emergency surgical intervention within a very short time frame to relieve pressure on the nerves in the spinal column - this is to prevent permanent nerve damage and life-long disability. The new guidance seems to steer away from this except for "exceptional circumstances" - but the delay caused while trying to define whether a patient falls into this category may result in permanent damage.	clinical comment
Expect a "can do" ethos from the NHS. Before reducing services explore improving performance and effectiveness. Too many examples of poor management and professional standards, not getting it right first time, and inefficient use of capital assets.	clinical comment
Myself and my partner have no children, my partner is unable to father a child naturally due to severe infertility (No active sperm) and would require treatment to father a child! This change would mean that we would only be given to opportunity to have one child if at all! The change would also only allow 2-3 attempts at ICSI and with his current the success rate is very limited within the first 2-3 attempts.	clinical comment
I do agree with change. However not all has been discussed around a table with the relevant questions asked.	clinical comment

The cataract policy does not comply with NICE or Royal College guidance (I am familiar with both these sets of guidance). If this one doesn't comply with NICE guidance how can I be sure that any of them do? The way it doesn't comply is by suggesting there is some agreed level of sight loss at which the procedure is of benefit. Also for the cataract policy, in the list of people affected you have not included optometrists. It says it affects family doctors who refer people for these procedures but in most areas it is actually optometrists who refer for eye conditions. This comment applies to all of the ophthalmic policies. I don't know, but would guess, that dentists are the most likely group of healthcare professionals to pick up oral conditions and refer for those - have you included them where appropriate. These are just the areas I know about - so how can I be confident you have included all appropriate healthcare professionals in the consultation for the other disease policies?	clinical comment
All agreed as decisions of local GPs to refer should be based on latest evidence (but then the hospitals should be CLOSELY monitored on whether they are delivering these rather than monitoring be faced on outcomes or complaints and number of referrals.	clinical comment
Prostatism is an overly vague term. It is not clear from the document under exactly what conditions any more specificaly defined illness would not be treated with surgery.	clinical comment
I agree in principle with what needs to be completed.	clinical comment
There are two topics I do not agree with: 7.1 Infertility services 1.1 Bariatric surgery	clinical comment
Although I agree with the planned changes I accept that funds are limited and as such it may not be feasable to treat minor cosmetic cases.	clinical comment

The policy makes no distinction between adults and children. CGM is likely to benefit much greater number of children than adults. CGM would result in lower costs for test strips (2 tests per day to calibrate rather than 8 or more per day for many children) This would save approx £650 p.a.to offset against cost of CGM. Provides information of overnight control and alerts for hypo and hyperglycaemia, improving carers sleep. Some test once or twice during the night, or more often if child has poor control.	clinical comment
As an over-arching principle, I believe that priority should be given to treating patients who have a serious condition that has, or is likely to have, a major impact on their quality of life or their life expectancy. I believe that the rarity of the condition (i.e. the size of the population group benefiting) is irrelevant at the point of delivery. The high cost of development of treatments for rare conditions will already have been borne if a treatment is currently available.	clinical comment
Reduction of pain in nerves, joints - back pain - is crucial. Acute pain especially if prolonged is a terrible, tragic business - everything possible needs to be done (in line with evidence available) to reduce the pain suffered, short of over drug use.	clinical comment
The planned changes should be gently brought into service, after looking at costs.	clinical comment
these are not as urgently needed where as the NERVOUS SYSTEM is essential for each and everyone of so this has to be treated as the vital organ followed by EYE CONDITION here again the eye is very sensitive and we only have 2 so if treatment is delayed it could be very detrimental Then EAR NOSE THROAT each and everyone of us relies on our senses and further this is needed more by the young that have still got a life ahead of them in comparison to only having a few years.	clinical comment
Having a BMI limit of 25 is an obstacle many people will not be able to achieve.	clinical comment
I agree in part but not completely.	clinical comment

Yes, but I have a problem with Wirral Hospitals and the quantity of medication they provide for the patients they discharge. Specifically those who are on monitored dosage systems. When representatives of Wirral Hospitals spoke at a Voice of Wallasey meeting several years ago they stated that patients would be discharged with four weeks medication. This does not happen with MDS patients which I regard as more important than none MDS patients as the logistics involved in providing continuing medication to these patients means that a two week supply that they are actually provided with is barely enough.	clinical comment
I partly disagree, services available in GP practices such has physio, podiatry, and etc. should remain there.	clinical comment
I need to be assured that the patients' views have been taken into account. In one survey there were only 10 comments received and for such a large population this can hardly be described as representative. I do not agree with only comments made by those 10 respondents being quoted in the survey review by the CCG . More effort needs to be made in getting comments and views from a wider group of patients if patient participation is part of the resources which go to create the strategy.	clinical comment

My daughter Angela has written a letter to be presented or read out at the meeting on Wednesday 9th April at the dermatology unit at clatterbridge, she has explained why she cannot be present in her letter. I also am having difficulty trying to attend due to total knee replacement 3 weeks ago, I would like to express my views as Angela's parent and next of kin. Regarding what this unit has meant to me. Angela was diagnosed with Psoriasis with arthritis at the age of 20 and at that stage still living at home, I do not know where we would be today if the dermo unit was not available to have helped , Angela has had several visits over the years, at this stage her condition is under control using biological drugs, but the idea of needing the help and expertise of this unit ever again and it not being available is devastating. It is not only a life saver for the patient but also for the rest of the family, to see the change once Angela was admitted to the unit when her condition was critical and her skin in such an advanced stage of flare up, was unbelievable it is such a sanctuary for people with extreme skin disorders, and as a mother I ask those who are making these decisions to really think hard on the effect this will have on those in need of such help, it will never survive in the community it is unmanageable in lots of severe cases unless it is 24- 7 on a dermatology unit for a given period, I have nursed in the community in the past and I do think that chronic skin disorders that are presented as inpatient on the unit are totally unmanageable on a stay at home visit daily concept. It is surely out of the remit of community nursing, Angela has had stays of up to 4 to 5 weeks on the unit in the passed, the fact that her condition is now under control with drugs and as a 37 year old has a wonderful career and is totally independent has definitely been a major contribution of the unit. Please take all patient's views and that of their families into serious consideration before reaching your decision.	clinical comment
I want to see more support for the hospital and less schemes aimed at gps making money hosting services in the community.	clinical comment
Why is Wirral planning to de commission and re design the Rheumatology department when it does not appear as a priority for any change ? Or do they think they will have worked through the rest and have spare capacity ? Or are their motivations entirely different ?	clinical comment
I find it disconcerting the document re sleep apnoea comments on treatment modality BiPAP. This is not used in osahs unless there is an overlap syndrome or type 2 Resp failure	clinical comment
My surgery works fine never have a problem so why change.	clinical comment

No need for extended access to own GP above current extended hours.	clinical comment
Closer working between primary and secondary care are essential - this will not be achieved by pulling out services from the hospital. Any savings made should be reinvested into the health economy and not profits for private providers.	clinical comment
Postcode lottery springs to mind. There is also risk to patients when the G.P's hold back on treatment to save money/ give less effective treatment. The commissioning of private physiotherapy causes huge issues of patient duty of care when there are NHS Ohysios and O.T's working in the same surgeries! The savings in the NHS trust are 'Estates' led, staff are being moved around and placed in buildings that are not fit for purpose and being asked to hot desk. There are plans to halve the IT available for them and to start charging for car parking for community clinical staff who are required to run their cars in order to fulfill their community duties. There are proposals to use office space in central Birkenhead and provide parking on another site. I have done a calculation that if this were to go ahead we would incurr a loss of face to face clinical time with patients at a cost over 18 weeks between 33 staff of over £133,000.00 in income generation. The loss in clinical face to face hours with patients would be 1,782 hours which will also lead to delays in seeing patients. There have been 'consultations with managers but morale within the staff groups is very low. We have not had a pay rise in some years now, the cost of fuel is escalating and the charges to park for work purposes will cause real hardship to some staff. May I also say that the Essential car users allowance has been removed and there is a ceiling now which some staff have exceeded already that results in a sharp drop in pennies per mile.	clinical comment
Patients should be referred to a specialist service.	clinical comment

Political Comments:

I feel this is the first step of the privatisation of our beloved N.H.S . I worked in the NHS for 42 yrs and dealt with a myriad of changes during that period, some excellent, some not so. All of these changes in some way benefited both the service users and employers within the service. Of course, if the present government had not implemented Billions of pounds from the NHS, there would be no reason to go down the path of PRIVATISATION. So much for Mr. Cameron's statement that " the N H S will be SAFE in his hands". Maybe the people should have a IN-- OUT Referendum re the NHS.	political comment
Any reduction of services however well intentioned is not on.	political comment
It appears that the policy is based on cost reduction and not patient choice or benefit to the well being of patients. This document has not been widely distributed to the general public. Most people I have spoken to have not heard anything about it.	political comment
No privatising of the N.H.S	political
Keep things as there are this is privatisation by the back door	political
I do not think it should be either or, There is unlimited money for flooding, billions for nuclear weapons. Any culture that puts spending on systems for death ahead of spending on health is perverse	political
I am very concerned by the CCG and would like to know if any of the governing body have financial interests in the private clinics that have been set up in opposition to our local hospital	political
I feel that the NHS should be the main/preferred provider of healthcare	political
This is a way of privatisation and it will not benefit service users. If the Practice runs out of funds what then? If the practice cannot offer certain treatment to services users because the treatment is expensive, who pays that? Cancer treatments are based on post code - who pays in this case for expensive treatment? GP are not Finance Managers and doctors second. They are health professionals who must concentrate on medical issues and not management of systems and finances.	political
Great care should be taken to avoid back door privatization.	political
This is your way of introducing and corruptly being complicit in making it easy for big business to infiltrate the local NHS services to profit from peoples illness.	political

Doctors, are under enough pressure as it is now you are making them make decisions which are financial and not medical which is what they have been trained for. Our area is an area of deprivation and it has one of the highest heart problems of the North West. We need a Doctor to judge medically what is needed not be a accountant for which he has not been trained.	Political

Complex consultation: all consultation processes by their nature are complex and don't suit everyone – however, the 'Commissioning of low clinical value' was especially technical and 'technical orientated' consultations can be particularly difficult for interested parties to follow, understand and grasp. Many comments where left on the web site raising concerns. These comments will be used to help inform and design further consultations.

Complex Consultation Comments:

The comments on the consultation have been 'picked up' and will be incorporated in to further consultation processes.

Comment	Type
You have not suggested " Don't Know" as a response, because I do not fully understand what is being said. You have indicated the changes to previous policies very clearly by the colour coding, but this the first time the general public have seen the document. The full criteria document is not designed for the patient, therefore to comment is not readily done. I suspect you will see this in the response figures. It is difficult to get at the implications of the policies. As regards medications , what are you talking about. Which medications are you supporting or not supporting.	too complex consultation
This document is too complicated for Joe Public to understand. I would ask that you consider the following: All treatments should be available, cost should not come into it. This shoddy Government can't afford to go private. Secondly, when one becomes an OAP, we are still human beings - this is not a third world country.	too complex consultation
Populist views is not the way to make selections on such a diverse set of options of which some e.g. penile implants should never be classified in the same category as infertility	too complex consultation

I mostly agree, but I am very conscious of how this information is going to be shared with patients, will it mostly when its too late when people are sitting in the consultation room? In many cases it is a case of too little information given too late.	too complex consultation
Insufficient information to comment. Neither the existing criteria or the proposed criteria is provided. In conjunction with an existing Continuous Glucose Monitoring user a draft criteria has been produced for your consideration- it has been forwarded to xxxxx Engagement & Involvement Manager, St Helens Clinical Commissioning Group due to space limitation here	too complex consultation
I think there should be more consultation first and these changes need much nore explanation. I realise the need for cuts but I do not think the details are clear enough for me to give my comments on them.	too complex consultation
At a superficial level it looks OK but with the proviso that I do not have sufficient information to make a decision	too complex consultation
Where is it to read?	too complex consultation
I think you need to distinguish clearly what is meant by commissioning and other forms of CCG procurement e.g. 3rd sector funding in relation to complementary therapies provision.	too complex consultation
Document not available to me to comment on.	too complex consultation
what changes?	too complex consultation
No, the reason being there is insufficient information provided in most documents for me to be in a position to make an informed decision. There needs to be specific information as to what the changes are.	too complex consultation
Could not find a copy of the CCG policy document. Tried various methods of enquiry on the search panels of all pages directed to, to no avail. Therefore unable to agree or disagree with any statements made in the planned changes to draft policy.	too complex consultation
I do not have enough knowledge of the impact of the proposals to make an informed comment I will therefore have to trust the CCG that they are making the correct proposals.	too complex consultation

Even after reading the planned changes I do not feel qualified to make such a comment. As stated earlier patients have to put their trust in the professionalism of the medical practitioners to make the most appropriate choices without loss of quality of care.	too complex consultation
Could not find document	too complex consultation

Annex 2

Transgender Focus Group

The focus group took place on the 20th May 2014 and lasted for approximately 2 hours 40 minutes
The E&D lead for the Cheshire and Merseyside Commissioning Support Unit facilitated and met representatives of the transgender community across the north of England including specific reps from:

- In Trust Merseyside
- Trans Youth
- Spirit level

This information has also been sent to Intrust Merseyside for wider distribution across Cheshire and Wirral transgender community groups for further comments which can continue to inform the future EIA delivery action plan, once recommendations have been noted by decision makers across all CCGs.

The focus group met because it was expected that low numbers from the transgender community were expected to contribute to the on line and survey and a new interim The Gender Dysphoria Protocol & Service Guidelines 2013/14 (http://www.england.nhs.uk/wp-content/uploads/2013/10/int-gend-proto.pdf) adopted by NHS England impacts and interacts significantly with a substantial number of the low clinical value policies under review.

Previous to this focus group previous meetings and discussions took place with a representative of In trust Merseyside to determine which policies the focus group concentrated on. This selective and focussed approach was also steered by the Gender Dysphoria Protocol, which highlights issues governed by specialist commissioning routes and those ***non-core treatments*** (highlighted below), which is the responsibility of local CCG commissioning,

Findings and Outcomes of the Group

The group feedback has been categorised by the key below and comments have been included against relevant policies using the original policy document used during the public consultation.

Ensure that key messages and areas that require further clarity were forwarded to NHS England

1- High importance – disadvantages trans patients and transition and advances equality of opportunity (Equality Act 2010- Gender reassignment).
2- Medium importance and further clarity will be requested from NHS England in relation to the Gender Dysphoria Protocol and service Guidelines.
3- Low only occurs in rare circumstances.

Key recommendations from this exercise are included in the main recommendation section of the EIA but will include;

- Recommendations that high importance areas are agreed by local CCGs Individual Funding requests if the treatment is relevant to protected characteristic and life chances (Advance equality of Opportunity- Equality Act 2010- gender reassignment).
- Ensuring GPs and health professional understand the new interim guidance and pathway for gender dyphoria and how this interacts with the low clinical value policies.
- Seek clarity from NHS England on any grey areas detected as a result of the feedback.
- Support training and briefings that need to be distributed or delivered to health professional who refer patients and decision makers who form the panel in relation to Individual Funding Requests.
- Information to be included in the So What document Re Commissioning Policy Review.

The CSU and CCGs would like to sincerely thanks the individual and groups involved who took part in the focus group session and the wider engagement and feedback process for their time effort and expertise

Procedures not exclusive to gender reassignment ("non-core" procedures)
Some patients may require other medical procedures as part of the process of transforming their body to be more congruent with their gender. Other procedures that are not considered within the Gender Reassignment Protocol can only be considered by the patient's Clinical Commissioning Group (CCG). Examples of such procedures are given in the table below.

"Non-core" surgical procedures are not routinely commissioned by the NHS and can only be provided on an exceptional clinical need basis.

Patients will only be referred for this surgery following a clinical assessment by their GIC and where a symptomatic or functional requirement for surgery has been identified. All cases will be referred to the patient's GP's CCG for consideration and assessment against CCG Policy. Access criteria will consider age, body mass index (BMI), impairment of function, and psychological distress.

Referral for consideration does not necessarily mean that surgery will be offered.

This must be communicated to the patient. Treatments that may be sought through the CCG Policy

Condition	Comment
Breast augmentation (augmentation mammoplasty)	This should only be considered where there is a clear failure of breast growth in response to adequate hormone treatment. Review of breast development in anticipation of breast augmentation surgery should be made no earlier than after the completion of 18 months of adequate hormone treatment. It should be made clear to patients during individual treatment plan discussions that assessments of the appropriateness of breast augmentation will be made no earlier than after the completion of 18 months of adequate hormone treatment.
Facial Feminisation Surgery (FFS)	Treatments may include: - Thyroid chondroplasty / Tracheal shave (reducing size of larynx) - Rhinoplasty (nasal surgery) - Facial bone reduction - Blepharoplasty / Facelift
Lipoplasty/Contouring	Liposuction and/or body sculpture.
Gamete storage	Using similar protocols as with those receiving radiotherapy and other gamete damaging procedures

Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.

Focus Group responses and importance are incorporated onto the actual policy document below

	Treatment/ Procedure	Exceptionality - Prior Approval - Criteria	Comments
3.	***Dermatology***		
3.1 High	Skin Resurfacing Techniques (including laser dermabrasion and chemical peels)	Only be commissioned in the following circumstances: Severe scarring following: • acne once the active disease is controlled. • chicken pox. Or • trauma (including post-surgical). Procedures will only be performed on the head and neck area..	Impacts on Transwomen – currently under the new pathway 8 sessions are covered by the GI clinic. Many Trans people feel the need to come to the GP after 8 sessions often because 8 is not enough. Works much more effectively with younger Transwomen. CCG should under the right circumstances approve more treatments locally
3.3 NEW	Treatments for Hypo-pigmentation	NHS Cosmetic Camouflage is commissioned. This is provided by Changing Faces formerly the Red	Trans-men can be subject to severe acne due to hormone treatments. Trans community would like the CCGs to consider this treatment and be referred to

	meduim	Cross	NHS beauticians – during gender reassignment Trans people need to demonstrate they are living in their chosen sex in society – in this treatment is not provided it can causes issues of safety and/or isolation in their own homes.
5.2	Pinnaplasty – for Correction of Prominent Ears Low	May be commissioned in the following circumstances: The patient should be between 5 and 19 years of age. Patient assessed by plastic or ENT surgeon who has the option to refer, when appropriate to a specialist paediatric psychologist. If there is evidence of psychological distress likely to be alleviated by surgery, prior approval is not required . Incisionless otoplasty is not commissioned.	Prominent ears could impact on young Trans women who have difficulty growing their hair long.

5.7 High	Rhinoplasty - Surgery to Reshape the Nose.	This procedure is NOT available under the NHS on cosmetic grounds. Only commissioned in any of the following circumstances: • Objective nasal deformity caused by trauma. • Problems caused by obstruction of nasal airway. • Correction of complex congenital conditions e.g. cleft lip and palate.	Transwomen, particularly elderly transwomen, urge the CCG to consider this treatment. Particularly those who have not accessed hormone therapy.

5.8 NEW High	Surgery of Laser Treatment of Rhinophyma	Not routinely commissioned.	Should not be refused for an older trans women – again linking to hormone use which can trigger this condition.

10	***Gynaecology***		
10.1	Surgical Procedures – for the Treatment of Heavy Menstrual Bleeding Hysterectomy D&C (Dilatation and curettage)	Hysterectomy not commissioned unless all of the following requirements have been met: • An unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena) unless medically contra-indicated or the woman has made an informed choice not to use this treatment. • The following treatments have failed, are not appropriate or are contra-indicated in line with NICE guidance. - Tranexamic acid or nonsteroidal anti-inflammatory drugs or combined oral contraceptives. - Norethisterone (15mg) daily from days 5 to 26 of the menstrual cycle, or injected long-acting progestogens. - Endometrial ablation has been tried (unless patient has fibroids >3cm). Dilatation and curettage not commissioned as a diagnostic or therapeutic procedure.	Covered in the Gender Reassignment Care Pathway

11 Specialist commissioning Gender dysphoria High	Treatment of Gender Dysphoria	Patients with Gender Dysphoria issues should be referred to the Gender Identity Clinic (GIC) at Charring Cross. It is no longer necessary to access local services for assessment. Core surgery is commissioned by NHS England but there are a number of non- core treatments which will need consideration for funding by the CCG. These requests should be made by the GIC only and considered on an individual basis.	Written changes to policy, GPs under the new pathway can directly refer patients to the Gender Identity Clinic. This includes charring cross, Leeds, Nottingham and Sheffield. Trans community would like wider referrals to the Abacus service (currently commissioned by Liverpool CCGs) This services are vital in providing holistic support to patients and will avoid drop outs from the GICs.
16	***Plastic & Cosmetic Surgery***		
16.1 medium	Reduction Mammoplasty - Female Breast Reduction	Commissioned only if all of the following circumstances are met: Musculo-skeletal symptoms are not due to other causes. And There is at least a two year history of attending the GP with the problem. And Other approaches such as analgesia and physiotherapy have been tried. And The patient is suffering from functional symptoms as a result of the size of her breasts (e.g. candidal intertrigo; backache). And The wearing of a professionally fitted brassiere has	Addressed in the new pathway

		not helped. And Patients BMI is <25 and stable for at least twelve months. And There is a proposed reduction of at least 500g per side. And It is envisaged there are no future planned pregnancies. Unilateral breast reduction is considered for asymmetric breasts of three or more cup size difference as measured by a specialist.	
16.2 High	Augmentation Mammoplasty - Breast Enlargement	Only commissioned in the following circumstance: The BMI is <25 and stable for at least twelve months. And any of the following: Unilateral breast enlargement is considered for breasts of three or more cup size difference as measured by a specialist. . Congenital absence i.e. no obvious breast tissue. In special circumstances reconstructive surgery may be appropriate for tubular breast abnormality.	Trans community may refute the BMI stipulation for this service to be commissioned, this is a local CCG procedure and there needs to be greater awareness amongst GPs. Trans community recommend this is commissioned to support gender reassignment. There are further clinical options to breast enlargement and these should be made clear to the transcommunity.
16.3	Removal and/or Replacement of	Revisional surgery will ONLY be considered if the NHS commissioned the original surgery and	Same response as 16.2

High	Silicone Implants - Revision of Breast Augmentation	complications arise which necessitates surgical intervention , such as: Capsule contraction causing significant deformity or Implant rupture. If revisional surgery is being carried out for implant failure, the decision to replace the implant(s) rather than simply remove them will be based upon the clinical need for replacement and whether the patient meets the policy for augmentation at the time of revision.	
16.4	Mastopexy - Breast Lift	Not routinely commissioned May be considered as part of other breast surgery to achieve an appropriate cosmetic result subject to prior approval.	Same response as 16.2
16.5 High	Surgical Correction of Nipple Inversion	This is not routinely commissioned. .	Transmen, sometimes Transmen receive surgery which is “botched”, it is highly recommended that CCGs support this if the surgery has a disfiguring effect.
16.6 High/	Male Breast Reduction Surgery for Gynaecomastia.	Not routinely commissioned except on an exceptional basis where all of the following criteria are met: True gynaecomastia not just adipose tissue. AND Underlying endocrine or liver abnormality excluded. AND Not due to recreational use of drugs such as steroids	Transmen

		or cannabis or other supplements known to cause this. AND Not due to prescribed drug use. AND Has not responded to medical management for at least three months. AND Post pubertal. AND BMI <25kg/m2 and stable for at least 12 months. AND Patient experiences pain. AND Experiences significant functional impairment.	
16.7 high	Hair Removal Treatments including Depilation Laser treatment or Electrolysis –for Hirsutism –	Routinely commissioned in the case of those undergoing treatment for pilonidal sinuses to reduce recurrence. In other circumstances only commissioned if all of the following clinical circumstances are met; • Abnormally located hair-bearing skin following reconstructive surgery located on face and neck.	Impacts on Transwomen – currently under the new pathway 8 sessions are covered by the GI clinic. Many Trans people feel the need to come to the GP after 8 sessions often because 8 is not enough. Works much more effectively with younger Transwomen Works less effectively with older Trans patients with grey hair.

		• There is an existing endocrine medical condition and severe facial hirsutism. 1. Ferryman Gallwey Score 3 or more per area to be treated. 2. Medical treatments have been tried for at least one year and failed. 3. Patients with a BMI of>30 should be in a weight reduction programme and should have lost at least 5% body weight. All cases will be subject to individual approval by the IFR Team and must be accompanied by an opinion from a secondary care consultant (i.e. dermatologist or endocrinologist). Photographs will also be required to allow the PCTs to visibly asses the severity equitably. Funded for 6 treatments only at an NHS commissioned premises.	
16.8 NEW	Surgical treatment for Pigeon Chest	This procedure is not routinely commissioned by the NHS on cosmetic grounds.	N/A
16.9 High	Surgical revision of Scars.	Funding of treatment will be considered only for scars which interfere with function following burns, trauma, treatments for keloid, or post-surgical scarring.	Impacts on Transwomen
16.10 Low	Laser Tattoo Removal	Only commissioned in any of the following circumstances: • Tattoo is result of trauma inflicted against the patient's will. • The patient was a child and not responsible for his/her actions at the time of tattooing. • Inflicted under duress • During adolescence or disturbed periods (only in very exceptional circumstances where tattoo causes marked limitations of psycho-social function).	Male to female transition Masculine tattoos

		An individual funding request will be required.	
16.11 Low	Apronectomy or Abdominoplasty (Tummy Tuck).	Not routinely commissioned other than if all of the following criteria are met: The flap hangs at or below the level of the symphysis pubis. Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction). Bariatric surgery (if performed) was performed at least 3 years previously. AND any of the following: Causes significant problems with activities of daily life (e.g. ambulatory restrictions). Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. Poorly-fitting stoma bag. (If the patient does not fulfil all of the required criteria, an IFR should be submitted detailing why exception should be made) IFR information ***must*** contain the following information; • Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates. • Series of weight and BMI readings demonstrating weight loss and stability achieved.	Trans men who have had children Exceptions to be considered

		• Date stable weight and BMI achieved. • Current weight BMI. • Patient compliance with continuing nutritional supervision and management (if applicable). • Details of functional problems. • Details of associated medical problems.	
16.12 medium	Other Skin Excisions/ Body Contouring Surgery e.g. Buttock Lift, Thigh Lift, Arm Lift (Brachioplasty)	Not routinely commissioned. If an IFR request for exceptionality is made, the patient must fulfil all of the following criteria before being considered. Patients BMI is <25 and stable for at least 12 months. (Some allowance may be made for redundant tissue not amenable to further weight reduction). Bariatric surgery (if performed) was performed at least 3 years previously. AND any of the following: Causes significant problems with activities of daily life (e.g. ambulatory restrictions). Causes a chronic and persistent skin condition (e.g. intertriginous dermatitis, panniculitis, cellulitis or skin ulcerations) that is refractory to at least six months of medical treatment. In addition to good hygiene practices, treatment should include topical antifungals, topical and/or systemic corticosteroids and/or local or systemic antibiotics. IFR information ***must*** contain the following information; • Date of bariatric surgery (where relevant). • Pre-operative or original weight and BMI with dates.	Clarity on the national pathway on this issue

		• Series of weight and BMI readings demonstrating weight loss and stability achieved. • Date stable weight and BMI achieved. • Current weight BMI. • Patient compliance with continuing nutritional supervision and management(if applicable). • Details of functional problems. • Details of associated medical problems.	
16.13 High	Treatments to correct Hair Loss for Alopecia.	Only commissioned in either of the following circumstances: • Result of previous surgery • Result of trauma, including burns Hair Intralace System is not commissioned. Dermatography is not commissioned. NHS wigs will be available according to NHS policy.	Transwomen significant issue – hormone therapy can cause hair loss Recommend that it is provided in the right circumstances to Trans patients as well as highlighting other alternative options for treatment which could be funded on the NHS
16.14 high	Hair Transplantation	Commissioned only in exceptional circumstance, e.g. reconstruction of the eyebrow following cancer or trauma. Dermatography may be an acceptable alternative in eyebrow reconstruction.	As above
16.15 High	Treatments to correct Male Pattern Baldness	This is not routinely commissioned.	As above
16.16 medium	Labial Reduction Surgery	This is not routinely commissioned.	Included on the new care pathway but greater clarity needed
16.17 Low	Liposuction	Liposuction is sometimes an adjunct to other surgical procedures e.g. thinning of a transplanted flap. Not commissioned simply to correct fat distribution. May be commissioned as part of the management of	Transmen, liposuction of potential “dog ears” i.e excessive fat distribution Funded by exceptions- IFR

		true lipodystrophias or non-excisable clinical significant lipomata. An individual funding request will be required.	
16.18 High/ medium	Rhytidectomy - Face or Brow Lift	This procedure is not available under the NHS on cosmetic grounds. Routinely commissioned in the following circumstances: • Congenital facial abnormalities. • Facial palsy. • Treatment of specific conditions affecting the facial skin, e.g. cutis, laxa, pseudoxanthoma elasticum, neurofibromatosis. • To correct consequences of trauma. • To correct deformity following surgery.	Transwomen – this can be commissioned by specialist commissioning or local CCGs there needs to be greater clarity within the pathway.
medium	Radiotherapy Collagenase injections	These procedures are not commissioned.	Transwomen – feminine lips exceptions
19	***Urology***		
19.1 NEW	Circumcision	This not offered for social, cultural or religious reasons. However certain CCGs may have individual policies. Indicated for the following condition; ➢ balantis xerotica obliterans. ➢ traumatic foreskin injury/scarring where it cannot be salvaged. ➢ 3 or more episodes of balanitis/balanoposthis. ➢ Pathological phimosis. ➢ Irreducible paraphimosis. ➢ Recurrent proven Urinary Tract Infections (UTIs) with an abnormal urinary tract.	n/a
19.2	Penile Implant: A surgical procedure to	Not routinely commissioned.	Similar treatment on the new pathway – Phalloplasty but greater clarification is needed.

Medium	implant a devise into the penis .	 59 PenileImplants.pdf See attached sheet.	
19.3 NEW	Reversal of Male Sterilisation medium	The NHS does not commission this service. Patients consenting to vasectomy should be made fully aware of this policy. Reversal will be only considered in exceptional circumstances such as the loss of a child.	Transwomen – after transition and how this interacts with fertility policys Dealt with through exceptions route- IFR

Footnote: Draft commissioning policy document shared for engagement and comments

END OF ANNEXES