NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public
Agenda

Date: Wednesday 25th March 2015, 1300 hrs to 1600 hrs
Venue: Family Life Centre, Ash Street, Southport, Merseyside, PR8 6JH

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

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

The Governing Body

Dr Rob Caudwell	Chair and Clinical Director	RC
Dr Niall Leonard	Clinical Vice Chair and Clinical Director	NL
Paul Ashby	Practice Manager and Governing Body Member	PA
Dr Doug Callow	GP Clinical Director and Governing Body Member	DC
Dr Peter Chamberlain	Lead Clinician for Strategy & Innovation	PC
Hannah Chellaswamy	Deputy Director of Public Health, SMBC	HC
Fiona Clark	Chief Officer	FLC
Michelle Creed	Chief Nurse, NHSE (Merseyside) *(co-opted member on behalf of Clare Duggan)*	MC
Dr Martin Evans	GP Clinical Director and Governing Body Member	ME
Debbie Fagan	Chief Nurse	DF
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Martin McDowell	Chief Finance Officer	MMcD
Peter Morgan	Deputy Chief Executive, Sefton MBC *(co-opted member on behalf of M Carney)*	PM
Dr Hilal Mulla	GP Clinical Director and Governing Body Member	HM
Helen Nichols	Vice Chair and Lay Member for Governance	HN
Roger Pontefract	Lay Member for Patient & Public Engagement	RP
Colette Riley	Practice Manager and Governing Body Member	CR
Dr Kati Scholtz	GP Clinical Director and Governing Body Member	KS
Dr Jeff Simmonds	Secondary Care Doctor and Governing Body Member	JS

In Attendance

Billie Dodd	Head of CCG Development *for Item 15/52*	BD
Jan Leonard	Chief Redesign & Commissioning Officer *for Items 15/50 & 15/51*	JL
Karl McCluskey	Chief Strategy & Outcomes Officer *for Items 15/56 and 15/58*	KMcC
Melanie Wright	Lead for Intermediate Care *for Item 15/53*	MW

Presentation on “Mental Health Transformation”

No	Item	Lead	Report	Receive/ Approve	Time
Governance					
GB15/41	Apologies for Absence	Chair	-	R	3 mins
GB15/42	Declarations of Interest	Chair	✔	R	1 mins
GB15/43	Hospitality Register	Chair	✔	R	1 mins
GB15/44	Minutes of Previous Meeting	Chair	✔	A	5 mins
GB15/45	Action Points from Previous Meeting	Chair	✔	A	5 mins
GB15/46	Business Update	Chair	Verbal	R	5 mins
GB15/47	Chief Officer Report	FLC	✔	R	10 mins
GB15/48	GP Pressures and Supporting Practices	All	Verbal	R	5 mins

No	Item	Lead	Report	Receive/ Approve	Time
GB15/49	NHS Southport & Formby CCG Constitution	FLC	✔	A	10 mins
GB15/50	NHS Southport & Formby and NHS England Joint Committee – Terms of Reference	JL	✔	A	10 mins
Service Improvement/Strategic Delivery					
GB15/51	Breast Care Services Engagement and Equality Report and Recommendations	JL	✔	A	10 mins
GB15/52	Care Closer to Home Strategy 2013 – 2018 (refreshed in 2015)	BD	✔	A	10 mins
GB15/53	Sefton Joint Intermediate Care Strategy	MW	✔	A	10 mins
GB15/54	Draft CCG Quality Strategy	DF	✔	A	10 mins
GB15/55	Safeguarding Strategy	DF	✔	A	10 mins
GB15/56	2015/16 Planning Submission	KMcC	✔	A	10 mins
GB15/57	Home Oxygen Assessment Service Contract	MC	✔	A	10 mins
Finance and Quality Performance					
GB15/58	Integrated Performance Report	KMcC/ MMcD/ DF	✔	R	10 mins
For Information					
GB15/59	Emerging Issues	ALL	-	R	5 mins
GB15/60	Key Issues reports from committees of Governing Body: a) Finance & Resource Committee b) Quality Committee c) Service Improvement Redesign Committee d) Audit Committee		 ✔ ✔ ✔ ✔	 R R R R	5 mins
GB15/61	Finance & Resource Committee Minutes	-	✔	R	5 mins
GB15/62	Quality Committee Minutes	-	✔	R	
GB15/63	Service Improvement & Redesign Committee Minutes	-	✔	R	
GB15/64	Audit Committee Minutes	-	✔	R	
GB15/65	Locality Meetings: a) Ainsdale & Birkdale (South) Locality b) Formby Locality c) Central Locality d) North	 - -	 ✔ ✔	 R R	
Closing Business					
GB15/66	Any Other Business *Matters previously notified to the Chair no less than 48 hours prior to the meeting*				5 mins
GB15/67	Date of Next Meeting Wednesday 27th May 2015 at 15.00 hrs, Family Life Centre, Southport				
Estimated meeting close					16.00

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
Southport and Formby
Clinical Commissioning Group

Hospitality Register
February 2015 - March 2015

Recipient	Nature of Gift / Hospitality	Date Received	Approximate Value	Sponsored By
-	-	-	-	-

No hospitality received.

NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public
DRAFT Minutes

Date: Wednesday 28th January 2015 at 13.00 to 15.00 hrs
Venue: Family Life Centre, Ash Street, Southport

The Governing Body		
Dr Rob Caudwell	Chair & GP Clinical Director	RC
Dr Niall Leonard	Clinical Vice-Chair & Governing Body Member	NL
Paul Ashby	Practice Manager & Governing Body Member	PA
Dr Doug Callow	GP Clinical Director & Governing Body Member	DC
Hannah Chelleswamy	Consultant in Public Health *(co-opted Member on behalf of Dr Janet Atherton)*	HC
Fiona Clark	Chief Officer	FLC
Michelle Creed	Chief Nurse, NHSE (Cheshire & Mersey) *(co-opted member on behalf of Clare Duggan)*	MC
Dr Martin Evans	GP Clinical Director & Governing Body Member	ME
Debbie Fagan	Chief Nurse & Quality Officer	DF
Maureen Kelly	Chair, Healthwatch *(co-opted Member)*	MK
Martin McDowell	Chief Finance Officer	MMcD
Peter Morgan	Deputy Chief Executive, Sefton MBC *(co-opted member on behalf of M Carney)*	PM
Dr Hilal Mulla	GP Clinical Director & Governing Body Member	HM
Helen Nichols	Lay Member - Governance	HN
Roger Pontefract	Lay Member, Patient & Public Involvement	RP
Colette Riley	Practice Manager & Governing Body Member	CR
Dr Kati Scholtz	GP Clinical Director & Governing Body Member	KS
Dr Jeff Simmonds	Secondary Care Doctor	JS
In Attendance		
Fiona Doherty	Transformational Change Manager *for Integrated Performance Report*	FD
Karen Garside	Deputy Designated Nurse Safeguarding Children *for Child Sexual Exploitation & Safeguarding Declaration*	KG
Tracy Jeffes	Chief Delivery & Integration Officer *for Q3 Update - CRR & GBAF*	TJ
Jan Leonard	Chief Redesign & Commissioning Officer *for Co-Commissioning Submission*	JL

Questions from Members of the Public

Mr Bob Giles, a Birkenhead resident, was concerned that financial support for the iVAN service, currently funded by directors of Public Health on Merseyside, would cease on 31st March 2015. He had used the service and believed it to be a great initiative and should not be 'down skilled'.

HC confirmed Bridgewater Community Trust had taken over responsibility for the service which would visit areas where it was needed, not just areas surrounding Bridgewater.

No	Item	Action
GB15/1	**Apologies for Absence** were received from Dr Doug Callow, Mrs Maureen Kelly, Mr Roger Pontefract and Dr Jeff Simmonds. Dr Leonard on call so arrived late to the meeting.	
GB15/2a	**Declarations of Interest** All CCG employees holding dual responsibilities declared their interest.	
GB15/2	**Hospitality Register** No issues were raised. FLC explained only items above £25 in value needed to be declared.	

No	Item	Action
GB15/3	**Minutes of the Previous Meeting** were accepted as a true record once the following amendments have made: • Add Helen Nichols to the list of attendees; • Change date of next meeting to January not March.	JBy
GB15/4	**Action Points from Previous Meeting** *14/125 – Review of Case for Change* – the paper is currently being revised and will be brought back to the Governing Body for review. *14/127 – Finance Report* – the quality premium has now been factored into the latest report. *14/146 – Neuro Rehab Acquired Brain Injury (ABI)* – an independent review is to be undertaken looking at links with various services across Merseyside, one aspect of which will be the rehabilitation unit. Published findings will be brought back to the appropriate committee (Service and Implementation Review Committee?) *14/152 – Update on CCG Strategy* – HC confirmed invitations had been sent out for a hypertension event at the Halliwell Jones stadium on 9th March 2015, facilitated by the Blood Pressure Board, at which Primary Care representation would be welcomed. *14/156 – Better Care Fund (BCF) Update* – the resubmitted bid has been approved and the 2 outstanding conditions removed. The Section 75 agreement is currently being reviewed. *14/157 – Future Financial Allocations* – this item is on the agenda.	KMcC
GB15/5	**Business Update** *Alcohol Recovery Centre* – a recovery centre has been piloted in Southport town centre over the Christmas period. Numbers were far lower than anticipated, however, it has been successful in terms of the cohesiveness between the CCG, Southport & Ormskirk Hospital NHS Trust, the paramedics, the licensing trade and police. Lessons learnt are currently being evaluated to see whether the exercise should be repeated. *A&E* – is currently facing massive pressures. The CCG is proactively reviewing this on an ongoing basis; several walk rounds have been undertaken in recent weeks and a GP has been placed in A&E for 6 weeks to help ease the pressure. *New Chair at Southport & Ormskirk NHS Trust* – Sue Musson has been appointed as Chair and recently met the CCG's Senior Leadership Team. Rob Caudwell, Chair of Southport & Formby CCG, will be meeting Sue regularly so any issues are dealt with promptly.	
GB15/6	**Chief Officer Report** *Shaping Sefton – Future Models of Care* – the CCG's strategy has been formulated and a session involving The King's Fund and all other interested parties/sectors in the health economy will take place on Thursday 12th February to bring all the thinking together. *Dalton Review* – this will be discussed at the Shaping Sefton event as part of a conversation regarding appropriate organisational models for smaller district hospitals, such as Southport & Ormskirk Hospital NHS Trust. *Better Care Fund* – the bid has now been signed off with the 2 outstanding conditions removed. The CCG is receiving ongoing support from the NHS England sub regional Cheshire & Mersey team. *Breast Care Services* – the CCG is working with Southport & Ormskirk Hospital NHS Trust to help support staff and to help shape the most appropriate future service for the Southport & Formby population, by way of an engagement exercise. RC assured the Governing Body that any patients who are already in the system will get the appropriate follow up and their care will not be compromised. Any new patients are currently being referred elsewhere although a sustainable local service is being sought as part of the exercise.	

	Chief Officer Report (cont'd) *Commissioning Support Unit (CSU)* – it has been announced the CSU has not been successful in getting on the national Lead Provider Framework. FLC and TJ have met with the managing director to understand implications going forward. It will be discussed at the next CCG Network meeting and FLC will report back to the Governing Body in due course. *SMBC Budget* – it has been announced that Sefton Council's budget is to be reduced by 46% in the coming year. The Council is working together with CCG colleagues to discuss how the implications of these budget changes can be managed. *Systems Leadership* – the CCG has managed to secure £20K to help improve services for the Sefton population, part of which will be used to fund the 'Shaping Sefton – Future Models of Care' event on 12th February. **Action: The Governing Body received the Chief Officer report.**	
GB15/7	**GP Pressures and Supporting Practices** This item has been added as a standing item to Governing Body agendas following a recommendation from Chaand Nagpaul, the Chairman of the General Practitioner's Committee (GPC). The aim is to provide an opportunity for any issues or ideas to be raised and RC has written to GPs advising them to that effect. ME believed some of the pressure on primary care could be eased if the whole system (ie primary, secondary and tertiary) was taken into consideration and we worked collaboratively. *Pressures on A&E* – RC had also written to GPs to advise contractual work should be prioritised.	
GB15/8	**Integrated Performance Report** MMcD updated the Governing Body on several issues he expected to arise in the final quarter of the year. *Continuing Health Care (CHC) Claims* - the CCG has received a letter from NHS England setting out national timescales for restitution of outstanding claims. There is possible concern over whether or not there is sufficient staffing resource available to complete in the timescale set. HN added that expenditure on CHC was causing the CCG enormous headaches – the rate this year was phenomenal and if the rate of increase was to continue it would become a huge financial pressure. As a result, the Finance & Resource Committee has undertaken a review to understand trends and how we compare nationally with other CCGs. A separate steering group has also been established involving both CCG and North West Commissioning Support Unit personnel to understand the broader agenda in terms of quality of service and ensure that reviews are being carried out in a timely manner. *Emergency Tariff* - once the premium goes above a certain baseline, it triggers a 30% payment to the Southport & Ormskirk NHS Trust, being the marginal rate for the emergency tariff. The remaining 70% should then be invested in the community. MMcD believes this has been used as intended.	

	Integrated Performance Report (cont'd) *NPfIT (National Programme for IT in the NHS) Programme* - the CCG has built additional money into the plan to help Southport & Ormskirk NHS Trust's NPfIT programme, particularly around community services. However, the CCG has notified the Trust it is not satisfied with current progress and MMcD asked the Governing Body to approve the recommendation to withhold this year's payment. MMcD assured the Governing Body that the CCG has an action plan in place and remains on target to deliver its final position and asked the Governing Body to approve the recommendations contained in the report. HN asked where the mandated money was in final action plan. MMcD replied it had already been included and he would forward the Finance & Resource Committee paper to her for information. The Governing Body approved the recommendation to transfer funding from the earmarked NPfIT support and Locality developments to bridge the financial gap facing the CCG. Fiona Doherty updated the meeting on key performance areas in the month. *NWAS* – the ambulance service is currently showing as red on the dashboard and the CCG is working with NWAS to resolve issues. *Stroke* – there is a significant review of stroke services being undertaken, which has been discussed in the Quality Committee meetings. FLC has asked Michelle Creed, NHS England (Cheshire & Mersey), to work with the Debbie Fagan as the work is region-wide. FD updated the Governing Body on the local measures introduced by the CCG in terms of the quality premium. Data relating to diabetes and smoking is currently being reviewed as it may have been collated incorrectly. Localities had been asked to review the data so the accuracy of coding could be checked as soon as possible. *Healthcare Acquired Infections (HCAI)* - figures were still red rag rated but seeing some improvement. DF/MC had conducted a quality walk around at both Southport & Ormskirk and Aintree Hospitals recently, to ensure patients were safe and getting the required standard of care . It was a positive experience in terms of knowledge of and commitment from medical and nursing staff. *Mortality performance* – this has previously been reported to the Quality Committee. The Trust has invited the CCG to be part of a Mortality Review Group and DF, DC and RC will liaise back through Quality Committee.	MMcD MMcD DF/MC DF/DC/ RC

	Complaints – FLC expressed concern that the figure for Southport & Ormskirk Hospital NHS Trust has almost doubled. HN explained a review of the complaints processes had been completed, which meant any reported concern had to be treated as a formal complaint if the process for completion took over 24 hours. As a direct result of this, the number of complaints received in September was 63, more than double the average of 29 seen in previous months during this financial year. This change in the way concerns are now graded makes it inappropriate to draw direct comparisons on complaint numbers for the previous year. The Quality Committee has tasked the Engagement & Patient Experience Group (EPEG) with conducting a review of provider complaints' reports. *Mental Health Issues* – DF to check and report back to the Governing Body on the dip in performance (85% against a target of 95%) in relation to the Care Programme (CPA). **Actions:** **(i) The Governing Body received the report and approved the recommendation to transfer funding from the earmarked NPfIT support and Locality developments to bridge the financial gap facing the CCG;** **(ii) MMcD to forward HN a copy of the Finance & Resource Committee paper;** **(iii) DF to work with MC and NHSE on the stroke service review;** **(iv) DF to report back to Quality Committee regarding mortality performance from Mortality Review Group at Southport & Ormskirk Hospital NHS Trust;** **(v) *Mental Health Issues* – DF to check and report back to the Governing Body on the dip in performance (85% against a target of 95%) in relation to the Care Programme (CPA).**	DF DF MMcD MMcD DF/MC DF DF
GB15/9	**Quarter 3 Update - 2014/15 Risk Assurance Framework & Corporate Risk Register** TJ presented the Governing Body with the six-monthly overview of the Corporate Risk Register and Risk Assurance Framework. Of 14 risks, 2 have increased one being the financial position which has been covered by MMcD in the previous item. Corporate Risk Register – 1 red rated risk, Continuing Healthcare (CHC) which has already been discussed in relation to funding and resource. HN believed the registers have improved in quality over the last year, but whilst she is satisfied that whilst the RAG rating approach was operating well and reviewed at the relevant places, some of the risks seemed to be static for longer than expected. She asked that the registers go to the Audit Committee on an annual basis starting in October 2015, as the external auditors will want to review them at year end. The Corporate Governance Support Group and the Quality Committee have reviewed and commented on the registers for additional assurance. Registers are also reviewed rigorously on a monthly basis at Senior Management Team meetings.	TJ/MMcD TJ/JBy

	Actions: **(i) The Governing Body received the report;** **(ii) The Corporate Risk Register & Risk Assurance Framework to be presented to the Audit Committee on an annual basis starting in October 2015;** **(iii) The Corporate Risk Register & Risk Assurance Framework continue to be reviewed by SMT on a monthly basis.**	TJ/MMcD TJ/JBy
GB15/10	**Child Sexual Exploitation** Karen Garside updated the Governing Body on the key national priority areas of work that the safeguarding service is engaged with and the resulting action plan that has previously been presented to the Quality Committee. MC has received a letter from the Police Commissioner about the fragmentation of commissioning who had asked for assurance that it was a priority for the CCG and has subsequently met with him to provide that assurance. **Action: The Governing Body received the report.**	
GB15/11	**Care Quality Commission Safeguarding Declaration** The Safeguarding Declaration has been scrutinised by the Quality Committee and was recommended for approval to the Governing Body **Action: The Governing Body approved the declaration.**	
GB15/12	**Strategic Plan: National Guidance & Implications** FLC outlined the approach the CCG intended to take in reviewing its two-year operational and five year strategic plan and to have a balanced financial plan to support the population. Key issues that the CCG needed to consider were highlighted as well as a timetable setting out key national dates. Due to the requirement to conform to the national timetable, the Governing Body was asked for the delegation of authority to the CCG Chair, Accountable Officer, Chief Finance Officer and Chief Strategy & Outcomes Officer to meet the necessary submission deadlines. All plans and the review of plans will be received by the Governing Body for agreement and endorsement, regardless. **Actions:** **(i) The Governing Body noted the detail contained in the national planning guidance and the implications for the review of existing two year operational and five year operational plans;** **(ii) The Governing Body agreed to support the development of a refreshed five year activity, financial and investment plan which addressed identified the QIPP shortfall, with a view to approval being sought via Governing Body, as per the planning timetable;** (iii) **The Governing Body approved delegated authority via the CCG Chair, Accountable Officer, Chief Financial Officer and Chief Strategy & Outcomes Officer to progress the necessary work to enable national return requirements to be met.**	KMcC RC/FLC/ MMcD/ KMcC

GB15/13	**Out of Hours (OOH) Pharmacy Engagement Report** Having considered the outcomes of the initial review to decommission the OOH Pharmacy at Litherland Town Hall, the CCGs took the decision in November 2014 to commission an Equality Analysis Report and a borough-wide consultation to further understand how patients might be affected if the service were to be decommissioned. This consultation was undertaken in December 2014 and January 2015. HN asked why the paper had come to the Southport & Formby Governing Body meeting to be discussed if it was fully funded by South Sefton. FLC explained the OOH Pharmacy had been set up as borough-wide service. FLC commented that the Equality Analysis Report was of a particularly high standard. **Actions:** **(i) The Governing Body approved the recommendation to decommission the OOH Pharmacy at Litherland Town Hall;** **(ii) The Governing Body approved the development of an action plan to address the recommendations of the equality analysis report and the results of the public consultation including:** - **working with the Go to Doc GP OOH provider to ensure that the supply of medicines when there is no local community pharmacy open, particularly for those patients with mobility, transport or carer difficulties in accessing the community pharmacy;** - **a targeted patient information campaign focusing on the changes to the OOH Pharmacy at Litherland Town Hall and how patients can access medicines in the OOH period in the future;** - **confirm that Governing Body will receive an update on progress with the action plan at future Governing Body public meetings.**	BP
GB15/14	**Re-Procurement of Patient Transport Services** Patient Transport Services (PTS) was first tendered in 2011 with a start date for a new service of 1st April 2012. North West Ambulance Services (NWAS) won the contract for the Cheshire and Merseyside area. The contract was awarded as a three-year contract and is due to be re-tendered this year to enable the re-commissioned service to start on 1st April 2016. **Action: The Governing Body approved the recommendation to participate in the North West procurement for patient services, to make amendments to the specification as appropriate; and to report the outcome of the procurement in 2015/16.**	
GB15/15	**Re-Procurement of NHS 111 North West Service** North West CCGs are in the latter stages of the re-procurement exercise for the NHS 111 North West Service and the bids received are being evaluated. The timetable is to ensure that that new contract is operational before winter 2015. This is very tight and as a result delegated authority was sought to sign off the recommendations of the procurement panel in order to ensure that contracts will be in place and the new provider is mobilised to enable the contract start date of October 2015. **Actions: The Governing Body approved the delegated authority to sign off the recommendations of the procurement panel to the Chair and the Chief Officer.**	RC/FLC

GB15/16	**Co Commissioning Submission** Following guidance from NHS England (NHSE) the CCG membership has expressed interest in entering into a joint commissioning arrangement with NHSE for primary medical services. In order to proceed with this the CCG has needed to amend its Constitution and once NHSE has approved these changes the Governing Body will be asked to approve them in March 2015. **Action: the Governing Body received the update.**	
GB15/17	**Emerging Issues** The importance of two-way interaction between the Governing Body and Localities was reiterated. KS brought the meeting's attention to the fact that there was no Governing Body member in the Central Locality. Billie Dodd to arrange for a Governing Body member to attend Central Locality meetings to ensure links are strengthened.	BD
GB15/18	**Key Issues reports from committees of Governing Body:** **a) Quality Committee** *Safeguarding Peer Review* - there have been challenges beyond the CCG's control in implementing changes in safeguarding peer review. A Safeguarding Steering Group has been set up to work through issues with partners. *Rapid Access Chest Pain Clinic* – the CCG is currently in discussion with Southport & Ormskirk Hospital NHS Trust and other providers to improve the service. It forms part of the programme work on cardiology as a whole. *Mortality* - being addressed through the contracting process and the Trust's Quality and Safety meetings. A new steering group specifically looking at this issue has been set up involving GP clinical leads. FLC asked what work was being done on acuity and age. DF confirmed this was being reviewed case by case. Post Discharge Community Services were also being reviewed to understand what was happening. Rob Gillies, Southport & Ormskirk Hospital NHS Trust Executive Medical Director, is proactively involved. *Friends and Family Test* – Southport & Ormskirk Hospital NHS Trust is still struggling to implement in terms of response rate and it will also need to be implemented across the community. A discussion around technology has been arranged which may help. FLC will ensure that key issues are uploaded onto the website. **b) Finance & Resource Committee** *Finance Strategy* – February's Governing Body Development session will focus on the Finance Strategy for 2015/16. *External Auditors* - new guidance regarding conflict of interest to be fully implemented. Effectiveness of committee checklist and training has been identified. *Audit Committee* - notes of primary care approvals group and all follow up actions should be received by audit committee twice per year. **c) Service Improvement Redesign Committee** *Vice Chair* – needs to be agreed. *End of Life Strategy* - ongoing work needed to make sure service is equitable. *Frail and Elderly* - financial modelling being undertaken. *Prime Minister's Challenge Fund* – the CCG is expecting feedback on its submission in February.	FLC

GB15/19	**Quality Committee Meeting Minutes** – were received by the Governing Body.	
GB15/20	**Finance & Resource Committee Meeting Minutes** – were received by the Governing Body.	
GB15/21	**Audit Committee Meeting Minutes** – were received by the Governing Body.	
GB15/22	**Service Improvement and Redesign Committee Minutes** – were received by the Governing Body.	
GB15/23	**Locality Meeting Minutes** - were received by the Governing Body.	
GB15/24	**Any Other Business** Governance – Roger Pontefract had been appointed as Vice Chair of the Service Integration and Redesign Committee which needed ratification from the Governing Body. **Action: The Governing Body ratified the appointment of Roger Pontefract as Vice Chair of the Service Integration and Redesign Committee.**	
GB15/25	**Date, Time and Venue of Next Meeting** *Thursday 26th March 2015 at 13.00 at Boardroom, Merton House, Bootle*	

NHS
Southport and Formby
Clinical Commissioning Group

Governing Body Meeting in Public
Actions from meeting held on Wednesday 28th January 2015

No	Item	Action
15/4 (14/125)	***Review of Case for Change*** – the paper is currently being revised and will be brought back to the Governing Body for review.	KMcC
15/8(a)	***Integrated Performance Report -*** MMcD to forward HN a copy of the Finance & Resource Committee paper '15/05 Financial Position Month 9'.	MMcD
15/8(b)	***Integrated Performance Report*** - The Governing Body approved the recommendation to transfer funding from the earmarked NPfIT support and Locality developments to bridge the financial gap facing the CCG.	MMcD
15/8(c)	***Stroke Service Review -*** DF to work with MC, NHS England (Cheshire & Mersey) on the stroke service review.	DF/MC
15/8(d)	***S&O Mortality Rates*** - DF to report back to Quality Committee regarding mortality performance from Mortality Review Group at Southport & Ormskirk Hospital NHS Trust.	DF
15/8(e)	***Mental Health Issues*** – DF to check and report back to the Governing Body on the dip in performance (85% against a target of 95%) around the Care Programme (CPA).	DF
15/9(a)	***Corporate Risk Register & Risk Assurance Framework*** – should be presented to the Audit Committee annually starting in October 2015.	TJ/ MMcD
15/9(b)	***Corporate Risk Register & Risk Assurance Framework*** - to be reviewed by SMT on a monthly basis.	TJ
15/12(a)	***Strategic Plan: National Guidance & Implications*** - The Governing Body agreed to support the development of a refreshed five year activity, financial and investment plan which addressed identified the QIPP shortfall, with a view to approval being sought via Governing Body, as per the planning timetable.	KMcC
15/12(b)	***Strategic Plan: National Guidance & Implications*** - The Governing Body approved delegated authority via the CCG Chair, Accountable Officer, Chief Financial Officer and Chief Strategy & Outcomes Officer to progress the necessary work to enable national return requirements to be met.	RC/ FLC/ MMcD/ KMcC
15/13(a)	***Out of Hours (OOH) Pharmacy*** - The Governing Body approved the recommendation to decommission the OOH Pharmacy at Litherland Town Hall and the development of an action plan to address the recommendations of the equality analysis report/results of the public consultation. Progress on the action plan will be presented at future Governing Body public meetings.	BP
15/15	***Re-Procurement of NHS 111 North West Service*** - The Governing Body approved the delegated authority to sign off the recommendations of the procurement panel to the Chair and the Chief Officer.	RC/ FLC
15/17	***Emerging Issues -*** KS brought the meeting's attention to the fact that there was no Governing Body member in the Central Locality. Billie Dodd to arrange for a Governing Body member to attend Central Locality meetings to ensure links are strengthened.	BD
15/18	***Key Issues Reports from Committees of the Governing Body*** – FLC will ensure that key issues are uploaded onto the website.	FLC

NHS
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MEETING OF THE GOVERNING BODY
March 2015

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

Title: Chief Officer Report

Summary/Key Issues:

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

Recommendation

The Governing Body is asked to receive 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 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 *(x those that apply)*
Patient and Public Engagement		x		
Clinical Engagement		x		
Equality Impact Assessment		x		
Legal Advice Sought		x		
Resource Implications Considered		x		
Locality Engagement		x		
Presented to other Committees		x		

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

Report to the Governing Body
March 2015

1. Shaping Sefton – Future Models of Care

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

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

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

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

2. Planning & Contracting 2015/16 Update

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

3. NHS 111 Procurement

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

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

4. Community Service Transformation Update

The CCG continues to work in conjunction with NHS West Lancashire CCG around the continued transformation of community services in the Southport and Ormskirk Health economy. This work supports the SFCCG Care Closer to Home objectives. Key areas for development include District Nursing, Treatment Room Services Redesign, Workforce and Leadership Development and Single Point of Access. All areas have clear actions plans with timescales for delivery.

5. Mental Health Task Group Update

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

6. NHS England – National Public Health Commissioning Intentions

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

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

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

7. NHS England Guidance on Quality Accounts

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

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

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

8. Approval of Annual Accounts

The date for submission of the draft annual report and annual accounts is noon on 23rd April. Governing Body members are reminded that approval of the annual report and accounts has been delegated to the CCG's Audit Committee which will meet on Wednesday 20th May (SF) / Thursday 21st May (SS) to discuss content. The audited report and accounts must be submitted to NHS England by noon on 29th May which is one week earlier than last year's deadline.

9. Dermatology Procurement 2015/16

Following the agreed extension of the community dermatology service contract to March 2016 work is now beginning on the detail required for the procurement of the service going forward. Initial plans are to work with Liverpool CCG in agreeing a North Mersey dermatology pathway. Difficulties in delivering the 2-week wait targets in dermatology are suggesting that this is the best approach. A lead GP from each CCG will need to be identified to support development of specification and to work through the procurement process which will include the evaluation of bids. The bulk of this work will be undertaken during the Quarter 3/4 of 2015/16.

10. North West Commissioning Support Unit Update

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

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

11. Innovation Fund - Community Sefton Adolescent Service

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

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

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

12. Joint CCG CHC Steering Group

This continues to meet on a weekly basis chaired by Helen Nichols - Lay Member from Southport & Formby CCG. Weekly reporting on the status and progress of the CHC reviews backlog that is to be completed by the end of March 2015 continues. Progress on completing the CHC Restitution Cases continues to be presented on a monthly basis - as this has been outsourced in order to manage the demand and the performance management of NWCSU for this area of work is undertaken through the CCG SLA meeting. A CHC Service Specification has been developed that is currently being finalised for an 'end to end service'. Locality leadership remains challenging and the CCG are monitoring closely with CSU colleagues the effectiveness of the interim temporary solution that has been put in place. A costed option appraisal will be submitted to the Senior Leadership Team for the end of March 2015 to enable informed decision making for future service options.

13. Quality Surveillance Group

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

14. Developing Student placements within a Clinical Commissioning Group project

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

15. Sign Up to Safety Campaign

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

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

The five Sign up to Safety Pledges:

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

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

16. Peter Morgan - Retirement

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

17. Merseyside CCG Network

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

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

18. Informatics Merseyside Partnership Board

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

The key issues worthy of note include:

- Governance - the partnership agreement was noted, the Strategic Accountability Framework approved and the underlying operational group work programme agreed;

- Financial/ Business Development - an update was received on the partner SLA 2015/16 and a proposal for business development and benchmarking framework approved;

- Performance - the performance was noted as being on track;

- Communication & Engagement - the board received a summary document for approval.

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

Fiona Clark
March 2015

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/49	**Author of the Paper:** Name: Fiona Clark Job Title: Chief Officer Email: fiona.clark@southportandformbyccg.nhs.uk Tel: 0151 247 7069
Report date: March 2015	

Title: NHS Southport & Formby CCG Constitution

Summary/Key Issues:

The Constitution has now been updated to incorporate the necessary provisions to enable the establishment of Joint Committees with other CCGs or Joint Committees with NHS England.

Recommendation

The Governing Body is asked to ***approve*** the Constitution.

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 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 *(x those that apply)*
Patient and Public Engagement				
Clinical Engagement	Yes			
Equality Impact Assessment				
Legal Advice Sought	Yes			

Process	Yes	No	N/A	Comments/Detail *(x those that apply)*
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
Southport and Formby
Clinical Commissioning Group

CONSTITUTION

Version: 24

Approved by Membership by Wider Constituent Membership: January 2015

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CONTENTS

FOREWORD

NHS Southport and Formby Clinical Commissioning Group (CCG) consists of local primary care practices and is responsible for commissioning a significant amount of health care for the residents of Southport and Formby.

Our aim is to create an environment where everyone who needs health care can be assured that they will have the best possible local services and the information to make the choices that are right for them.

For us, treating illness and disability is only part of what we will achieve. Of equal importance is creating communities where health and wellbeing is the norm and that residents live their lives to their full potential.

We will achieve this by effective working with those that use the services and those that provide them such as local authorities, primary care providers, Acute and Community care services, Mental Health services and our great range of volunteer services available.

General Practice is at the heart of our community and is central to the changes that need to occur to deliver our aims. It is therefore vital that clinical commissioning is developed and delivered through its constituent membership.

This document lays out how we will achieve this and our responsibilities to our stakeholders.

Dr Rob Caudwell
Chair
NHS Southport and Formby CCG

1. INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is NHS Southport and Formby Clinical Commissioning Group. (NHS SFCCG)

1.2. Statutory Framework

1.2.1. Clinical commissioning groups are established under the Health and Social Care Act 2012 ("the 2012 Act").[1] They are statutory bodies which have the function of commissioning services for the purposes of the health service in England and are treated as NHS bodies for the purposes of the National Health Service Act 2006 ("the 2006 Act").[2] The duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act, and the regulations made under that provision.[3]

1.2.2. NHS Commissioning Board (all future references in this document refer to NHS England, the Operational name for the NHS Commissioning Board) is responsible for determining applications from prospective groups to be established as clinical commissioning groups and undertakes an annual assessment of each established group. It has powers to intervene in a clinical commissioning group where it is satisfied that a group is failing or has failed to discharge any of its functions or that there is a significant risk that it will fail to do so.

1.2.3. Clinical commissioning groups are clinically led membership organisations made up of general practices. The members of the clinical commissioning group are responsible for determining the governing arrangements for their organisations, which they are required to set out in a constitution.[4]

1.3. Status of this Constitution

1.3.1. This constitution is made between the members of NHS Southport and Formby Clinical Commissioning Group and has effect from 1st April 2013, when NHS England established the group.[5] The constitution is:

a) published on the group's website at www.southportformbyccg.org.uk

b) or available in hard copy by writing to Melanie Wright at NHS SFCCG, 5 Curzon Rd, Southport, PR8 6PL

1.4. Amendment and Variation of this Constitution

1 See section 1I of the 2006 Act, inserted by section 10 of the 2012 Act
2 See section 275 of the 2006 Act, as amended by paragraph 140(2)(c) of Schedule 4 of the 2012 Act
3 Duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act
4 See in particular sections 14L, 14M, 14N and 14O of the 2006 Act, inserted by section 25 of the 2012 Act and Part 1 of Schedule 1A to the 2006 Act, inserted by Schedule 2 to the 2012 Act and any regulations issued
5 See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act

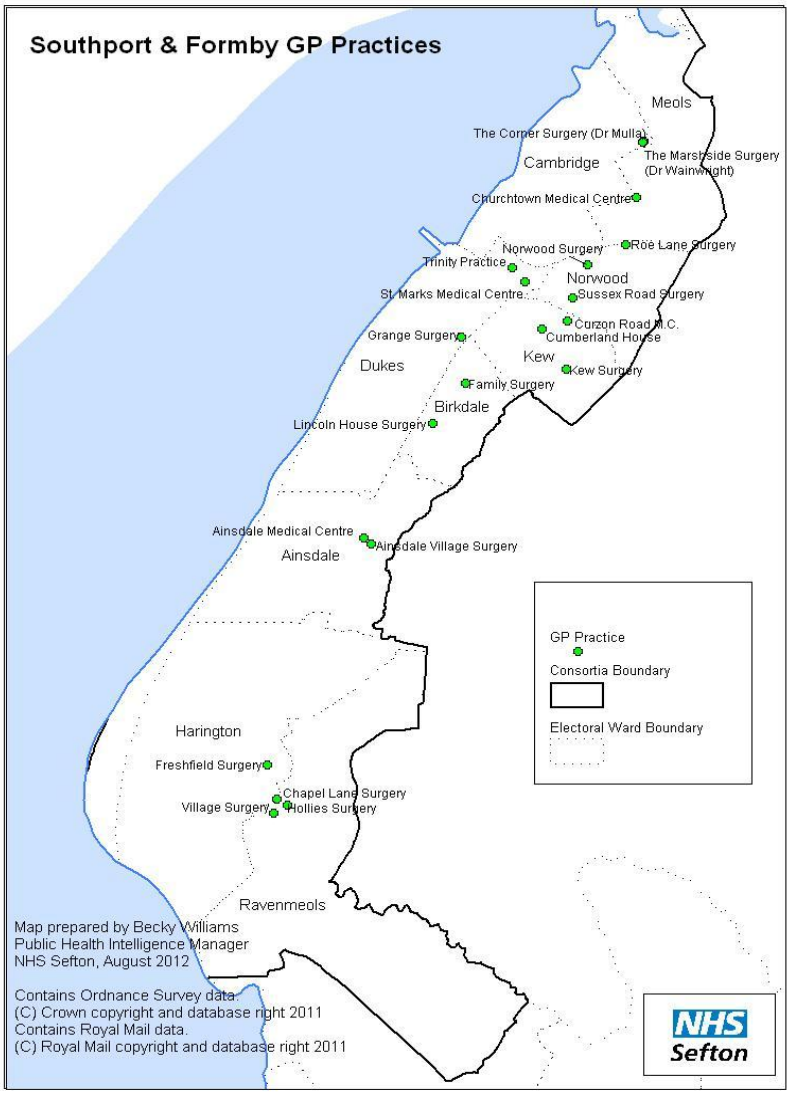
1.4.1. This constitution can only be varied in two circumstances.[6]

a) where the group applies to NHS England and that application is granted;

b) where in the circumstances set out in legislation NHS England varies the group's constitution other than on application by the group.

2. AREA COVERED

2.1. The geographical area covered by NHS Southport and Formby Clinical Commissioning Group is from Formby and Ince Blundell in the south to Crossens, Southport in the north of the borough of Sefton.



3. MEMBERSHIP

3.1. **Membership of the Clinical Commissioning Group**

[6] See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued

3.1.1. The following practices comprise the members of NHS Southport and Formby Clinical Commissioning Group.

Practice Name and Address	Practice Locality Group
Churchtown Medical Centre Cambridge Road, PR9 7LT	North
Marshside Surgery 117 Flyde Road, Southport, PR9 9XL	North
Corner Surgery 117 Fylde Road, Southport, PR9 9XL	North
Norwood 11 Norwood Avenue, Southport, PR9 7EG	North
Roe Lane 172 Roe Lane, Southport, PR9 7PN	North
Sussex Rd Surgery 125 Sussex Rd PR8 6AF	North
Curzon Rd Surgery 5 Curzon Rd, PR8 6PN	Central
Trinity Practice Houghton St Southport	Central
Cumberland House 58 Scarisbrick New Road, Southport, PR8 6PG	Central
Kew Surgery 85 Town Lane PR8 6RG	Central
St Marks 42 Derby Road, Southport, PR9 0TZ	Central
The Grange 41 York Road, Southport, PR8 2AD	Ainsdale and Birkdale
Family Surgery 107 Liverpool Road, Southport, PR8 4DB	Ainsdale and Birkdale
Lincoln 33 Lincoln Road, Southport, PR8 4PR	Ainsdale and Birkdale
Ainsdale Medical Centre 66 Station Road, Ainsdale, Southport, PR8 3HW	Ainsdale and Birkdale
Ainsdale Village 2 Leamington Road, Ainsdale, Southport, PR8 3LB	Ainsdale and Birkdale
Chapel Lane 13 Chapel Lane, Formby, L37 4DL	Formby
The Hollies Elbow Lane, Formby, L37 4AD	Formby
The Village Surgery Elbow Lane, Formby, L37 4AD	Formby
Freshfield 61 Gores Lane, Formby, L37 3NU	Formby

3.1.2. Appendix B of this constitution contains the list of practices, together with the signatures of the practice representatives confirming their agreement to this constitution.

3.2. **Eligibility**

Providers of primary medical services to a registered list of patients under a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract, will be eligible to apply for membership of this group[7].

4. VISION, VALUES AND AIMS

4.1. Vision

Southport and Formby: a sustainable healthy community.

4.2. Values

4.2.1. Good corporate governance arrangements are critical to achieving the group's objectives.

4.2.2. The values that lie at the heart of the group's work are:

Responsive We will enable action, be accountable and transparent

Approachable We will listen and remain open minded

Respectful We will have integrity; we are fair, inclusive, and reflective and will respect each other

Efficient We will work informally, yet robustly, be innovative and flexible to make things happen.

4.3. Aims

4.3.1. The group's aims are to:

a) To collaborate with other organisations to ensure that the care people receive is delivered in a timely and effective manner
b) To improve health and reduce inequalities of practice populations
c) To consult with patients about the care we commission on their behalf
d) To ensure that our population receive the best possible outcomes
e) To ensure that services that we commission deliver good value for money.

4.4. Principles of Good Governance

4.4.1. In accordance with section 14L (2) (b) of the 2006 Act,[8] the group will at all times observe "such generally accepted principles of good governance" in the way it conducts its business. These include:

a) the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;

b) *The Good Governance Standard for Public Services*;[9]

[7] See section 14A(4) of the 2006 Act, inserted by section 25 of the 2012. Regulations to be made
[8] Inserted by section 25 of the 2012 Act

c) the standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles'[10]

d) the seven key principles of the *NHS Constitution*;[11]

e) the Equality Act 2010.[12]

4.5. **Accountability**

4.5.1. The group will demonstrate its accountability to its members, local people, stakeholders and NHS England in a number of ways, including by:

a) publishing its constitution;
b) appointing independent lay members and non GP clinicians to its Governing Body;
c) holding meetings of its Governing Body in public (except where the group considers that it would not be in the public interest in relation to all or part of a meeting);
d) publishing annually a commissioning plan;

e) complying with Local Authority health overview and scrutiny requirements;
f) meeting annually in public to publish and present its annual report (which must be published);
g) producing annual accounts in respect of each financial year which must be externally audited;
h) having a published and clear complaints process;
i) complying with the Freedom of Information Act 2000;
j) providing information to NHS England as required.

4.5.2. In addition to these statutory requirements, the group will demonstrate its accountability by:

a) publishing its principal commissioning and operational policies, e.g. a policy about funding exceptional cases
b) holding engagement events
c) engaging with the local medical committee in respect of its functions as these affect their constituent members
d) engaging with other relevant clinical and non-clinical bodies such as Local Optical Committee, Local Dental Committee, relevant nursing bodies.

4.5.3. The Governing Body of the group will throughout each year have an ongoing role in reviewing the group's governance arrangements to ensure that the group continues to reflect the principles of good governance.

5. FUNCTIONS AND GENERAL DUTIES

5.1. **Functions**

[9] *The Good Governance Standard for Public Services*, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004
[10] See Appendix F
[11] See Appendix G
[12] See http://www.legislation.gov.uk/ukpga/2010/15/contents

5.1.1. The functions that the group is responsible for exercising are largely set out in the 2006 Act, as amended by the 2012 Act. An outline of these appears in the Department of Health's *Functions of clinical commissioning groups: a working document*. They relate to:

a) commissioning certain health services (where NHS England is not under a duty to do so) that meet the reasonable needs of:

i) all people registered with member GP practices, and
ii) people who are usually resident within the area and are not registered with a member of any clinical commissioning group;

b) commissioning emergency care for anyone present in the group's area;
c) paying its employees' remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the group's employees;
d) determining the remuneration and travelling or other allowances of members of its Governing Body.

5.1.2. In discharging its functions the group will:

a) act[13], when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and NHS England of their duty to ***promote a comprehensive health service***[14] *and* with the objectives and requirements placed on NHS England through *the mandate*[15] published by the Secretary of State before the start of each financial year by:

i) Delegating responsibility to the Governing Body
ii) Preparing and publishing your commissioning plans
iii) Consulting on those plans (with public, Overview and Scrutiny Committee, Health and Wellbeing Boards and other relevant stakeholders)
iv) Using effective procurements to secure quality health services.

b) **meet the public sector equality duty**[16] by:

i) delegating responsibility for compliance to the Chief Nurse through the Quality Committee, reporting to the Governing Body
ii) having arrangements in place for PSED reporting to the Governing Body
iii) the development and application of a Equality and Diversity policy
iv) ensuring staff compliance with mandatory E&D training
v) publish, at least annually, sufficient information to demonstrate compliance with this general duty across all CCG function
vi) prepare and publish specific and measurable equality objectives, revising these at least every four years.

c) work in partnership with its local authority to develop ***joint strategic needs assessments***[17] and ***joint health and wellbeing strategies***[18] by:

13 See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act
14 See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act
15 See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act
16 See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act

i) delegating responsibility for delivery of this objective to the Chief Corporate Delivery and Integration Officer who shall report to the Governing Body
ii) ensuring the Joint Strategic Needs Assessment (JSNA) and Health and Well-Being Strategy(HWBS) process is integral to the work of the localities and can be articulated by local practices
iii) that Patient Participation Groups, HealthWatch and Patient and Public Involvement networks have been involved in the JSNA and HWBS process
iv) accessing expertise on health and wellbeing demand modelling and forecasting
v) ensuring partner provider services are actively involved in the JSNA and HWBS
vi) producing an easy and relevant one page summary for all stakeholders that sets out the relevant strategies

5.2. **General Duties** - **in discharging its functions the group will:**

5.2.1. Make arrangements to ***secure public involvement*** in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements[19] by:

a) building on the developed and robust systems and processes and networks for patient and public involvement which were developed jointly by the Sefton Equalities Partnership, comprising the NHS, Local Authority and third sector. This framework is reflected in its Engagement and Communications Strategy
b) using a process of Managed engagement , Setting the context with realistic timeframes while enabling debate on clear areas of influence using ambassadors and understanding stakeholders while ensuring that everyone has a voice
c) consulting with the Overview and Scrutiny Committee
d) reporting to the Governing Body by the Lay advisor lead for Patient and Public Involvement.

5.2.2. **NHS Southport and Formby CCG Statement of Principles;**

We will:

a) work in partnership with patients and the local community to secure the best care for them
b) adapt engagement activities to meet the specific needs of the different patient groups and communities
c) publish information about health services on the group's website and through other media
d) encourage and act on feedback from all stakeholders
e) delegate responsibility for ensuring compliance with these principles to the Engagement and Patient Experience Group (EPEG).

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17 See section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by section 192 of the 2012 Act

18 See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act

19 See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act

5.2.3. ***Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution***[20] **by:**

a) Delegating responsibility for delivery of this objective to the Chief Corporate Delivery and Integration Officer
b) Delegating responsibility for monitoring compliance with the NHS Constitution to the EPEG
c) Ensuring the princples are considered as part of any commissioning policy development
d) ensuring CCG support team are aware of significance through team meetings and in practice locality group work.

5.2.4. ***Act effectively, efficiently and economically***[21] **by:**

a) delegating responsibility for compliance to the Governing Body
b) ensuring effective management of budgets in line with the scheme of reservation and delegation, Prime Financial Policies and Standing Orders
c) ensuring value for money in commissioned services through contract management and procurement.

5.2.5. ***Act with a view to securing continuous improvement to the quality of services***[22] by:

a) reporting to the Governing Body via Quality Committee on the performance of providers
b) establishment of a Service Improvement and Re-Design Committee
c) using real-time information to challenge the system
d) performance management of the quality of commissioned services.

5.2.6. ***Assist and support NHS England in relation to the NHS England's duty to improve the quality of primary medical services***[23] by:

a) delegated responsibility for compliance to the Quality Committee
b) working in partnership with the NHS England
c) peer review and benchmarking
d) promoting and undertaking development of Practice Locality Groups
e) sharing best practice
f) development of QOF QP indicators by the localities

By:

i) using data and triangulation of information
ii) practice/practitioner dashboards
iii) measuring real time improvements.

5.2.7. ***Have regard to the need to reduce inequalities***[24] by:

20 See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)
21 See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act
22 See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act
23 See section 14S of the 2006 Act, inserted by section 26 of the 2012 Act
24 See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act

a) delegating responsibility for this objective to the Governing Body via the Memorandum of Understanding with the Local Authority
b) being involved in the work with Sefton's Health and Wellbeing Board which will be essential in tackling existing health inequalities
c) working in partnership with local government to develop Joint Strategic Needs Assessment and robust joint health and wellbeing strategies
d) ensure there are mechanisms to monitor inequalities in health and to evaluate the effectiveness of measures taken to reduce them
e) evaluating all policies that may have direct or indirect effect on health inequalities.

5.2.8. ***Promote the involvement of patients, their carers and representatives in decisions about their healthcare***[25] by:

a) supporting the funding and development of a Sefton Public Engagement and Patient Experience group. The group will be a sub group to the Quality Committee and will have representation from community, third sector, local authority, HealthWatch and the Governing Body. The group will report to the Quality committee and provide assurances that there are adequate and effective models are in place to ensure inclusion of Southport and Formby's patients and public in their locality commissioning plans
b) holding an annual commissioning patient and public conference will be held to set out the CCG Vision, Values, and priorities annually
c) establishing quarterly patient and public meetings to bring together and further develop GP patient participation groups, HealthWatch community champions and community group representatives as part of a quarterly cycle of "meet the commissioner events" . The annual conferences will then focus on "you said, we did" model of feedback.
d) targeting patient and carer engagement to inform care pathway programmes of work and will inform specific commissioning plans (e.g. long term conditions).

5.2.9. ***Act with a view to enabling patients to make choices***[26] by:

a) commissioning multiple providers to facilitate patient choice
b) developing Policy which promotes patient choice
c) promoting links to NHS Choices by including contact details on the CCG website
d) promotion of Choose and Book systems
e) delegating responsibility for this objective to the Chief Nurse through the Quality Committee.

5.2.10. ***Obtain appropriate advice***[27] from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) delegated responsibility to Chief Officer to ensure that multi-professional input is available at relevant meetings
b) joint working with Local authority including the Director of Public Health
c) joint working across the health economy with groups such as:
   - the Wider Constituent Group
   - the local Acute Trust Clinical Senate and GP Operational Group
   - Practice Nurse forum
d) identifying Clinical leads in Wider Constituent Group

[25] See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act
[26] See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act
[27] See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act

e) involvement in clinical senates across the wider health economy
f) appointing a Chief Nurse to the Governing Body
g) appointing a secondary care doctor to the Governing Body
h) ensuring a range of skilled Governing Body members
i) involvement in Regional and National clinical network meetings
j) involvement in contractual performance and quality groups with providers.

5.2.11. ***Promote innovation***[28] by:

a) delegating responsibility for the promotion of innovation to the Chief Officer and members of Governing Body including the Chief Nurse and relevant Clinical Leads
b) commitment to service redesign across providers
c) establishment of a Service Improvement and Redesign Committee that has responsibility for promoting innovation
d) empowering practitioners to develop themselves
e) supporting service developments identified and prioritised in primary care
f) providing opportunities for practitioners to be innovative through locality groups
g) entering into joint ventures using up to date technology as appropriate.

5.2.12. ***Promote research and the use of research***[29] by:

a) delegating responsibility for the promotion and use of research to the Chief Nurse and members of the Quality Committee
b) working with support from Cheshire and Merseyside Commissioning Support Unit (the CSU) Library Services function via the SLA
c) promoting the dissemination and use of research findings through the locality groups
d) promoting and support the development and delivery of research within the CCG
e) using research to support the redesign of services across the system
f) reporting from localities to Quality Committee.

5.2.13. Have regard to the need to ***promote education and training***[30] for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty[31] by:

a) delegating responsibility for promoting education and training to the Chief Corporate Delivery and Integration Officer
b) reporting on compliance to the Finance and Resources Committee
c) demonstrating commitment to education and training for all CCG employees
d) procuring Organisational Development and Human Resources expertise and support from the CSU via the SLA
e) demonstrating commitment to regional processes with links to education planning
f) supporting the provision of education and training for all primary care health professionals through maintenance of existing Protected Learning Times.

28 See section 14X of the 2006 Act, inserted by section 26 of the 2012 Act
29 See section 14Y of the 2006 Act, inserted by section 26 of the 2012 Act
30 See section 14Z of the 2006 Act, inserted by section 26 of the 2012 Act
31 See section 1F(1) of the 2006 Act, inserted by section 7 of the 2012 Act

5.2.14. Act with a view to ***promoting integration*** of *both* health services with other health services *and* health services with health-related and social care services where the group considers that this would improve the quality of services or reduce inequalities[32] by:

i) delegating responsibility for the promotion of integration to the Chief Officer and members of the Governing Body
ii) establishment of an Integrated Management Group that comprises members of the CCG and Local Authority
iii) working with the Strategic Integrated Commissioning Group (Local Authority)
iv) developing policies to reflect integration.

5.3. **General Financial Duties** – the group will perform its functions so as to:

5.3.1. ***Ensure its expenditure does not exceed the aggregate of its allotments for the financial year***[33] by

a) The CCG Financial duties will be performance managed via the Finance and Resources Committee, reporting to the Governing Body. The Chief Finance Officer as accountable lead will ensure that all financial duties and requirements are identified for the Governing Body to enact its full statutory duty.

5.3.2. ***Ensure its use of resources*** *(both its capital resource use and revenue resource use)* ***does not exceed the amount specified by NHS England for the financial year***[34] by

a) The CCG Financial duties will be performance managed via the Finance and Resources Committee reporting to the Governing Body. The Chief Finance Officer as Accountable led will ensure that all financial duties and requirements are identified for the Governing Body to enact its full statutory duty.

5.3.3. ***Take account of any directions issued by NHS England, in respect of specified types of resource use in a financial year, to ensure the group does not exceed an amount specified by NHS England*** [35] by

a) The CCG Financial duties will be performance managed via the Finance and Resources Committee, reporting to the Governing Body. The Chief Finance Officer as Accountable led will ensure that all financial duties and requirements are identified for the Governing Body to enact its full statutory duty.

5.3.4. **Publish an explanation of how the group spent any payment in respect of quality** made to it by NHS England[36] by

a) delegating responsibility for publishing reports to the Chief Officer and Governing Body
b) managing and reporting on performance of all providers in relation to quality
c) providing, as part of corporate reporting process, information with regard to quality performance and payments for achievement of targets, including CQUIN
d) publication of appropriate Annual reports.

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32 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
33 See section 223H(1) of the 2006 Act, inserted by section 27 of the 2012 Act
34 See sections 223I(2) and 223I(3) of the 2006 Act, inserted by section 27 of the 2012 Act
35 See section 223J of the 2006 Act, inserted by section 27 of the 2012 Act
36 See section 223K(7) of the 2006 Act, inserted by section 27 of the 2012 Act

5.4. **Other Relevant Regulations, Directions and Documents**

5.4.1 The group will

a) comply with all relevant regulations;
b) comply with directions issued by the Secretary of State for Health or NHS England; and
c) take account, as appropriate, of documents issued by NHS England.

5.4.2 The group will develop and implement the necessary systems and processes to comply with these regulations and directions, documenting them as necessary in this constitution, its scheme of reservation and delegation and other relevant group policies and procedures.

6. DECISION MAKING: THE GOVERNING STRUCTURE

6.1. **Authority to act**

6.1.1 The clinical commissioning group is accountable for exercising the statutory functions of the group. It may grant authority to act on its behalf to:

a) any of its members;
b) its Governing Body;
c) employees;
d) a committee or sub-committee of the group.

6.1.2 The extent of the authority to act of the respective bodies and individuals depends on the powers delegated to them by the group as expressed through:

e) the group's scheme of reservation and delegation; and
f) for committees, their terms of reference.

6.2. **Scheme of Reservation and Delegation**[37]

6.2.1. The group's scheme of reservation and delegation sets out:

a) those decisions that are reserved for the membership as a whole;
b) Those decisions that are the responsibilities of its Governing Body (and its committees), the group's committees and sub-committees, individual members and employees.

6.2.2. The clinical commissioning group remains accountable for all of its functions, including those that it has delegated.

6.3. **General**

6.3.1. In discharging functions of the group that have been delegated to its Governing Body (and its committees), committees, Joint Committees, Sub-committees and individuals must:

[37] See Appendix D

a) comply with the group's principles of good governance,[38]
b) operate in accordance with the group's scheme of reservation and delegation,[39]
c) comply with the group's standing orders,[40]
d) comply with the group's arrangements for discharging its statutory duties,[41]
e) Where appropriate, ensure that member practices have had the opportunity to contribute to the group's decision making process.

6.3.2. When discharging their delegated functions, committees, sub-committees and joint committees must also operate in accordance with their approved terms of reference.

6.3.3. Where delegated responsibilities are being discharged collaboratively, the joint (collaborative) arrangements must:

a) identify the roles and responsibilities of those clinical commissioning groups who are working together;
b) identify any pooled budgets and how these will be managed and reported in annual accounts;
c) specify under which clinical commissioning group's scheme of reservation and delegation and supporting policies the collaborative working arrangements will operate;
d) specify how the risks associated with the collaborative working arrangement will be managed between the respective parties;
e) identify how disputes will be resolved and the steps required to terminate the working arrangements;
f) Specify how decisions are communicated to the collaborative partners.

6.4. **Committees of the group**

6.4.1. The following committees have been established by the group:

a) Quality Committee
b) Finance and Resource Committee
c) Audit Committee
d) Remuneration Committee
e) Service Improvement and Redesign Committee
f) Approvals Committee
g) Southport and Formby CCG and NHS England Joint Commissioning Committee

6.4.2. Committees will only be able to establish their own sub-committees, to assist them in discharging their respective responsibilities, if this responsibility has been delegated to them by the group or the committee they are accountable to.

[38] See section 4.4 on Principles of Good Governance above
[39] See appendix D
[40] See appendix C
[41] See chapter 5 above

6.5. **Joint Arrangements**

6.5.1. The group has entered into joint arrangements with the following clinical commissioning groups:

a) NHS Southport and Formby CCG has entered into a joint arrangement with respect to a shared management team, with NHS South Sefton CCG
b) under the terms of a memorandum of understanding
c) NHS Southport and Formby CCG has entered into a joint arrangement with The Merseyside CCG Network which acts as an advisory committee to each of the named CCGs below.

i) Halton CCG
ii) Knowsley CCG
iii) Liverpool CCG
iv) Southport & Formby CCG
v) South Sefton CCG
vi) St Helens CCG
vii) Warrington CCG
viii) West Lancashire CCG.

6.5.2. Memoranda of Agreement are available on the website: www.southportformbyccg.org.uk.

6.5.3. The group has joint committees with the following local authorities:

Strategic Integrated Commissioning group, Sefton Metropolitan Borough Council, whose purpose is to oversee the strategy for integrated commissioning of adult and children's care and public health programmes.

6.6. **Joint commissioning arrangements with other Clinical Commissioning Groups**

6.6.1. The clinical commissioning group (CCG) may wish to work together with other CCGs in the exercise of its commissioning functions.

6.6.2. The CCG may make arrangements with one or more CCG in respect of:

a) delegating any of the CCG's commissioning functions to another CCG;
b) exercising any of the commissioning functions of another CCG; or
c) exercising jointly the commissioning functions of the CCG and another CCG

6.6.3. For the purposes of the arrangements described at paragraph [6.6.2], the CCG may:

a) make payments to another CCG;
b) receive payments from another CCG;
c) make the services of its employees or any other resources available to another CCG; or
d) receive the services of the employees or the resources available to another CCG.

6.6.4. Where the CCG makes arrangements which involve all the CCGs exercising any of their commissioning functions jointly, a joint committee may be established to exercise those functions.

6.6.5. For the purposes of the arrangements described at paragraph [6.6.2] above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.6.6. Where the CCG makes arrangements with another CCG as described at paragraph [6.6.2], the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:

a) How the parties will work together to carry out their commissioning functions;
b) The duties and responsibilities of the parties;
c) How risk will be managed and apportioned between the parties;
d) Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

6.6.7. The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph [6.6.2] above.

6.6.8. The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.6.9. Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

6.6.10. The governing body of the CCG shall require, in all joint commissioning arrangements, that the lead clinician and lead manager of the lead CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives

6.6.11. should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year

6.7. **Joint commissioning arrangements with NHS England for the exercise of CCG functions**

6.7.1. The CCG may wish to work together with NHS England in the exercise of its commissioning functions.

6.7.2. The CCG and NHS England may make arrangements to exercise any of the CCG's commissioning functions jointly.

6.7.3. The arrangements referred to in paragraph [6.7.2] above may include other CCGs.

6.7.4. Where joint commissioning arrangements pursuant to [6.7.2] above are entered into, the parties may establish a joint committee to exercise the commissioning functions in question.

6.7.5. Arrangements made pursuant to [6.7.2] above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

6.7.6. Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph [6.7.2] above, the CCG shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

a) How the parties will work together to carry out their commissioning functions;
b) The duties and responsibilities of the parties;
c) How risk will be managed and apportioned between the parties;
d) Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements; and

6.7.7. The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph [6.7.2] above.

6.7.8. The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.7.9. Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

6.7.10. The governing body of the CCG shall require, in all joint commissioning arrangements that the Accountable Officer of the CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.7.11. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months' notice period.

6.8. **Joint commissioning arrangements with NHS England for the exercise of NHS England's functions**

6.8.1. The CCG may wish to work with NHS England and, where applicable, other CCGs, to exercise specified NHS England functions.

6.8.2. The CCG may wish to work with NHS England and, where applicable, other CCGs, to exercise specified NHS England functions.

6.8.3. The CCG may enter into arrangements with NHS England and, where applicable, other CCGs to:

a) Exercise such functions as specified by NHS England under delegated arrangements;
b) Jointly exercise such functions as specified with NHS England.

6.8.4. Where arrangements are made for the CCG and, where applicable, other CCGs to exercise functions jointly with NHS England a joint committee may be established to exercise the functions in question.

6.8.5. Arrangements made between NHS England and the CCG may be on such terms and conditions (including terms as to payment) as may be agreed between the parties.

6.8.6. For the purposes of the arrangements described at paragraph [6.8.2] above, NHS England and the CCG may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.8.7. Where the CCG enters into arrangements with NHS England as described at paragraph [6.8.2] above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

a) How the parties will work together to carry out their commissioning functions;
b) The duties and responsibilities of the parties;
c) How risk will be managed and apportioned between the parties
d) Financial arrangements, including payments towards a pooled fund and management of that fund
e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

6.8.8. The liability of NHS England to carry out its functions will not be affected where it and the CCG enter into arrangements pursuant to paragraph [6.8.2] above.

6.8.9. The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.8.10. Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

6.8.11. The governing body of the CCG shall require, in all joint commissioning arrangements that the Accountable Officer of the CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.8.12. Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months' notice period.

6.9. The Governing Body

6.9.1. ***Functions*** - the Governing Body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations and in this constitution.[42] The Governing Body has responsibility for:

a) ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance[43] (its main function);
b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;
c) approving any functions of the group that are specified in regulations;[44]
d) i) leading the setting of vision and strategy
ii) approving commissioning plans
iii) monitoring performance against plans
iv) providing assurance of strategic risk
e) the promotion a comprehensive health service
f) meeting public sector equality duty
g) Promoting awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution
h) Acting effectively, efficiently and economically
i) securing continuous improvement to the quality of services
j) the improvement of the quality of primary medical services
k) promoting the involvement of patients, their carers and representatives in decisions about their healthcare
l) enabling patients to make choices
m) enabling patients to make choices
n) Promote innovation
o) Promote research and the use of research
p) promote education and training
q) promoting integration
r) Have regard to the need to reduce inequalities.

[42] See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act
[43] See section 4.4 on Principles of Good Governance above
[44] See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act

6.9.2. **Composition of the Governing Body** - the Governing Body shall not have less than 15 members and comprise of:

a) the chair; (GP)
b) 5 GP representatives of member practices;
c) 2 Practice Managers
d) two lay members:
    i) one to lead on audit, governance, remuneration and conflict of interest matters,
    ii) one to lead on patient and public participation matters;
e) registered nurse;
f) secondary care specialist doctor;
g) the Chief Officer;
h) the Chief Finance Officer;
i) 1 additional nurse.

6.9.3. **Committees of the Governing Body** - the Governing Body has appointed the following committees and sub-committees:

a) **Audit Committee** – the audit committee, which is accountable to the group's Governing Body, provides the Governing Body with an independent and objective view of the group's financial systems, financial information and compliance with laws, regulations and directions governing the group in so far as they relate to finance. The Governing Body has approved and keeps under review the terms of reference for the audit committee, which includes information on the membership of the audit committee[45].

In addition the group or the Governing Body has conferred or delegated the following functions, connected with the Governing Body's main function[46,] to its audit committee:

The committee shall critically review the clinical commissioning group's financial reporting and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained.

The key duties of an audit committee will be:

i) Integrated governance, risk management and internal control
ii) External audit
iii) Other assurance functions
iv) Counter fraud
v) Financial reporting.

b) **Remuneration Committee** – the remuneration committee, which is accountable to the group's Governing Body makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme. The Governing Body has approved and keeps under review the terms of reference for the

[45] See appendix H for the terms of reference of the Audit Committee
[46] See section 14L(2) of the 2006 Act, inserted by section 25 of the 2012 Act

remuneration committee, which includes information on the membership of the remuneration committee[47].

In addition the group or the Governing Body has conferred or delegated the following functions, connected with the Governing Body's main function, to its Remuneration Committee:

i) The committee shall make recommendations to the Governing Body on determinations about pay and remuneration for employees of the clinical commissioning group and people who provide services to the clinical commissioning group and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme].

c) **The Quality Committee** –which is accountable to the group's Governing Body, will monitor the quality of commissioned services, consider information from governance, risk management and internal control systems and; provide corporate focus, strategic direction and momentum for governance and risk management. The Governing Body has approved and keeps under review the terms of reference for the Quality committee which includes information on the membership of the Quality committee. [48]

d) **Finance and Resources Committee** which is accountable to the group's Governing Body, will oversee and monitor financial and workforce development strategies; monitor the annual revenue budget and planned savings; Develop and deliver capital investment; financial and workforce risk registers; financial, workforce and contracting performance.[49]

e) **Approvals Committee** which is accountable to the group's Governing Body and is responsible for ensuring that the CCG applies conflict of interest principles and policies rigorously and provides the CCG with independent advice and judgment where there is any doubt about how to apply them to individual or group cases involving commissioning clinical services. The role of the Committee will be to provide neutrality in the evaluation and decision making processes. It will be made up of non-conflicted members of the Governing Body and its decisions will be noted by the Governing Body[50].

f) **Service Improvement and Redesign Committee** which is accountable to the Governing Body is established to enable thorough and open discussion about all service improvement priorities, quality issues and innovation. It will provide a forum for Southport and Formby localities, their practices clinical leads, Clinical Director, CCG locality leads and practice representatives to identify potential areas of improvement and support plans and proposals for implementation[51].

g) **Southport and Formby CCG and NHS England Joint Commissioning Committee** which is accountable to the Governing Body is established to deliver the main objective of aligning the commissioning of primary care with delivery of the CCG's Primary Care Quality Strategy to enable transformation in primary care.[52]

[47] See appendix HI for the terms of reference of the remuneration committee
[48] See appendix H for the terms of reference of the Quality Committee
[49] See appendix H for the terms of reference of the Finance and Resource Committee
[50] See Appendix H for the terms of Reference of the Approvals Committee
[51] See appendix H for the terms of reference of the Service Improvement and Redesign Committee
[52] See appendix H for the terms of reference of Southport and Formby CCG and NHS England Joint Commissioning Committee

h) **Practice Locality Groups** – There are four locality groups; North, Central, Ainsdale and Birkdale, and Formby, determined by the Governing Body. Their role is as is determined by the Governing Body. [53]

ROLES AND RESPONSIBILITIES

7.1. Practice Representatives

7.1.1. Practice representatives represent their practice's views and act on behalf of the practice in matters relating to the group. The role of each practice representative is to:

a) act as the designated lead GP for the CCG within each practice and should make him/herself available to meet Governing Body members or their representatives on a regular basis
b) attend meetings of the Wider Constituent Group
c) contribute to the CCG's goals by using their holistic understanding of patients' needs to help shape the design of services
d) understand how they can provide services in ways that enhance quality and promote the most effective use of NHS resources
e) feedback to the practice so that all GPs and their practice colleagues will have a broad understanding of how the CCG works.

7.2. Other GP and Primary Care Health Professionals

7.2.1. In addition to the practice representatives identified in section 7.1 above, the group has identified a number of other GPs / primary care health professionals from member practices to either support the work of the group and / or represent the group rather than represent their own individual practices. These GPs and primary care health professional undertake the following roles on behalf of the group:

a) Lead GP for Quality who will be responsible for the development of and monitoring of quality indicators with providers and primary care quality with the GP membership and reports to the Governing Body
b) Lead GP for prescribing, responsible for the local development of prescribing initiatives, monitoring prescribing processes
c) Lead GPs for Clinical Care Pathways
d) Locality lead GP's, and Practice Nurses who will lead the localities work and report to the Governing Body.

7.3. All Members of the Group's Governing Body

7.3.1. Guidance on the roles of members of the group's Governing Body is set out in a separate document[53]. In summary, each member of the Governing Body should share responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

[53] Draft *clinical commissioning group Governing Body Members – Roles Attributes and Skills,* NHS Commissioning Board Authority, March 2012

7.4. **The Chair of the Governing Body**

7.4.1. The Chair of the Governing Body is a GP and is responsible for:

a) leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;
b) building and developing the group's Governing Body and its individual members
c) ensuring that the group has proper constitutional and governance arrangements in place
d) ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties
e) supporting the Chief Officer in discharging the responsibilities of the organisation
f) contributing to building a shared vision of the aims, values and culture of the organisation
g) leading and influencing to achieve clinical and organisational change to enable the group to deliver its commissioning responsibilities
h) overseeing governance and particularly ensuring that the Governing Body and the wider group behaves with the utmost transparency and responsiveness at all times
i) ensuring that public and patients' views are heard and their expectations understood and, where appropriate as far as possible, met
j) ensuring that the organisation is able to account to its local patients, stakeholders and NHS England
k) ensuring that the group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authority(ies).

7.4.2. Where the chair of the Governing Body is also the senior clinical voice of the group they will take the lead in interactions with stakeholders, including NHS England.

7.5. **The Deputy Chair of the Governing Body**

7.5.1. The deputy chair of the Governing Body deputises for the chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act.

7.6. **Role of the Chief Officer**

7.6.1. The Chief Officer of the group is a member of the Governing Body.

7.6.2. This role of Chief Officer has been summarised in a national document[54] as:

a) being responsible for ensuring that the clinical commissioning group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money
b) at all times ensuring that the regularity and propriety of expenditure is discharged, and that arrangements are put in place to ensure that good practice (as identified through such agencies as the Audit Commission and the National Audit Office) is embodied and that safeguarding of funds is ensured through effective financial and management systems
c) working closely with the chair of the Governing Body, the Chief Officer will ensure that proper constitutional, governance and development arrangements

[54] See the latest version of NHS England Authority's *Clinical commissioning group Governing Body members: Role outlines, attributes and skills*

are put in place to assure the members (through the Governing Body) of the organisation's ongoing capability and capacity to meet its duties and responsibilities. This will include arrangements for the ongoing developments of its members and staff

d) Other duties as the Governing Body decides.

7.7. **Role of the Chief Finance Officer**

7.7.1. The Chief Finance Officer is a member of the Governing Body and is responsible for providing financial advice to the clinical commissioning group and for supervising financial control and accounting systems. The Chief Finance Officer will also act as deputy Chief Officer of the CCG.

7.7.2. This role of Chief Finance Officer has been summarised in a national document[55] as:

a) being the Governing Body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged
b) making appropriate arrangements to support, monitor on the group's finances
c) overseeing robust audit and governance arrangements leading to propriety in the use of the group's resources
d) being able to advise the Governing Body on the effective, efficient and economic use of the group's allocation to remain within that allocation and deliver required financial targets and duties; and
e) producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England
f) and any other duties the Governing Body decides.

7.8. **Role of Registered Nurse**

7.8.1. As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, as a registered nurse on the governing body, this person will bring a broader view, from their perspective as a registered nurse, on health and care issues to underpin the work of the CCG especially the contribution of nursing to patient care.

7.8.2. This role has been summarised in a national document[56] as an individual that;

a) has a high level of professional expertise and knowledge
b) is competent, confident and willing to give an independent strategic clinical view on all aspects of CCG business
c) is highly regarded as a clinical leader, probably across more than one clinical discipline and/or specialty – demonstrably able to think beyond their own professional viewpoint
d) is able to take a balanced view of the clinical and management agenda and draw on their specialist skills to add value
e) is able to contribute a generic view from the perspective of a registered nurse whilst putting aside specific issues relating to their own clinical practice or employing organisation's circumstances; and

[55] See the latest version of NHS England Authority's *Clinical commissioning group Governing Body members: Role outlines, attributes and skills*

[56] *Ibid*

f) is able to bring detailed insights from nursing and perspectives into discussions regarding service re-design, clinical pathways and system reform.

7.9. **Role of the Secondary Care Doctor**

7.9.1. As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, this clinical member will bring a broader view, on health and care issues to underpin the work of the CCG. In particular, they will bring to the Governing Body an understanding of patient care in the secondary care setting.[57]

7.9.2. This role has been summarised in a national document[58] as an individual that;

a) is a doctor that is, or has been, a secondary care specialist, who has a high level of understanding of how care is delivered in a secondary care setting
b) is competent, confident and willing to give an independent strategic clinical view on all aspects of CCG business
c) is highly regarded as a clinical leader, preferably with experience working as a leader across more than one clinical discipline and/or specialty with a track record of collaborative working
d) is able to take a balanced view of the clinical and management agenda, and draw on their in depth understanding of secondary care to add value
e) is able to contribute a generic view from the perspective of a secondary care doctor whilst putting aside specific issues relating to their own clinical practice or their employing organisation's circumstances; and
f) provides an understanding of how secondary care providers work within the health system to bring appropriate insight to discussions regarding service redesign, clinical pathways and system reform.

7.10. **Role of the Lay Member for Governance**

7.10.1. This role has been summarised in a national document[59].

7.10.2. The role of this lay member is to bring specific expertise and experience to the work of the Governing Body. Their focus is strategic and impartial, providing an external view of the work of the CCG that is removed from the day-to-day running of the organisation. Their role is be to oversee key elements of governance including audit, remuneration and managing conflicts of interest.

This member is also the Chair of the Audit Committee. This member has a lead role in ensuring that the governing body and the wider CCG behaves with the utmost probity at all times. This person is responsible for ensuring that appropriate and effective whistle blowing and anti-fraud systems are in place.

7.11. **Role of the Lay Member for Patient and Public Involvement**

7.11.1. This role has been summarised in a national document[60].

[57] See the latest version of NHS England Authority's *Clinical commissioning group Governing Body members: Role outlines, attributes and skills*
[58] See the latest version of NHS England Authority's *Clinical commissioning group Governing Body members: Role outlines, attributes and skills*

7.11.2. As well as sharing responsibility with the other members for all aspects of the CCG Governing Body business, as a lay member on the CCG's Governing Body this lay member knowledge of the local community and is integral to the work of the governing body. Their focus is strategic and impartial, providing an independent view of the work of the CCG that is external to the day-to-day running of the organisation.

This member will help to ensure that, in all aspects of the CCG's business the public voice of the local population is heard and that opportunities are created and protected for patient and public empowerment in the work of the CCG. In particular, they are responsible for ensuring that:

a) public and patients' views are heard and their expectations understood and met as appropriate
b) the CCG builds and maintains an effective relationship with Local Healthwatch and draws on existing patient and public engagement and involvement expertise; and

the CCG has appropriate arrangements in place to secure public and patient involvement and responds in an effective and timely way to feedback and recommendations from patients, carers and the public.

7.12. **Joint Appointments with other Organisations**

7.12.1. The group has the following joint appointments with NHS South Sefton CCG:

a) Chief Officer
b) Chief Finance Officer.

And others as identified within the memorandum of understanding

7.12.2. These joint appointments are supported by a memorandum of understanding (available on CCG website) between the organisations who are party to these joint appointments.

8. STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

8.1. **Standards of Business Conduct**

8.1.1. Employees, members, committee and sub-committee members of the group and members of the Governing Body (and its committees) will at all times comply with this constitution and be aware of their responsibilities as outlined in it. They should act in good faith and in the interests of the group and should follow the *Seven Principles of Public Life*; set out by the Committee on Standards in Public Life (the Nolan Principles) The Nolan Principles are incorporated into this constitution at Appendix F.

8.1.2. They must comply with the group's policy on business conduct, including the requirements set out in the policy for managing conflicts of interest. This policy will be available on the group's website at www.southportformbyccg.org.uk.

8.1.3. Individuals contracted to work on behalf of the group or otherwise providing services or facilities to the group will be made aware of their obligation with regard to declaring conflicts or potential conflicts of interest. This requirement will be written into their contract for services.

8.2. **Conflicts of Interest**

8.2.1. As required by section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act, the clinical commissioning group will make arrangements to manage conflicts and potential conflicts of interest to ensure that decisions made by the group will be taken and seen to be taken without any possibility of the influence of external or private interest.

8.2.2. Where an individual, i.e. an employee, group member, member of the Governing Body, or a member of a committee or a sub-committee of the group or its Governing Body has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the group considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this constitution.

8.2.3. A conflict of interest will include:

a) a direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services)
b) an indirect pecuniary interest: for example, where an individual is a partner, member or shareholder in an organisation that will benefit financially from the consequences of a commissioning decision
c) a non-pecuniary interest: where an individual holds a non-remunerative or not-for profit interest in an organisation, that will benefit from the consequences of a commissioning decision (for example, where an individual is a trustee of a voluntary provider that is bidding for a contract)
d) a non-pecuniary personal benefit: where an individual may enjoy a qualitative benefit from the consequence of a commissioning decision which cannot be given a monetary value (for example, a reconfiguration of hospital services which might result in the closure of a busy clinic next door to an individual's house)
e) where an individual is closely related to, or in a relationship, including friendship, with an individual in the above categories.

8.2.4. If in doubt, the individual concerned should assume that a potential conflict of interest exists.

8.3. **Declaring and Registering Interests**

8.3.1. The group will maintain one or more registers of the interests of:

a) the members of the group (as defined in the Policy on Managing Conflicts of Interest)
b) the members of its Governing Body
c) the members of its committees or sub-committees and the committees or sub-committees of its Governing Body; and
d) its employees.

8.3.2. The registers will be published on the group's website at www.southportformbyccg.org.uk.

8.3.3. Individuals will declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the group, in writing to the

Governing Body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

8.3.4. Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter.

8.3.5. The Governing Body will ensure that the register of interest is reviewed regularly, and updated as necessary.

8.4. **Managing Conflicts of Interest: General**

8.4.1. Individual members of the group, the Governing Body, committees or sub-committees, the committees or sub-committees of its Governing Body and employees will comply with the arrangements determined by the group for managing conflicts or potential conflicts of interest.

8.4.2. The Chief Corporate Delivery and Integration Officer will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the group's decision making processes.

8.4.3. Arrangements for the management of conflicts of interest are contained within the CCG's Policy on Managing Conflicts of Interest and will include the requirement to put in writing to the relevant individual arrangements for managing the conflict of interests or potential conflicts of interests, within a week of declaration. The arrangements will confirm the following:

a) when an individual should withdraw from a specified activity, on a temporary or permanent basis

b) monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

8.4.4. Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the group's exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the Chief Corporate Delivery and Integration Officer.

8.4.5. Where an individual member, employee or person providing services to the group is aware of an interest which:

a) has <u>not</u> been declared, either in the register or orally, they will declare this at the start of the meeting

b) has <u>previously</u> been declared, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair of the meeting, together with details of arrangements which have been confirmed for the management of the conflict of interests or potential conflict of interests.

8.4.6. In accordance with the CCG's Policy on Managing Conflicts of Interest, the chair of the meeting will then determine how this should be managed and inform the member

of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

8.4.7. Where the chair of any meeting of the group, including committees, sub-committees, or the Governing Body and the Governing Body's committees and sub-committees, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting. Where arrangements have been confirmed for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

8.4.8. Any declarations of interests, and arrangements agreed in any meeting of the clinical commissioning group, committees or sub-committees, or the Governing Body, the Governing Body's committees or sub-committees, will be recorded in the minutes.

8.4.9. Where more than 50% of the members of a meeting are required to withdraw from a meeting or part of it, owing to the arrangements agreed for the management of conflicts of interests or potential conflicts of interests, the chair (or deputy) will determine whether or not the discussion can proceed.

8.4.10. In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the group's standing orders. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the meeting, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair of the meeting shall consult the Head of Corporate Delivery on the action to be taken.

8.4.11. This may include:

a) requiring another of the group's committees or sub-committees, the group's Governing Body or the Governing Body's committees or sub-committees (as appropriate) which can be quorate to progress the item of business, or if this is not possible

b) inviting on a temporary basis one or more of the following to make up the quorum (where these are permitted members of the Governing Body or committee / sub-committee in question) so that the group can progress the item of business:

   i) a member of the clinical commissioning group who is an individual;

c) an individual appointed by a member to act on its behalf in the dealings between it and the clinical commissioning group:

   i) a member of a relevant Health and Wellbeing Board;

   ii) a member of a Governing Body of another clinical commissioning group.

These arrangements must be recorded in the minutes.

d) In any transaction undertaken in support of the clinical commissioning group's exercise of its commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest, that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter. The individual must also inform either their line manager (in the case of employees), or the Chief Corporate Delivery and Integration Officer or the Chairman of the transaction.

8.4.12. The Chief Corporate Delivery and Integration Officer will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared

8.5. **Managing Conflicts of Interest: contractors and people who provide services to the group**

8.5.1. Anyone seeking information in relation to a procurement, or participating in a procurement, or otherwise engaging with the clinical commissioning group in relation to the potential provision of services or facilities to the group, will be required to make a declaration of any relevant conflict / potential conflict of interest.

8.5.2. Anyone contracted to provide services or facilities directly to the clinical commissioning group will be subject to the same provisions of this constitution in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

8.6. **Transparency in Procuring Services**

8.6.1. The group recognises the importance in making decisions about the services it procures in a way that does not call into question the motives behind the procurement decision that has been made. The group will procure services in a manner that is open, transparent, non-discriminatory and fair to all potential providers.

8.6.2. The group will publish a Procurement Strategy approved by its Governing Body which will ensure that:

a) all relevant clinicians (not just members of the group) and potential providers, together with local members of the public, are engaged in the decision-making processes used to procure services;

b) service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way

8.6.3. Copies of this Procurement Strategy will be available on the group's website at www.southortformbyccg.org.uk and;

a) available upon request for inspection at SFCCG headquarters

b) available upon application, either by post to 5 Curzon Rd Southport PR8 6PN or by

c) email from melanie.wright@southseftonccg.nhs.uk.

9. THE GROUP AS EMPLOYER

9.1. The group recognises that its most valuable asset is its people. It will seek to enhance their skills and experience and is committed to their development in all ways relevant to the work of the group.

9.2. The group will seek to set an example of best practice as an employer and is committed to offering all staff equality of opportunity. It will ensure that its employment practices are designed to promote diversity and to treat all individuals equally.

9.3. The group will ensure that it employs suitably qualified and experienced staff who will discharge their responsibilities in accordance with the high standards expected of staff employed by the group. All staff will be made aware of this constitution, the commissioning strategy and the relevant internal management and control systems which relate to their field of work.

9.4. The group will maintain and publish policies and procedures (as appropriate) on the recruitment and remuneration of staff to ensure it can recruit, retain and develop staff of an appropriate calibre. The group will also maintain and publish policies on all aspects of human resources management, including grievance and disciplinary matters.

9.5. The group will ensure that its rules for recruitment and management of staff provide for the appointment and advancement on merit on the basis of equal opportunity for all applicants and staff.

9.6. The group will ensure that employees' behaviour reflects the values, aims and principles set out above.

9.7. The group will ensure that it complies with all aspects of employment law.

9.8. The group will ensure that its employees have access to such expert advice and training opportunities as they may require in order to exercise their responsibilities effectively.

a) The group will adopt a Code of Conduct for staff and will maintain and promote effective 'whistleblowing' procedures to ensure that concerned staff have means through which their concerns can be voiced. Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, will be available on the group's website at www. Southportformbyccg.org.uk available upon request for inspection at SFCCG headquarters

b) available upon application, either by post to 5 Curzon Rd, Southport PR8 6PN or by

c) email from melanie.wright@southseftonccg.nhs.uk.

9.9. The group recognises and confirms that nothing in or referred to in this constitution (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined

in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the group, any member of its Governing Body, any member of any of its committees or sub-committees or the committees or sub-committees of its Governing Body, or any employee of the group or of any of its members, nor will it affect the rights of any worker (as defined in that Act) under that Act.

10. TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1. **General**

10.1.1. The group will publish annually a commissioning plan and an annual report, presenting the group's annual report to a public meeting.

10.1.2. Key communications issued by the group, including the notices of procurements, public consultations, Governing Body meeting dates, times, venues, and certain papers will be published on the group's website at www.southportformby.org.uk and be:

a) available upon request for inspection at SFCCG headquarters

b) available upon application, either by post to 5 Curzon Rd Southport PR8 6PN or by

c) email from melanie.wright@southseftonccg.nhs.uk.

10.1.3. The group may use other means of communication, including circulating information by post, or making information available in venues or services accessible to the public.

10.2. **Standing Orders**

10.2.1. This constitution is also informed by a number of documents which provide further details on how the group will operate. They are the group's:

10.2.2. Standing Orders (Appendix C) – which sets out the arrangements for meetings and the appointment processes to elect the group's representatives and appoint to the group's committees, including the Governing Body;

10.2.3. Scheme of Reservation and Delegation (Appendix D) – which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the group's Governing Body, the Governing Body's committees and sub-committees, the group's committees and sub-committees, individual members and employees;

10.2.4. Prime Financial Policies (Appendix E) – which sets out the arrangements for managing the group's financial affairs.

APPENDIX A
DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

2006 Act	National Health Service Act 2006
2012 Act	Health and Social Care Act 2012 (this Act amends the 2006 Act)
Chief Officer	an individual, as defined under paragraph 12 of Schedule 1A of the 2006 Act (as inserted by Schedule 2 of the 2012 Act), appointed by NHS England, with responsibility for ensuring the group: a) complies with its obligations under: i. sections 14Q and 14R of the 2006 Act (as inserted by section 26 of the 2012 Act), ii. sections 223H to 223J of the 2006 Act (as inserted by section 27 of the 2012 Act), iii. paragraphs 17 to 19 of Schedule 1A of the NHS Act 2006 (as inserted by Schedule 2 of the 2012 Act), and iv. any other provision of the 2006 Act (as amended by the 2012 Act) specified in a document published by the Governing Body for that purpose; b) exercises its functions in a way which provides good value for money.
Area	the geographical area that the group has responsibility for, as defined in Chapter 2 of this constitution
Chair of the Governing Body	the individual appointed by the group to act as chair of the Governing Body
Chief Finance Officer	the qualified accountant employed by the group with responsibility for financial strategy, financial management and financial governance
Clinical commissioning group	a body corporate established by NHS England in accordance with Chapter A2 of Part 2 of the 2006 Act (as inserted by section 10 of the 2012 Act)
Committee	a committee or sub-committee created and appointed by: a) the membership of the group b) a committee / sub-committee created by a committee created / appointed by the membership of the group c) a committee / sub-committee created / appointed by the Governing Body
Financial year	this usually runs from 1 April to 31 March, but under paragraph 17 of Schedule 1A of the 2006 Act (inserted by Schedule 2 of the 2012 Act), it can for the purposes of audit and accounts run from when a clinical commissioning group is established until the following 31 March
Group	NHS Southport & Formby Clinical Commissioning Group, whose constitution this is
Governing Body	the body appointed under section 14L of the NHS Act 2006 (as inserted by section 25 of the 2012 Act), with the main function of ensuring that a clinical commissioning group has made appropriate arrangements for ensuring that it complies with: a) its obligations under section 14Q under the NHS Act 2006 (as inserted by section 26 of the 2012 Act), and b) such generally accepted principles of good governance as are relevant to it.

Governing Body member	any member appointed to the Governing Body of the group
Lay member	a lay member of the Governing Body, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations
Member	a provider of primary medical services to a registered patient list, who is a members of this group (see tables in Chapter 3 and Appendix B)
Practice representatives	an individual appointed by a practice (who is a member of the group) to act on its behalf in the dealings between it and the group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act)
Registers of interests	registers a group is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: a) the members of the group; b) the members of its Governing Body; c) the members of its committees or sub-committees and committees or sub-committees of its Governing Body; and d) its employees.

APPENDIX B - LIST OF MEMBER PRACTICES

Practice Name and Address	Locality	Practice Representative Signature
Churchtown Medical Centre Cambridge Rd, Southport, PR9 7TL	**North**	
The Corner Surgery 117 Flyde Road, Southport, PR9 9XL	**North**	
Marshside Surgery 117 Fylde Road, Southport, PR9 9XL	**North**	
Norwood 11 Norwood Avenue, Southport, PR9 7EG	**North**	
Roe Lane 172 Roe Lane, Southport, PR9 7PN	**North**	
Sussex Rd Surgery 125 Sussex Rd PR8 6AF	**North**	
Trinity Practice Houghton St Southport	**Central**	
Curzon Rd Surgery 5 Curzon Rd, PR8 6PN	**Central**	
Cumberland House 58 Scarisbrick New Road, Southport, PR8 6PG	**Central**	
Kew Surgery 85 Town Lane PR8 6RG	**Central**	
St Marks 42 Derby Road, Southport, PR9 0TZ	**Central**	
The Grange 41 York Road, Southport, PR8 2AD	**Ainsdale & Birkdale**	
Family Surgery 107 Liverpool Road, Southport, PR8 4DB	**Ainsdale & Birkdale**	
Lincoln 33 Lincoln Road, Southport, PR8 4PR	**Ainsdale & Birkdale**	
Ainsdale Medical Centre 66 Station Road, Ainsdale, Southport, PR8 3HW	**Ainsdale & Birkdale**	
Ainsdale Village 2 Leamington Road, Ainsdale, Southport, PR8 3LB	**Ainsdale & Birkdale**	
Chapel Lane 13 Chapel Lane, Formby, L37 4DL	**Formby**	
The Hollies Elbow Lane, Formby, L37 4AD	**Formby**	
The Village Surgery Elbow Lane, Formby, L37 4AD	**Formby**	
Freshfield 61 Gores Lane, Formby, L37 3NU	**Formby**	

APPENDIX C – STANDING ORDERS

1. STATUTORY FRAMEWORK AND STATUS

1.1. Introduction

1.1.1. These standing orders have been drawn up to regulate the proceedings of the NHS Southport and Formby Clinical Commissioning Group so that group can fulfil its obligations, as set out largely in the 2006 Act, as amended by the 2012 Act and related regulations. They are effective from the date the group is established.

1.1.2. The standing orders and prime financial policies must be read in conjunction with the following guidance and other issued by the Secretary of State for Health and of NHS England.

a) The Human Rights Act 1998

b) Caldicott Guardian 1997

c) Freedom of Information Act 2000

1.1.3. The standing orders, together with the group's scheme of reservation and delegation[61] and the group's prime financial policies[62], provide a procedural framework within which the group discharges its business. They set out:

a) the arrangements for conducting the business of the group;

b) the appointment of member practice representatives and the members of the group's Governing Body;

c) the procedure to be followed at meetings of the group, the Governing Body and any committees or sub-committees of the group or the Governing Body;

d) the process to delegate powers,

e) the declaration of interests and standards of conduct.

These arrangements must comply, and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate[63] of any relevant guidance.

1.1.4. The standing orders, scheme of reservation and delegation and prime financial policies have effect as if incorporated into the group's constitution. Group members, employees, members of the Governing Body, members of the Governing Body's committees and sub-committees, members of the group's committees and sub-committees and persons working on behalf of the group should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the standing orders, scheme of reservation and

61 See Appendix D
62 See Appendix E
63 Under some legislative provisions the group is obliged to have regard to particular guidance but under other circumstances guidance is issued as best practice guidance.

delegation and prime financial policies may be regarded as a disciplinary matter that could result in dismissal.

1.2. **Schedule of matters reserved to the clinical commissioning group and the scheme of reservation and delegation**

1.2.1. The 2006 Act (as amended by the 2012 Act) provides the group with powers to delegate the group's functions and those of the Governing Body to certain bodies (such as committees) and certain persons. The group has decided that certain decisions may only be exercised by the group in formal session. These decisions and also those delegated are contained in the group's scheme of reservation and delegation (see Appendix D).

2. THE CLINICAL COMMISSIONING GROUP: COMPOSITION OF MEMBERSHIP, KEY ROLES, NOMINATION AND APPOINTMENT PROCESS

2.1. **Composition of Membership**

2.1.1. Chapter 3 of the group's constitution provides details of the membership of the group (also see Appendix B).

2.1.2. Chapter 6 of the group's constitution provides details of the governing structure used in the group's decision-making processes, whilst Chapter 7 of the constitution outlines certain key roles and responsibilities within the group and its Governing Body, including the role of practice representatives (section 7.1 of the constitution).

2.2. **Key Roles**

2.2.1. Paragraph 6.6.2 of the group's constitution sets out the composition of the group's Governing Body whilst Chapter 7 of the group's constitution identifies certain key roles and responsibilities within the it's membership council and its Governing Body. These standing orders set out how the group appoints individuals to these key roles.

2.2.2. The Chair of the Governing Body, as listed in 6.6.2 of the group's constitution, is subject to the following appointment process:

a) Election – as per the arrangements set out in Section 2.3 of this Constitution
b)
c) **Appointment process** – one vote per voting member of the CCG
d) **Term of office** – 3 years
e) **Eligibility for reappointment** - as above for 2 terms only
f) **Grounds for removal from office** - gross misconduct in office as brought to the governing bodies attention and removal sanctioned by them after due investigation
g) **Notice period** – one month.

2.2.3. The Deputy Chair, as listed in paragraph 6.6.2] of the group's constitution, is subject to the following appointment process:

a) **Nominations** – by 2 voting members of the Governing Body
b) **Eligibility** – Governing Body member assessed to meet the required attributes and skills
c) **Appointment process** – one vote per voting member of the Governing Body

d) **Term of office** – 3 years
e) **Eligibility for reappointment** - as above for 2 terms only
f) **Grounds for removal from office** - gross misconduct in office as brought to the governing bodies attention and removal sanctioned by them after due
g) **Notice period** – one month.

2.2.4. The Chief Officer, as listed in paragraph 6.6.2of the group's constitution, is subject to the national appointment process

2.2.5. The Chief Finance officer, as listed in paragraph 6.6.2 of the group's constitution, is subject to the national appointment process.

2.2.6. The Practice representatives, as listed in paragraph 6.6.2 of the group's constitution, are subject to the following appointment process:

a) **Nominations** – self with partner approval
b) **Eligibility** – GP with a practice in the geographical area
c) **Appointment process** – Voted by practice
d) **Term of office** – 3 years
e) **Eligibility for reappointment** - as above for 2 terms only
f) **Grounds for removal from office** - gross misconduct in office as brought to the governing bodies attention and removal sanctioned by them after due investigation
g) **Notice period** – one month.

2.2.7. The Nurse, as listed in 6.6.2 of the groups constitution are subject to the following appointment process:

a) **Nominations** – self with employer agreement
b) **Eligibility** – working within Sefton
c) **Appointment process** – Voted by member practices
d) **Term of office** – 3 years
e) **Eligibility for reappointment** - as above for 2 terms only
f) **Grounds for removal from office** - gross misconduct in office as brought to the governing bodies attention and removal sanctioned by them after due investigation
g) **Notice period** – one month.

2.2.8. The Practice Managers as listed in paragraph 6.6.2 of the group's constitution, is subject to the following appointment process:

a) **Nominations** –self with partner approval
b) **Eligibility** – working as a Practice Manager in a practice within the geographical area
c) **Appointment process** – voted by member practices
d) **Term of office** – 3 years
e) **Eligibility for reappointment** - as above for 2 terms only
f) **Grounds for removal from office** - gross misconduct in office as brought to the governing bodies attention and removal sanctioned by them after due investigation
g) **Notice period** – one month.

2.2.9. The Lay Member for Governance, as listed in paragraph 6.6.2 of the group's constitution, is subject to the following appointment process:

a) **Nominations** – advert and recruitment
b) **Eligibility** – able to demonstrate attribute and skills as outlined by NHS England
c) **Appointment process** – Interview by Governing Body members
d) **Term of office** – 3 years
e) **Eligibility for reappointment** - as above
f) **Grounds for removal from office** - gross misconduct in office as brought to the governing bodies attention and removal sanctioned by them after due investigation
g) **Notice period** – one month.

2.2.10. The Lay Member for Patient \and public involvement as listed in paragraph 6.6.2 the group's constitution, is subject to the following appointment process:

a) **Nominations** – advert and recruitment
b) **Eligibility** – able to demonstrate attribute and skills as outlined by NHS England
c) **Appointment process** – interview by Governing Body members
d) **Term of office** – 3 years
e) **Eligibility for reappointment** - as above
f) **Grounds for removal from office** - gross misconduct in office as brought to the governing bodies attention and removal sanctioned by them after due investigation
g) **Notice period** – one month.

2.2.11. The Secondary Care Clinician as listed in paragraph 6.6.2 of the group's constitution, is subject to the following appointment process:

a) **Nominations** – advert and recruitment
b) **Eligibility** – able to demonstrate attribute and skills as outlined by the NHSCB
c) **Appointment process** – Interview by Governing Body members
d) **Term of office** – 3 years
e) **Eligibility for reappointment** - as above
f) **Grounds for removal from office** - gross misconduct in office as brought to the governing bodies attention and removal sanctioned by them after due investigation
g) **Notice period** – one month.

2.2.12. The roles and responsibilities of each of these key roles are set out either in paragraph 6.6.2 or Chapter 7 of the group's constitution.

2.3. **Election Process**

2.3.1. The election of the Chair will be conducted by ballot arranged by the CCG.

2.3.2. Each Member Practice casts one (weighted) vote.

2.3.3. Voting will be by the nominated Member Practice Lead GP.

2.4. **General Principles of Appointment to Key Roles and Removal Of Office**

2.4.1. As a general principle all selections and appointments will be conducted in a fair and transparent manner.

2.4.2. The following individuals will not be eligible to either represent their practice, or to put themselves forward for election as chair of the group or for election to the group's Governing Body or to apply for position on the group's Governing Body if they are:

a) not eligible to work in the UK;

b) a clinician practising with conditions;

c) the subject to bankruptcy restrictions or an interim bankruptcy restrictions order;

d) a person who has been dismissed from employment in the last five years [other than by means of redundancy];

e) a person who has received a prison sentence or suspended sentence of three months or more in the last five years;

f) a person who has been disqualified from serving as a company director;

g) a person who has been removed from the management or control of a charity;

h) a serving civil servant with the Department of Health or members/employees of the Care Quality Commission; or

i) intending to serve as a chair or non-executive of another NHS body beyond the formal establishment of the relevant CCG.

2.4.3. As a general principle, practice will be asked to withdraw their nominated representative, or elected leaders be removed from office, or other Governing Body members removed from office, or other Governing Body members removed from office if:

a) where appropriate, they cease to be eligible to provide primary medical services or to carry out their clinical role;

b) they are unable to meet the specified attendance requirement for meetings;

c) they fail, without good reason, to meet the attendance requirement for meetings or, where permitted, fail to send a deputy to those meetings;

d) they have conflicts with the work of the group that cannot be managed;

e) in the opinion of the membership council or where appropriate the Governing Body the individual is no longer able to contribute to the work of the group;

f) they behave in a manner or exhibit conduct which is likely to undermine public confidence in the group;

g) they are declared bankrupt.

2.4.4. In all of the aforementioned circumstances, the group will adhere to best human resources practices. In respect of nominated practice members clinicians, elected clinicians or employees of the group, the group will consult with the appropriate representative bodies in drawing up the relevant procedures.

2.4.5. Employees of the group will be subject to the group's disciplinary policies which are available on the website at www.southportformbyccg.org.uk or from its headquarters. Any decision to terminate the appointment of employees shall be taken in accordance with those policies.

2.5. Representatives of Member Practice.

3. MEETINGS OF THE CLINICAL COMMISSIONING GROUP

3.1. **Openness**

3.1.1. Members of the public, including the media may attend meetings of the Governing Body. They may observe the deliberations of the Governing Body but do not have a right to contribute to debate. Contributions from the public at these meetings may be considered at the discretion of the chair.

3.1.2. Exceptionally there may be items of a confidential nature that the Governing Body needs to discuss in private. The public will be excluded from observing these discussions. Such items of business will include matters:

a) concerning a member of staff

b) concerning a patient

c) that could commercially disadvantage the group if discussed in public; or

d) could be detrimental to the operation of the group

3.1.3. Meetings of the membership council will be held in private.

3.2. **Calling meetings**

3.2.1. Ordinary meetings of the Governing Body shall be held at least bi-monthly, at such times and places determined by the chair of the Governing Body. Members of the Governing Body will be given at least 6 weeks' notice of the date of the meeting.

3.2.2. Ordinary meetings of the membership council shall be held at least quarterly at such times and places determined by the chair of the group. Members of the membership council will be given at least 6 weeks' notice of the date of the meeting.

3.2.3. An extraordinary meeting of the membership council or Governing Body may be called by the chair at any time, or by not less than a third of the members of the respective bodies lodging a written request with the Chief Officer stating the business to be transacted. No business shall be transacted at that meeting other than that specified in the notice of the meeting.

3.2.4. The written requests should ask for the meeting to take place within 28 days and the Chief Officer will give 21 days' notice of the date of the meeting.

3.3. **Agenda, supporting papers and business to be transacted**

3.3.1. Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the chair of the meeting or deputy at least 15 working days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted at least 10 working days before the meeting takes place. The agenda and supporting papers will be circulated to all members of a meeting at least 7 working days before the date the meeting will take place.

3.3.2. Agendas and certain papers for the group's Governing Body – including details about meeting dates, times and venues - will be published on the group's website at www.southportformbyccg.org.uk or Are available on request from melanie.wright@southseftonccg.nhs.uk

3.4. **Petitions**

3.4.1. Where a petition has been received by the group, the chair of the Governing Body shall include the petition as an item for the agenda of the next meeting of the Governing Body.

3.5. **Chair of a meeting**

3.5.1. At any meeting of the membership council or its Governing Body or of a committee or sub-committee, the chair of the membership council, Governing Body, committee or sub-committee, if any and if present, shall preside. If the chair is absent from the meeting, the deputy chair, if any and if present, shall preside.

3.5.2. If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If both the Chair and Deputy Chair are absent, or are disqualified from participating, or there is neither a chair or deputy a member of the group, Governing Body, committee or sub-committee respectively shall be chosen by the members present, or by a majority of them, and shall preside.

3.6. **Chair's ruling**

3.6.1. The decision of the chair of the Governing Body on questions of order, relevancy and regularity and their interpretation of the constitution, standing orders, scheme of reservation and delegation and prime financial policies at the meeting, shall be final.

3.7. **Quorum**

3.7.1. The Governing Body - quoracy of 65% of the Governing Body membership.

3.7.2. The Governing Body shall specify that no business will be transacted unless 5 members present (including)

a) at least one lay member
b) either Chief Officer/Chief Finance Officer
c) at least 3 clinicians.

3.7.3. The Practice Locality Groups – must have practices representing 50% of the vote present.

3.7.4. Representation on behalf of the designated GP lead for CCG is permitted by proxy, so long as the chair has been informed in writing and the representative GP.

3.7.5. For all other of the group's committees and sub-committees, including the Governing Body's committees and sub-committees, the details of the quorum for these meetings and status of representatives are set out in the appropriate terms of reference.

3.8. **Decision making**

3.8.1. Chapter 6 of the group's constitution, together with the scheme of reservation and delegation, sets out the governing structure for the exercise of the group's statutory functions. Generally it is expected that at the membership council or Governing Body meetings, decisions will be reached by consensus. Should this not be possible then a vote of members will be required, the process for which is set out below:

a) **Eligibility** – must have been elected to the Governing Body
b) **Majority necessary to confirm a decision** – 51% plus of vote
c) **Casting vote** - Chair
d) **Dissenting views** – will be recorded.

3.8.2. Should a vote be taken the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

3.8.3. For all other of the group's committees and sub-committees, including the Governing Body's committees and sub-committee, the details of the process for holding a vote are set out in the appropriate terms of reference.

3.9. **Emergency Powers and Urgent Decisions**

3.9.1. In exceptional circumstances, where the Chair of the Governing Body authorises urgent action in respect of a matter on behalf of the group which would have been considered by the membership council or the Governing Body respectively, such action will be reported at the next meeting of the respective bodies. In taking such action, the chair in conjunction with the Chief Officer should consult with at least two members of the membership council, in respect of decisions reserved to the membership council, or two members of the Governing Body, for decisions reserved to the Governing Body.

3.9.2. In dealing with such issues requiring an urgent decision and if timescales and practicalities allow, the chair may call a meeting of the membership council or Governing Body using video or telephone conferencing facilities. All such decisions will be ratified by the respective bodies at their next meeting.

3.10. **Suspension of Standing Orders**

3.10.1. Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or NHS England, any part of these standing orders may be suspended at any meeting, provided the Chief Finance Officer, Chair or Chief Officer is present and 8 group members are in agreement.

3.10.2. A decision to suspend standing orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

3.10.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Governing Body's audit committee for review of the reasonableness of the decision to suspend standing orders.

3.11. **Record of Attendance**

3.11.1. The names of all members of the meeting present at the meeting shall be recorded in the minutes of the group's meetings. The names of all members of the Governing Body present shall be recorded in the minutes of the Governing Body meetings. The names of all members of the Governing Body's committees / sub-committees present shall be recorded in the minutes of the respective Governing Body committee / sub-committee meetings.

3.12. **Minutes**

Will:

a) Record names of individuals
b) record the individual responsible for taking and drafting minutes
c) be formally signed off by the chair of the meeting at the next meeting
d) available internally within 2 weeks
e) will be available to the public when next meeting takes place
f) record additional/late attendances and leavers
g) record proxies and who they are representing.

3.13. **Admission of public and the press**

3.13.1. Ordinary meetings of the Governing Body will be open to the press and public (Part A). These meetings will also hold a meeting with a separate agenda (Part B) which will be closed to the press and public for the consideration of sensitive information, not for sharing within the public domain.

3.13.2. The chair of the Governing Body shall determine which items are considered in Part A and Part B of the ordinary meeting.

3.13.3. If the chair decides to exclude the press or public for any reason during Part A of an ordinary meeting, then the reason will be noted in the minutes.

3.14. **Annual General Meeting (AGM)**

The CCG will hold an annual general meeting (an "AGM") once a year. The AGM will be in public and a matter of public record. The CCG Chair or Deputy Chair will chair the AGM.

The matters to be considered at the AGM will be sent out in the notice, but will include:

a) consideration and (if thought appropriate) approval of the CCG's annual report, accounts, annual operating plan and commissioning strategy

b) consideration of an annual report describing all public consultations undertaken by the CCG, the findings and the actions it has taken as a result

c) review of the selection and appointment processes for members of the Governing Body for the relevant year

d) the transaction of any other business included in the notice.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1. **Appointment of committees and sub-committees**

4.1.1. The group may appoint committees and sub-committees of the group, subject to any regulations made by the Secretary of State[64], and make provision for the appointment of committees, joint committees, sub-committees and advisory bodies of its Governing Body and its membership council. Where such committees, joint committees, sub-committees and advisory bodies of the group, its Governing Body or its membership council, are appointed they are included in Chapter 6 of the group's constitution.

4.1.2. Other than where there are statutory requirements, such as in relation to the Governing Body's audit committee or remuneration committee, the membership council and Governing Body respectively shall determine the membership and terms of reference of committees, joint committees, sub-committees and advisory bodies and shall, if it requires, receive and consider reports of such committees at the next appropriate meeting of the group.

4.1.3. The provisions of these standing orders shall apply where relevant to the operation of the membership council and the Governing Body's committees, joint committees, sub-committees and advisory unless stated otherwise in the committee, joint committee, sub-committee or advisory body's terms of reference.

4.2. **Terms of Reference**

4.2.1. Terms of reference shall have effect as if incorporated into the constitution and shall be available on the CCG's public website at www.southportandformbyccg.org.uk.

4.3. **Delegation of Powers by Committees to Sub-committees**

4.3.1. Where committees are authorised to establish advisory groups they may not delegate executive powers to the sub-committee unless expressly authorised by either the membership council or Governing Body or appropriate body or advisory group.

4.4. **Approval of Appointments to Committees and Sub-Committees**

4.4.1. The group shall approve the appointments to each of the committees and sub-committees which it has formally constituted including those the Governing Body. The group shall agree such travelling or other allowances as it considers appropriate.

[64] See section 14N of the 2006 Act, inserted by section 25 of the 2012 Act

5. DUTY TO REPORT NON-COMPLIANCE WITH STANDING ORDERS AND PRIME FINANCIAL POLICIES

5.1. If for any reason these standing orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Governing Body for action or ratification. All members of the group and staff have a duty to disclose any non-compliance with these standing orders to the Chief Officer as soon as possible.

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1. **Clinical Commissioning Group's Seal**

6.1.1. The group may have a seal for executing documents where necessary. The following individuals or officers are authorised to authenticate its use by their signature:

a) the Chief Officer

b) the Chair of the Governing Body

c) the Chief Finance Officer.

6.1.2 The Chief Officer shall keep a register of every sealing made and numbered consecutively in a book for that purpose.

6.1.3 A report of all sealings shall be made to the Audit Committee at least bi-annually.

6.2. **Execution of a document by signature**

6.2.1. The following individuals are authorised to execute a document on behalf of the group by their signature.

a) the Chief Officer

b) the chair of the Governing Body

c) the Chief Finance Officer.

7. OVERLAP WITH OTHER CLINICAL COMMISSIONING GROUP POLICY STATEMENTS / PROCEDURES AND REGULATIONS

7.1. **Policy statements: general principles**

7.1.1. The group will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by NHS Southport and Formby Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate group minute and will be deemed where appropriate to be an integral part of the group's standing orders as per CCG scheme of delegation.

APPENDIX D – Scheme of Reservation and Delegation

Schedule of Matters Reserved to the Clinical Commissioning Group and Scheme of Delegation

1 The arrangements made by the Group as set out in this scheme of reservation and delegation of decisions shall have effect as if incorporated into the Group's constitution.

2 Nothing in the scheme of reservation and delegation should impair the discharge of the direct accountability to the Membership Council or Governing Body of the Chief Finance Officer (CFO). Outside of these requirements the Chief Finance Officer shall be accountable to the Group's Chief Officer.

3 The Clinical Commissioning Group remains accountable for all of its functions, including those that it has delegated.

4 Unless stated in the Group's Constitution or in its Scheme of Reservation and Delegation, the Group's Chief Officer has responsibility for the operational management of the Group.

Reserved or Delegated Matter	Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
			Governing Body or Committee	Individual Member or Officer		
Regulation and Control						
Determine the arrangements by which the members of the Group approve those decisions that are reserved for the membership.	Wider Constituent Meeting			Chair		Chief Officer
Consideration and approval of applications to NHS England on matters concerning changes to the Group's constitution, including proposed changes to the appendices to the Constitution.	Wider Constituent Meeting				Governing Body	Chief Officer
Exercise or delegation of those functions of the Clinical Commissioning Group which have not been retained as reserved by the Group or delegated to the Governing Body or to a committee or sub-committee of the Group or				Chief Officer		Chief Officer

Reserved or Delegated Matter	Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
			Governing Body or Committee	Individual Member or Officer		
to one of its members.						
Approval of the Group's overarching scheme of reservation and delegation, which sets out those decisions that are in statute the responsibility of the Group and that are reserved to the membership and those delegated to the: a) Governing Body b) Committees, sub committees c) Its members or employees.	Wider Constituent Meeting				Governing Body	Chief Officer
Final authority on interpretation of the Group's constitution and supporting appendices (i.e. standing orders, prime financial policies and scheme of reservation and delegation).				Chair		Chief Officer
Prepare the Scheme of Reservation and Delegation, which sets out those decisions that are in statute, and are the responsibility of the Governing Body, those reserved to the Governing Body and those delegated to the a) Governing Body b) Committees, sub committees c) Its members or employees.		Governing Body			Chief Officer	Chief Officer
Disclosure of non-compliance with the Group's Constitution (incorporating the standing orders, prime financial policies and scheme of reservation and Delegation).				All Staff All Members		Chief Officer
Suspension of provisions within the Constitution (incorporating the standing orders, prime financial policies and Scheme of Reservation and Delegation) due to extreme cause or emergency.				Chair and either Chief Officer or CFO together	Chief Officer	Chief Officer
Review of any such suspensions of the Constitution.			Audit CommitteeCo		Head of Internal Audit	Head of Internal Audit

Reserved or Delegated Matter	Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
			Governing Body or Committee	Individual Member or Officer		
			mmittee			
0. Approval of the Group's operational scheme of delegation that underpins the Group's Scheme of Reservation and Delegation within the Constitution.		Governing Body			Chief Officer	Chief Officer
1. Approval of the Group's detailed financial policies that are underpinned by the Prime Financial Policies within the Constitution including a) thresholds above which quotations or formal tenders must be obtained b) arrangements for seeking professional advice regarding the supply of goods and services c) delegated limits for the certification of invoices d) raising of orders.		Governing Body	Audit Committee		CFO	CFO
2. Executing a document by signature or use of the Group's seal.				Chair or CFO or Chief Officer		Chief Officer
Practice Member Representatives & Members of the Governing Body						
Approve the arrangements for identifying practice representatives for the Wider Constituent Meeting	Wider Constituent Meeting				Chair	Chief Officer
Approve the arrangements for appointing clinical leaders to the Group's Governing Body.	Wider Constituent Meeting				Chair	Chief Officer
Approve the arrangements for appointing the non-GP members to the Group's Governing Body (other than Chief Officer).	Wider Constituent Meeting				Chair	Chief Officer
Approve arrangements for recruiting the Group's Chief Officer.	Wider Constituent Meeting				Chair	Chair

Reserved or Delegated Matter	Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
			Governing Body or Committee	Individual Member or Officer		
Strategy and Planning						
Approve the Group's vision, values and overall strategic direction.	Wider Constituent Meeting				Chair	Chief Officer
Approve the Group's Operating Structure.		Governing Body			Chief Officer	Chief Officer
Approve the Group's Commissioning Plan.	Wider Constituent Meeting				Chief Officer	Chief Officer
Approve the Group's Financial Strategy and Annual Budget which meet the financial duties of the Group.		Governing Body			CFO	CFO
Approve the Group's arrangements for engaging the public and key stakeholders in the Group's planning and commissioning arrangements.		Governing Body			Chief Officer	Chief Officer
Approve variations to the approved budgets where variation would impact on the overall approved levels of income and expenditure or the Group's ability to achieve its strategic aims.		Governing Body			CFO	CFO
Approve a recovery plan where the CCG is faced with a deficit in excess of 1% or poor performance puts the Group's continued authorisation in doubt.		Governing Body			Chief Officer and CFO	Chief Officer and CFO
Annual Reports and Accounts						
Approval of the Group's Annual Accounts.			Audit Committee		CFO	CFO
Approval of the Group's Annual Report.			Audit Committee		Chief Officer	Chief Officer
Approval of appointment of auditors and their annual audit plans.			Audit Committee		CFO	CFO

Reserved or Delegated Matter	Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
			Governing Body or Committee	Individual Member or Officer		
Approval of arrangements for discharging the Group's statutory financial duties.			Audit Committee		Chief Officer	CFO
Human Resources and Organisational Development						
Approve the terms and conditions, remuneration and travelling or other allowances for Governing Body members and including pensions and gratuities.	Wider Constituent Meeting		Remuneration Committee		Chief Officer (exc. own post)	Chief Officer (exc. own post)
Approve other terms and conditions of service for all employees of the Group including pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the Group.		Governing Body	Remuneration Committee		Chief Officer	Chief Officer
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.			Remuneration Committee		Chief Officer / Chair (if Chief Officer)	Chief Officer / Chair (if Chief Officer)
Approve disciplinary arrangements where the Group has joint appointments with another Group and the individuals are employees of that Group.			Remuneration Committee		Chief Officer	Chief Officer
Approve the Group's succession planning for elected members on the Governing Body.	Wider Constituent Meeting				Chief Officer	Chief Officer
Approve the arrangements for discharging the Group's statutory duties as an employer.		Governing Body			Chief Officer	Chief Officer
Approve Organisational Development Plans.		Governing Body			Chief Officer	Chief Officer
Approve HR policies.			Quality		Chief Officer	Chief Officer

Reserved or Delegated Matter	Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
			Governing Body or Committee	Individual Member or Officer		
			Committee			
Quality and Safety						
Approve arrangements including supporting policies to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.			Quality Committee		Chief Officer	Chief Nurse
Approve the arrangements for handling complaints.			Quality Committee		Chief Nurse	Chief Nurse
Approve arrangements for safeguarding children and adults.		Governing Body			Chief Nurse	Chief Nurse
Approve the Group's arrangements for engaging patients and their carers in decisions concerning their healthcare.			Quality Committee		Chief Nurse	Chief Nurse
Approve arrangements for supporting the NHSCB in discharging its responsibilities to secure continuous improvement in the quality of general medical services.			Quality Committee		Chief Officer	Chief Nurse
Operational and Risk Management						
Approve counter fraud and security management arrangements.			Audit Committee		CFO	CFO
Approve risk management arrangements			Quality Committee		Chief Nurse	Chief Nurse
Approve arrangements for risk sharing and or risk pooling with other organisations including Section 75 agreements.		Governing Body	Governing Body		Chief Officer	Chief Officer
Approve a comprehensive system of internal control, including budgetary control, which underpins the effective, efficient and economic operation of the Group.			Audit Committee		Chief Officer	CFO
Approve the thresholds above which quotations or formal tenders must be obtained.		Governing Body			CFO	CFO

Reserved or Delegated Matter	Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
			Governing Body or Committee	Individual Member or Officer		
Approve the arrangements for seeking professional advice regarding the supply of goods and services.		Governing Body			CFO	CFO
Approve proposals for action on litigation against or on behalf of the Group.				Chief Officer and CFO together	Chief Officer	Chief Officer
Approve arrangements for emergency planning and business continuity.			Quality Committee		Chief Officer	Chief Officer
Approve banking arrangements.			Finance & Resource Committee		CFO	CFO
0. Approve the arrangements for the proper safekeeping of records in accordance with NHS procedures and information governance requirements.			Quality Committee		Chief Nurse	Chief Nurse
Partnership, Joint and Collaborative Working						
Approve the arrangements governing joint or collaborative working between the Group and other statutory bodies where those arrangements incorporate decision making responsibilities.		Governing Body			Chief Officer	Chief Officer
Approve the delegated decision making responsibilities of individuals who represent the Group in joint or collaborative arrangements with other statutory bodies.		Governing Body			Chief Officer	Chief Officer
Review the minutes of meetings of, or reports from, joint or collaborative arrangements with other statutory bodies.		Governing Body			Chief Officer	Chief Officer
Authorise an individual to act on behalf of the Group in discharging the Group's duty in respect of statutory and local joint working arrangements within the financial limits determined under sections 9 and 10 of this scheme of reservation and delegation.		Governing Body			Chief Officer	Chief Officer

Reserved or Delegated Matter	Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
			Governing Body or Committee	Individual Member or Officer		
Tendering						
Approve the group's tendering arrangements for any commissioned or corporate support service in excess of £500,000 per annum.		Governing Body			CFO	CFO
Approve the group's tendering arrangements for any commissioned or corporate support service with a value below £500,000 per annum.				Chief Officer and Chair together	CFO	CFO
Approve the award of tender for any service or contract in excess of £500,000 per annum.		Governing Body			CFO	CFO
Approve the award of tender for any service or contract less than £500,000 per annum.				Chief Officer and Chair together	CFO	CFO
Commissioning and Contracting for Clinical Services						
1. Approve arrangements (including individual authority to act, where appropriate) for discharging the Group's statutory responsibilities for commissioning clinical services including collaborative arrangements with a) other CCGs b) NHS England c) Local Authorities.		Governing Body			Chief Officer	Chief Officer
2. Sign off annual contract renewals for clinical services with health care providers.				Chair or CFO or Chief Officer	CFO	CFO
3. Determine arrangements for handling requests for exceptional or "novel" individual patient treatments.			Finance & Resources Committee		Chief Officer	CFO

Reserved or Delegated Matter	Matter Reserved to the Membership	Matter Reserved to the Governing Body	Delegated to		Responsible for Preparing or Recommending a Course of Action	Operational Responsibility
			Governing Body or Committee	Individual Member or Officer		
Commissioning and Contracting for Non-Clinical Services						
1. Approve arrangements (including individual authority to act, where appropriate) for discharging the Group's statutory responsibilities for commissioning clinical services including collaborative arrangements with a) other CCGs b) NHS England c) Local Authorities.		Governing Body			Chief Officer	Chief Officer
2. Sign off annual contract renewals for non-clinical services with providers.				Chair or CFO or Chief Officer	CFO	CFO
Communications						
1. Approve arrangements and policies for communication including a) handling Freedom of Information requests b) public engagement on commissioning decisions c) press enquiries.		Governing Body			Chief Officer	Chief Officer

APPENDIX E – PRIME FINANCIAL POLICIES

1. INTRODUCTION

1.1. General

1.1.1. These prime financial policies and supporting detailed financial policies shall have effect as if incorporated into the group's constitution.

1.1.2. The prime financial policies are part of the group's control environment for managing the organisation's financial affairs. They contribute to good corporate governance, internal control and managing risks. They enable sound administration; lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. They also help the Chief Officer and Chief Finance Officer to effectively perform their responsibilities. They should be used in conjunction with the scheme of reservation and delegation found at Schedule 15.

1.1.3. In support of these prime financial policies, the group has prepared more detailed policies, approved by the Chief Finance Officer, known as detailed financial policies. The group refers to these prime and detailed financial policies together as the clinical commissioning group's financial policies.

1.1.4. These prime financial policies identify the financial responsibilities which apply to everyone working for the group and its constituent organisations. They do not provide detailed procedural advice and should be read in conjunction with the detailed financial policies. The Chief Finance Officer is responsible for approving all detailed financial policies.

1.1.5. A list of the group's detailed financial policies will be published and maintained on the group's website at www.southportformbyccg.org.uk.

1.1.6. Should any difficulties arise regarding the interpretation or application of any of the prime financial policies then the advice of the Chief Finance Officer must be sought before acting. The user of these prime financial policies should also be familiar with and comply with the provisions of the group's constitution, standing orders and scheme of reservation and delegation.

1.1.7. Failure to comply with prime financial policies and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

1.2. Overriding Prime Financial Policies

1.2.1. If for any reason these prime financial policies are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Governing Body's audit committee for referring action or ratification. All of the group's members and employees have a duty to disclose any non-compliance with these prime financial policies to the Chief Finance Officer as soon as possible.

1.3. Responsibilities and delegation

1.3.1. The roles and responsibilities of group's members, employees, members of the Governing Body, members of the Governing Body's committees and sub-committees, members of the group's committee and sub-committee (if any) and persons working on behalf of the group are set out in chapters 6 and 7 of this constitution.

1.3.2. The financial decisions delegated by members of the group are set out in the group's scheme of reservation and delegation (see Schedule 14).

1.4. Contractors and their employees

1.4.1. Any contractor or employee of a contractor who is empowered by the group to commit the group to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Officer to ensure that such persons are made aware of this.

1.5. Amendment of Prime Financial Policies

1.5.1. To ensure that these prime financial policies remain up-to-date and relevant, the Chief Finance Officer will review them at least annually. Following consultation with the Chief Officer and scrutiny by the Governing Body's audit committee, the Chief Finance Officer will recommend amendments, as fitting, to the Governing Body for approval. As these prime financial policies are an integral part of the group's constitution, any amendment will not come into force until the group applies to NHS England and that application is granted.

2. INTERNAL CONTROL

POLICY – the group will put in place a suitable control environment and effective internal controls that provide reasonable assurance of effective and efficient operations, financial stewardship, probity and compliance with laws and policies

2.1. The Governing Body is required to establish an Audit Committee with terms of reference agreed by the Governing Body (see Schedule 9).

2.2. The Chief Officer has overall responsibility for the group's systems of internal control.

2.3. The Chief Finance Officer will ensure that:

a) prime financial policies are considered for review and updated when appropriate annually;
b) detailed financial policies are considered for review and updated where appropriate at least bi-annually;
c) a system is in place for proper checking and reporting of all breaches of financial policies; and
d) a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

3. AUDIT

POLICY – the group will keep an effective and independent internal audit function and fully comply with the requirements of external audit and other statutory reviews

3.1.1. In line with the terms of reference for the Governing Body's audit committee, the person appointed by the group to be responsible for internal audit and the Audit Commission appointed external auditor will have direct and unrestricted access to audit committee members and the chair of the Governing Body, Chief Officer and Chief Finance Officer for any significant issues arising from audit work that management cannot resolve, and for all cases of fraud or serious irregularity.

3.1.2. The person appointed by the group to be responsible for internal audit and the external auditor will have access to the audit committee and the Chief Officer to review audit issues as appropriate. All audit committee members, the chair of the Governing Body and the Chief Officer will have direct and unrestricted access to the head of internal audit and external auditors.

3.1.3. The Chief Finance Officer will ensure that:

a) the group has a professional and technically competent internal audit function; and
b) the Governing Body approves any changes to the provision or delivery of assurance services to the group.

4. FRAUD AND CORRUPTION

POLICY – the group requires all staff to always act honestly and with integrity to safeguard the public resources they are responsible for. The group will not tolerate any fraud perpetrated against it and will actively chase any loss suffered

4.1. The Governing Body's Audit Committee will satisfy itself that the group 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.

4.2. The Governing Body's audit committee will ensure that the group has arrangements in place to work effectively with NHS Protect.

5. EXPENDITURE CONTROL

5.1. The group is required by statutory provisions to ensure that its expenditure does not exceed the aggregate of allotments from NHS England and any other sums it has received and is legally allowed to spend.

5.2. The Chief Officer has overall executive responsibility for ensuring that the group complies with certain of its statutory obligations, including its financial and accounting

obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

5.3. The Chief Finance Officer will:

a) provide reports in the form required by NHS England
b) ensure money drawn from NHS England is required for approved expenditure only is drawn down only at the time of need and follows best practice
c) be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of NHS England.

6. ALLOTMENTS

6.1. The group's Chief Finance Officer will:

a) periodically review the basis and assumptions used by NHS England for distributing allotments and ensure that these are reasonable and realistic and secure the group's entitlement to funds;
b) prior to the start of each financial year submit to the Governing Body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and
c) regularly update the Governing Body on significant changes to the initial allocation and the uses of such funds.

7. COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

POLICY – the group will produce and publish an annual commissioning plan that explains how it proposes to discharge its financial duties. The group will support this with comprehensive medium term financial plans and annual budgets

7.1. The Chief Officer will compile and submit to the Governing Body a commissioning strategy which takes into account financial targets and forecast limits of available resources.

7.2. Prior to the start of the financial year the Chief Finance Officer will, on behalf of the Chief Officer, prepare and submit budgets for approval by the Governing Body.

7.3. The chief financial officer shall monitor financial performance against budget and plan, periodically review them, and report to the Governing Body. This report should include explanations for variances. These variances must be based on any significant departures from agreed financial plans or budgets.

7.4. The Chief Officer is responsible for ensuring that information relating to the group's accounts or to its income or expenditure, or its use of resources is provided to NHS England as requested.

7.5. The Chief Officer will approve consultation arrangements for the group's commissioning plan.

8. ANNUAL ACCOUNTS AND REPORTS

POLICY – the group will produce and submit to NHS England accounts and reports in accordance with all statutory obligations, relevant accounting standards and accounting best practice in the form and content and at the time required by NHS England

8.1. The Chief Finance Officer will ensure the group:

a) prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Governing Body
b) prepares the accounts according to the timetable approved by the Governing Body
c) complies with statutory requirements and relevant directions for the publication of annual report
d) considers the external auditor's management letter and fully address all issues within agreed timescales; and
e) publishes the external auditor's management letter on the group's website at www.southportformbyccg.org.uk.

9. INFORMATION TECHNOLOGY

POLICY – the group will ensure the accuracy and security of the group's computerised financial data

9.1. The Chief Finance Officer is responsible for the accuracy and security of the group's computerised financial data and shall

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the group's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998
b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system
c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment
d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Finance Officer may consider necessary are being carried out.

9.2. In addition the Chief Finance Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

10. ACCOUNTING SYSTEMS

POLICY – the group will run an accounting system that creates management and financial accounts

10.1. The Chief Finance Officer will ensure:

a) the group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of NHS England

b) that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

10.2. Where another health organisation or any other agency provides a computer service for financial applications, the Chief Finance Officer shall periodically seek assurances that adequate controls are in operation.

11. BANK ACCOUNTS

POLICY – the group will keep enough liquidity to meet its current commitments

11.1. The Chief Finance Officer will:

a) review the banking arrangements of the group at regular intervals to ensure they are in accordance with Secretary of State directions, best practice and represent best value for money
b) manage the group's banking arrangements and advise the group on the provision of banking services and operation of accounts
c) prepare detailed instructions on the operation of bank accounts.

11.2. The Chief Finance Officer shall approve the banking arrangements.

12. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

POLICY – the group will

- operate a sound system for prompt recording, invoicing and collection of all monies due
- seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the group or its functions
- ensure its power to make grants and loans is used to discharge its functions effectively

12.1. The Chief Financial Officer is responsible for:

a) designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due
b) establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments
c) approving and regularly reviewing the level of all fees and charges other than those determined by NHS England or by statute. Independent professional advice on matters of valuation shall be taken as necessary
d) for developing effective arrangements for making grants or loans.

13. TENDERING AND CONTRACTING PROCEDURE

POLICY – the group:
will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending
will seek value for money for all goods and services
shall ensure that competitive tenders are invited for
- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals

13.1. The group shall ensure that the firms / individuals invited to tender (and where appropriate, quote) are among those on approved lists or where necessary a framework agreement. Where in the opinion of the Chief Finance Officer it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Officer or the group's finance and remuneration committee.

13.2. Contracts may only be negotiated on behalf of the group by those committees or individuals authorised to do so in the group's scheme of reservations and delegation, and the group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

a) the group's constitution
b) the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and
c) take into account as appropriate any applicable NHS England or the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above.

13.3. In all contracts entered into, the group shall endeavour to obtain best value for money. The Chief Officer shall nominate an individual who shall oversee and manage each contract on behalf of the group. The scope of individual responsibilities in relation to contracting and contract values shall be set out in the group's detailed scheme of reservation and delegation which will be published on the group's website www.southportformbyccg.org.uk.

14. COMMISSIONING

POLICY – working in partnership with relevant national and local stakeholders, the group will commission certain health services to meet the reasonable requirements of the persons for whom it has responsibility

14.1. The group will coordinate its work with NHS England, other clinical commissioning groups, and local providers of services, local authority(ies), including through Health & Wellbeing Boards, patients and their carers and the voluntary sector and others as appropriate to develop robust commissioning plans.

14.2. The Chief Officer will establish arrangements to ensure that regular reports are provided to the Finance and Resources committee detailing actual and forecast expenditure and activity for each contract. The Chief Officer will also ensure that the group's membership council is kept informed of the group's expenditure against contracts in accordance with arrangements for reporting agreed with the membership council.

14.3. The Chief Finance Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.

15. RISK MANAGEMENT AND INSURANCE

POLICY – the group will put arrangements in place for evaluation and management of its risks. Where available and appropriate insurance arrangements will support evaluated key risks.

15.1. The group's Chief Officer will ensure that the group has a robust and effective risk management policy, which has been approved by the group's Governing Body. This will include:

a) a procedure for identifying and qualifying risks and potential liabilities throughout the group

b) suitable management procedures to mitigate all significant risks and potential liabilities; and

c) arrangements to review risk management procedures periodically.

15.2. The group's Chief Officer will ensure that a report will be presented to the Governing Body's Audit Committee at least bi-annually on the key risks and the procedures for managing them. The Chief Finance Officer will undertake to present this report on behalf of the Chief Officer.

15.3. The Governing Body's Audit Committee must approve any significant changes to insurance arrangements that increase the risk to the group.

16. PAYROLL

POLICY – the group will put arrangements in place for an effective payroll service

16.1. The Chief Finance Officer will ensure that the payroll service selected:

a) is supported by appropriate (i.e. contracted) terms and conditions
b) has adequate internal controls and audit review processes
c) Has suitable arrangement's for the collection of payroll deductions and payment of these to appropriate bodies.

16.2. In addition the Chief Finance Officer shall set out comprehensive procedures for the effective processing of payroll.

17. NON-PAY EXPENDITURE

POLICY – the group will seek to obtain the best value for money goods and services received

17.1. The Governing Body will approve the level of non-pay expenditure on an annual basis and the Chief Officer will determine the level of delegation to budget managers

17.2. The Chief Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

17.3. The Chief Finance Officer will:

a) advise the Governing Body on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the scheme of reservation and delegation
b) be responsible for the prompt payment of all properly authorised accounts and claims
c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

18. CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

POLICY – the group will put arrangements in place to manage capital investment, maintain an asset register recording fixed assets and put in place polices to secure the safe storage of the group's fixed assets

18.1. The Chief Officer will:

a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans
b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost

c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges
d) be responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

18.2. The Chief Finance Officer will prepare detailed procedures for the disposals of assets.

19. RETENTION OF RECORDS

POLICY – the group will put arrangements in place to retain all records in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance

19.1. The Chief Officer shall:

a) be responsible for maintaining all records required to be retained in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance
b) ensure that arrangements are in place for effective responses to Freedom of Information requests
c) publish and maintain a Freedom of Information Publication Scheme.

20. TRUST FUNDS AND TRUSTEES

POLICY – the group will put arrangements in place to provide for the appointment of trustees if the group holds property on trust

20.1. The Chief Finance Officer shall ensure that each trust fund which the group is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

APPENDIX F - NOLAN PRINCIPLES

The 'Nolan Principles' set out the ways in which holders of public office should behave in discharging their duties. The seven principles are as follows.

a) **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

b) **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

c) **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

d) **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

e) **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

f) **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

g) **Leadership** – Holders of public office should promote and support these principles by leadership and example.

Source: *The First Report of the Committee on Standards in Public Life* (1995)[65]

[65] Available at http://www.public-standards.gov.uk/

APPENDIX G – NHS CONSTITUTION

The NHS Constitution sets out seven key principles that guide the NHS in all it does.

1. **The NHS provides a comprehensive service, available to all** - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

2. **Access to NHS services is based on clinical need, not an individual's ability to pay** - NHS services are free of charge, except in limited circumstances sanctioned by Parliament.

3. **the NHS aspires to the highest standards of excellence and professionalism** - in the provision of high-quality care that is safe, effective and focused on patient experience; in the planning and delivery of the clinical and other services it provides; in the people it employs and the education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion and conduct of research to improve the current and future health and care of the population.

4. **NHS services must reflect the needs and preferences of patients, their families and their carers** - patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.

5. **The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population** - the NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being.

6. **The NHS is committed to providing best value for taxpayers' money and the most cost-effective, fair and sustainable use of finite resources** - public funds for healthcare will be devoted solely to the benefit of the people that the NHS serves.

7. **The NHS is accountable to the public, communities and patients that it serves** - the NHS is a national service funded through national taxation, and it is the Government which sets the framework for the NHS and which is accountable to Parliament for its operation. However, most decisions in the NHS, especially those about the treatment of individuals and the detailed organisation of services, are rightly taken by the local NHS and by patients with their clinicians. The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff. The Government will ensure that there is always a clear and up-to-date statement of NHS accountability for this purpose.

Source: *The NHS Constitution: The NHS belongs to us all* (March 2012)[66]

[66] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961

APPENDIX H – COMMITTEE TERMS OF REFERENCE

Audit Committee

1. Authority

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

1.2. The principal functions of the Committee are as follows:

a) To support the establishment of an effective system of integrated governance, risk management and internal control, across the whole of the Group's activities to support the delivery of the Group's objectives.

b) To review and approve the arrangements for discharging the Group's statutory financial duties.

2. Membership

2.1. The following will be members of the Committee:

- Lay Member (Governance) (Chair)
- Lay Member (Patient Experience and Engagement)
- Secondary Care Doctor
- Practice Manager Governing Body Member.

2.2. A Vice Chair will be selected by the Committee from within its membership.

2.3. Other officers required to be in attendance at the Committee are as follows:

- Internal Audit Representative
- External Audit Representative
- Counter Fraud Representative
- Chief Finance Officer
- Chief Nurse.

2.4. The Chair of the CCG will not be a member of the Committee although he/she will be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee's operations.

2.5. Other senior members of the Group may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that Officer. Representatives from NHS Protect may be invited to attend meetings.

2.6. At least once a year the Committee should meet privately with the external and internal Auditors. Regardless of attendance, external audit, internal audit, local counter fraud and security management (NHS Protect) providers will have full and unrestricted rights of access to the Audit Committee.

2.7. Members are expected to personally attend a minimum of 75% of meetings held.

2.8. Relevant Officers from the CCG may be invited to attend dependent upon agenda items. Officers from other organisations including Mersey Commissioning Support Service (MCSS) and from the Local Authority Public Health team may also be invited to attend dependent upon agenda items.

3. Responsibilities of the Committee

The Audit Committee is responsible for:

3.1. reviewing the underlying assurance processes that indicate the degree of achievement of the Group's objectives and its effectiveness in terms of the management of its principal risks;

3.2. ensuring that there is an effective internal audit function which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, the Chief Officer and the Group;

3.3. reviewing the work and findings of the external auditors and consideration of the implications of management responses to their work;

3.4. reviewing policies and procedures for all work relating to fraud and corruption as set out by the Secretary of State Directions and as required by the NHS Protect;

3.5. reviewing findings of other assurance functions (where appropriate) and consider the implications for governance arrangements of the Group (e.g. NHS litigation authority, Care Quality Commission etc.);

3.6. monitoring the integrity of the financial statements of the Group and to consider the implications of any formal announcements relating to the Group's financial performance;

3.7. responding on behalf of the Governing Body, to any formal requirements of the Group in relation to the audit process (e.g. the report from those charged with governance);

3.8. monitoring and review of the CCG Assurance Framework (AF) to support the CCG's integrated governance agenda.

4. Duties of the Committee

The Committee is delegated by the Governing Body to undertake the following duties and any others appropriate to fulfilling the purpose of the Committee (other than duties which are reserved to the Governing Body or Membership alone).

4.1. To review and recommend approval of the detailed financial policies that are underpinned by the Prime Financial Policies within the Group's Constitution to the Group's Governing Body.

4.2. To review and approve the operation of a comprehensive system of internal control, including budgetary control, which underpin the effective, efficient and economic operation of the group.

4.3. To review and approve the annual accounts.

4.4. To review and approve the Group's annual report on behalf of the Governing Body

4.5. To review and approve the arrangements for the appointment of both internal and external audit and their annual audit plans.

4.6. To review and approve the arrangements for discharging the group's statutory financial duties.

4.7. To review and approve the Group's Counter Fraud and Security Management arrangements.

4.8. To review the circumstances relating to any suspensions to the Group's constitution (as set out in the Scheme of Delegation and Reservation) and to report to the Governing Body and Wider Membership Council on the appropriateness of such actions

4.9. To undertake annual review of its effectiveness and provide an annual report to the Governing Body to describe how it discharged its functions during the year.

5. Administration

5.1. The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee's business.

5.2. The agenda for the meetings will be agreed by the Chair of the Committee and papers will be distributed one week in advance of the meeting.

5.3. The Secretary will take minutes and produce action plans as required to be circulated to the members within 10 working days of the meeting.

6. Quorum

6.1. The Audit Committee Chair (or Vice Chair) and one other member will be necessary for quorum purposes.

6.2. The quorum shall exclude any member affected by a Conflict of Interest under the NHS Southport and Formby CCG Constitution. 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.

7. Frequency and notice of meetings.

The Audit Committee shall meet on at least four occasions during the financial year. Internal Audit and External Audit may request an additional meeting if they consider that one is necessary.

8. Reporting

The ratified minutes of Audit Committee will be submitted to the Governing Body. Exception reports will also be submitted at the request of the Governing Body. The ratified minutes will also be sent to the Quality Committee to support its role in monitoring the Group's integrated governance arrangements.

9. Conduct

9.1. 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 Southport and Formby CCG procedure for the management of Conflicts of Interest as set out in the Constitution.

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

Remuneration Committee

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 Southport and Formby CCG procedure for the management of Conflicts of Interest as set out in the Constitution.

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 Cheshire and Merseyside 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:

- Governing Body Member (Chair)
- Clinical 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 Lay 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 Southport and Formby 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 Southport and Formby 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.

Finance and Resources Committee

Terms of Reference

1. Authority

1.1. The Finance and Resource Committee shall be established as a committee of the Governing Body to perform the following functions on behalf of the CCG Governing Body.

1.2. The principal functions of the Committee are as follows:

- The Committee shall be authorised by the CCG Governing Body to undertake any activity within these terms of reference and act within the powers delegated to it in line with the Scheme of Reservation and Delegation.

- To provide assurance to the Governing Body that there are appropriate systems in place which operate in order to enable the Committee to fulfil its monitoring requirements.

- To provide regular reports to the Governing Body on a timely basis and to provide an annual report on the work carried out by the Committee including a self-assessment of how it has discharged its functions and responsibilities.

2. Membership

2.1. The following will be members of the Committee:

- Lay Member (Governance) (Chair)
- Clinical Governing Body Member (Vice Chair)
- Clinical Governing Body Member
- Lay Member (Patient Experience and Engagement)
- Practice Manager Governing Body Member
- Locality Clinical Representatives
- Chief Financial Officer
- Head of Primary Care and Corporate Performance
- Head of CCG Corporate Delivery and Integration
- Head of CCG Development
- Chief Nurse

The Chief Officer shall be an ex-offico member of the Committee

2.2. The Chair of the Governing Body will not be a member of the Committee although he/she will be invited to attend one meeting each year in order to form a view on, and understanding of, the Committee's operations.

2.3. Members are expected to personally attend a minimum of 60% of meetings held and can send a deputy to attend in their absence as required.

2.4. Relevant Officers from the CCG will be invited to attend in line with agenda items. Officers from other organisations including Cheshire and Mersey Commissioning Support Unit (CMSCU) and from the Local Authority Public Health team will also be invited to attend in line with agenda items.

3. Responsibilities of the Committee

The Finance and Resources Committee is responsible for the following.

3.1. Advising the Governing Body on all financial matters and to provide assurance in relation to the discharge of statutory functions in line with the Prime Financial Policies

3.2. Reviewing the overall financial position of the CCG to ensure that the organisation meets its statutory financial duties.

3.3. Overall financial management of the organisation including the delivery of investment plans, monitoring of reserves, and delivery of financial recovery plans and cost improvement plans.

3.4. Ensuring that the performance of commissioned services is monitored in line with CCG expectations.

3.5. Monitoring key performance indicators (e.g. any outlined in the NHS Operating Framework).

3.6. Advising the Governing Body on the approval of annual financial plans.

3.7. Monitoring and advising appropriate courses of action with regard to other key areas of CCG business (notably procurement, contracting and monitoring progress of Foundation Trust (FT) applications of local providers.

3.8. Supporting the work of the Audit Committee through review of financial arrangements as required.

3.9. Determining banking arrangements

3.10. Approving arrangements for exceptional/novel treatments which shall include arrangements for review and consideration of Individual Funding Requests (IFRs)

3.11. Reviewing and approving requests for Ex-Gratia payments

3.12. To receive recommendations from the local Individual patient review (IFR) panel and approve as appropriate.

4. Duties of the Committee

The Committee is delegated by the Governing Body to undertake the following duties and any others appropriate to fulfilling the purpose of the Committee (other than duties which are reserved to the Governing Body or Membership alone).

4.1. Oversee the development of the short and medium-term strategies for the CCG including assessment of the assumptions underpinning the financial models.

4.2. To ensure the delivery of financial balance and that the organisation meets its statutory financial targets.

4.3. Ensure that the Finance and Performance Plans are consistent with and complementary to the CCGs Annual Budget, Commissioning Plan ("One Plan") and Strategic Plan.

4.4. To monitor implementation of the annual financial plan to ensure that the total resource available to CCG is invested in high quality services that support the achievement and delivery of specified priorities.

4.5. Approving any variations to planned investment within the limits set out in the detailed financial policies of the CCG, ensuring that any amended plans remain within the overall CCG budget and do not adversely affect the strategic performance of the CCG.

4.6. Monitoring Financial and Operational Performance across all commissioned services on an exception basis, assessing potential shortfalls and risk and recommending actions to address them.

4.7. Monitoring Key Performance Indicators (KPIs) relating to CCG performance, for example as outlined in the NHS Operating Framework and One Plan.

4.8. Monitoring delivery of any QIPP programmes and agreeing corrective action if required.

4.9. Monitor key risks facing the CCG, understand the financial consequences and make recommendations for inclusion on the CCG risk register accordingly.

4.10. Oversee the development and delivery of capital investment plans including any schemes progressed through the LIFT or 3PD initiatives.

4.11. Oversee the development and implementation of the Estates strategy.

4.12. Oversee the development and implementation of Human Resource strategies, plans and policies.

4.13. Maintain an overview of recruitment, retention, turnover and sickness trends.

4.14. To ensure that services provided by other organisations, notably Cheshire and Merseyside CSU, are being delivered as per the CCG's expectations and to advise on remedial action where necessary.

4.15. To review, monitor and agree corrective action for all agreed financial performance indicators (KPIs to be determined based on CCG finance regime when published).

4.16. To review the CCG procurement strategy and advise on an appropriate course of action regarding commissioning of new services / re-tendering arrangements for existing services.

4.17. To review and monitor progress regarding contracting arrangements with healthcare providers.

4.18. To monitor progress of local provider plans, particularly aspirant FTs, to advise the Governing Body in terms of key issues and any recommend decisions as appropriate.

4.19. The Committee will review monthly reports detailing performance of commissioned services against core standards, national and local targets and the CCGs Strategic Plans, review may be on an exception basis.

4.20. To receive and consider the approval of business cases and proposals from the Service Improvement and Re-Design Committee and to approve such cases and proposals up to a value of £200K (subject to budgetary resources being available)

4.21. To recommend business cases to the Governing Body for approval when the value of the business case or proposal exceeds £200K

4.22. To review and approve plans for Emergency Planning and Business Continuity

4.23. **To produce an Annual Report of the key work programmes of the Committee to the Governing Body on an annual basis.**

5. Establishment of Sub-Groups of the Committee

5.1. The Committee will undertake regular review of its workload and will from time to time establish sub-groups to ensure that it conducts its business in an effective and appropriate manner. These sub groups will be required to provide key update reports as stipulated by the Finance and Resources Committee and submit ratified notes of meetings to the Finance and Resources Committee.

6. Administration

6.1. The Committee will be supported by an appropriate Secretary that will be responsible for supporting the Chair in the management of the Committee's business.

6.2. The agenda for the meetings will be agreed by the Chair of the Committee and papers will be distributed one week in advance of the meeting.

6.3. The Secretary will take minutes and produce action plans as required to be circulated to the members within 10 working days of the meeting.

7. Quorum

7.1. Meetings with at least 50% of the Committee membership, at least one Clinical Governing Body Member, at least one Lay Person and either the Chief Officer or Chief Finance Officer in attendance shall be quorate for the purposes of the CCG's business.

7.2. 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.

Frequency and notice of meetings

The Committee shall meet at least 8 times a year. Members shall be notified at least 10 days in advance that a meeting is due to take place.

8. Reporting

The ratified minutes of the Finance and Resources Committee will be submitted to the Governing Body private meeting. Exception reports will also be submitted at the request of the Governing Body. The minutes and key issues arising from this meeting will be submitted to the Audit Committee.

9. Conduct

9.1. 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.

9.2. In the event that there is a Conflict of Interest declared before or during a meeting the procedure for dealing with Conflicts of Interest as set out in the NHS Southport and Formby CCG Constitution shall apply.

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

Approvals (Conflicts of Interest) Committee

Terms of Reference

10. Authority

The Approvals Committee (the Committee) is established in accordance with NHS Southport and Formby Clinical Commissioning Group's (the CCG) Constitution, Standing Orders and Scheme of Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee.

11. Membership

The Approvals Panel will have the following membership:

- Deputy Chair (Lay member)
- Chief Officer
- Chief Finance Officer
- Chief Nurse
- Secondary Care Clinician
- Lay member Stakeholder engagement
- Patient representative

Other representatives in attendance, to provide clinical or procurement expertise as necessary, at the discretion of the Chief Officer.

12. Responsibilities of the Committee

The role of the Committee will be to provide neutrality in the evaluation and decision making processes. It will be made up of non-conflicted members of the Governing Body and its decisions will be noted by the Governing Body.

The Approvals Committee is responsible for ensuring that the CCG applies conflict of interest principles and policies rigorously and provides the CCG with independent advice and judgment where there is any doubt about how to apply them to individual or group cases involving commissioning clinical services.

The Approval Committee's responsibilities are to:

- judge whether or not there is a risk of a conflict of interest existing or arising
- confirm the appropriateness or otherwise of their handling of the matter as the best way to manage the risks.
- Provide advice to the CCG GB as to any other course of action which may be desirable or more appropriate on the matter under consideration

The Committee will operate:

- reactively, when the Chair of a meeting, individual Governing Body member, or Southport and Formby CCG as a whole seeks advice on a specific issue involving the commissioning of any clinical services,

- proactively, when such a potential Conflict of Interest risk is identified and acts on it.

In either mode, the Approvals Committee will discuss the issue with those involved (and any other relevant party) and issue its written decision, advice or judgement for the Governing Body. The members of the Governing Body, its committees and sub-committees will agree that they will accept the decision advice or judgement of the Committee in such cases.

The existence of the Committee does not preclude the Governing Body / or committee from discussing the appropriateness of certain clinical services or the desirability of significant investment in clinical services. The Committee would assume such informed discussion had taken place prior to items being submitted to it. The Committee does not replace the Governing Body and its committees but works with appropriate information to take the formal decision.

It should be noted that other conflicts of interest may arise that are not around the commissioning of clinical services and such conflicts are not currently proposed to be managed by this Committee.

13. Administration

The Committee Chair and Panel will be provided with appropriate support in the management of the Committee's business and will have dedicated administrative support.

14. Quorum

The Committee Chair or Vice Chair and at least 3 voting members. If exceptionally, any of the members are conflicted, an additional member will be substituted.

15. Frequency and notice of meetings.

The Committee will meet monthly or as necessary (virtually via teleconference or other means where applicable).

Members shall be notified at least 10 days in advance that a meeting is due to take place. Agendas and reports shall be distributed to members at least 5 working days in advance of the meeting date.

16. Reporting

The Governing Body will receive and note the Panel's conclusions and ratified minutes of the Approvals Committee.

17. Conduct

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 Southport and Formby CCG procedure for the management of Conflicts of Interest as set out in the Constitution.

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

Service Improvement and Re-Design Joint Committee

Terms of Reference

18. Authority

The Service Improvement and Re-Design Committee has been established as a joint committee of the Governing Bodies of Southport and Formby CCG and South Sefton CCG.

The purpose of the Joint Committee is to enable thorough and open discussion about all service improvement and re-design priorities for both CCGs.

It will provide a forum for South Sefton CCG and Southport and Formby CCG localities, their practices clinical leads, Clinical Director, CCG locality leads and practice representatives to identify potential areas of improvement and support plans and proposals for implementation.

The Joint Committee does ***not*** have power to authorise expenditure and any proposals in respect of the allocation of resources shall be submitted to the Finance and Resources Committee of each CCG for consideration of approval.

Nothing in these terms of reference shall prevent the "Localities" from retaining their ability to utilise their allocated ***total*** improvement budget of £50K per annum.

19. Membership

The following will be members of the Committee:

- Clinical Director Lead – Strategy
- Clinical Director Lead – Redesign
- Clinical Director Lead - Corporate
- Head of Strategic Planning and Assurance (joint post for both CCGs)
- Head of Commissioning and Re-Design (joint post for both CCGs)
- CCG Finance Lead (joint post for both CCGs)
- Head of Corporate Delivery and Integration (joint post for both CCGs)
- Locality Leads
- GP Governing Body Members
- Chief Nurse (joint post for both CCGs)
- Programme Lead for Quality and Safety (joint post for both CCGs)
- Deputy Head of Quality and Safety and Medicines Management Lead, (joint post for both CCGs)
- Locality Manager with lead for Primary Care

The Committee will nominate a Vice Chair at its inaugural meeting. A Vice Chair will be nominated each time the Chair rotates.
All Members are required to nominate a deputy to attend in their absence. Deputies will count towards the quorum.
All members are expected to attend a minimum of 50% of meetings held.
Chair

Chairing of the Committee shall be done on a rotational basis to ensure a blend of leadership in Strategy, Re-Design and Corporate delivery. Each Chair will serve for a period of six months on the following basis.

- Clinical Director Lead for Strategy – September 2014 – February 2015
- Clinical Director Lead for Re-design – March 2015 – August 2015
- Clinical Director Lead for Corporate Delivery – September 2015 – February 2016

20. Responsibilities of the Committee

- **Identifying, prioritising and supporting service improvement and re-design opportunities**
- **Engaging and involving all relevant stakeholders on service improvement and re-design opportunities**
- **Developing Business Cases for service improvement and re-design programmes**
- **Monitoring and Evaluation of all service improvement and re-design programmes**

21. Duties of the Committee

Identifying, prioritising and supporting service improvement and re-design opportunities

- To identify potential areas of service improvement in all localities and provide recommendations to SMT and Governing Body
- To support service improvements in Primary Care
- Consider utilisation of various improvement models
- To develop an annual service improvement and re-design plan that is prioritised in accordance with the CCGs Strategic Plan
- To support the development of the CCGs commissioning intentions and to make recommendations to the Governing Body

Developing Business Cases for service improvement and re-design programmes

- To determine the rationale and evidence base supporting the need for improvement
- To support the development of business cases
- To recommend business cases for approval to the Finance and Resources Committee[67i]
- To ensure that all service improvement proposals take account of national recommendations such as the Francis report.

[67] The Finance and Resources Committee can approve business cases up to a value of £200K, subject to availability of budgetary resources. All other business cases will require sign off by the Governing Body following recommendation by the Finance and Resources Committee and subject to resources available.

- To ensure that the financial resources are available within an identified budget before making a recommendation to the Finance and Resources Committee
- To assess business cases for service improvement or re-design and provide assurances that they contribute to the delivery of the CCGs Strategic Plan
- To ensure that all service reviews, business cases and the implementation of new services comply with all relevant laws and legislation including duties in respect of:
    - Engagement
    - Consultation
    - Overview and Scrutiny
    - Equality and Diversity
    - Procurement

Engaging and involving all relevant stakeholders on service improvement and re-design opportunities

- Engage with localities, their practices and clinical leads to ensure they are fully involved with the strategic planning of the CCG
- To facilitate engagement with all stakeholders
- To liaise with Engagement and Patient Experience Group to ensure "patient voice" is appropriately reflected in all proposals
- Ensure the right people are involved in the project
- Ensure appropriate communications channels are in place

Monitoring and Evaluation of all service improvement and re-design programmes

- Ensure each programme of service improvement has an identified clinical lead and operational lead
- To monitor the progress of all service reviews and ensure there are robust project management arrangements to assure successful delivery of service review programmes.
- Ensure robust KPIs are in place for the monitoring of all schemes
- To monitor and measure impact of improvements and ensure delivery of the anticipated clinical and financial benefits
- To monitor programmes including, but not limited to, Virtual Ward, Care Close to Home, Children's, Mental Health, planned and unplanned care
- Ensure that work of the Cheshire and Merseyside Commissioning Support Unit is aligned to support successful delivery of programmes
- Ensure there are appropriate arrangements for measuring and monitoring change.

22. Administration

PA to the Head of Strategic Planning and Assurance shall provide secretarial support to the Committee.
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.
The minutes of the meeting will be produced in 10 working days.

23. Quorum

The quorum shall consist of the Chair the Committee (or Vice Chair), a representative CCG Locality Lead, 1 CCG Head of Service, at least 2 clinical representatives (one of whom may be the Chair or Vice Chair)

24. Frequency and notice of meetings and reporting

The Committee will meet at least 6 times per year and submit the ratified minutes of its meeting to the next available Governing Body meeting of each CCG.
The Committee will submit Key Issues reports to the Governing Body of each to ensure that the Governing Bodies are full apprised of the work of the joint committee.
The jointly appointed Accountable Officer of both CCGs of will provide an annual report on the work of the Committee to the Governing Bodies.

25. Conduct

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 and NHS Southport and Formby CCG procedures for the management of Conflicts of Interest as set out in the Constitution.
All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

NHS Southport and Formby CCG and NHSE Joint Commissioning Committee

Terms of Reference

Background

Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would jointly commission primary medical services.

Area covered by Joint Commissioning arrangements

The NHS England and **NHS Southport and Formby CCG** joint commissioning committee is a joint committee with the primary purpose of jointly commissioning primary medical services for the people of Southport and Formby.

Statutory Framework

The National Health Service Act 2006 (as amended) ("**NHS Act**") provides, at section 13Z, that NHS England's functions may be exercised jointly with a CCG, and that functions exercised jointly in accordance with that section may be exercised by a joint committee of NHS England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between NHS England and the CCG.

Role of the Joint Committee

The role of the Joint Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England

This includes the following activities:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);

- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");

- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

In performing its role the Joint Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Southport and Formby CCG, which will sit alongside the delegation and terms of reference.[68]

Geographical coverage

The Joint Committee will comprise NHS England **Cheshire and Merseyside Sub Regional Team** and the **NHS Southport and Formby** CCG. It will undertake the function of jointly commissioning primary medical services for Southport and Formby.

Membership (to be completed following discussion and agreement with Area Team)

The Joint Committee shall consist of:

- **Lay Chair**
- **Director** - NHSE Cheshire and Merseyside Sub Regional Team Director (or other Senior Manager as nominated by the Cheshire and Merseyside Sub Regional Team) with delegated authority to make decisions
- **Primary Care Lead – NHSE**
- **S&F CCG Chief Commissioning and Re-design Officer**
- **GP Clinical Lead – S&F CCG**
- **GP Clinical Lead – S&F CCG**

The membership will meet the requirements of **NHS Southport and Formby** CCG's constitution.

The Chair of the Joint Committee shall be the **Lay Chair for Governance** of the **NHS Southport and Formby CCG**

The Vice Chair, who shall be a Lay Member[69] of the Joint Committee will be **determined by the Committee at the inaugural meeting**

[68] *This is the proposed agreement to deal with such as information sharing, resource sharing, contractual mechanisms for service delivery (and ownership) and interplay between contractual and performance list management.*

[69] A Lay Member is defined as a "non clinician"

Non-voting attendees

The following representatives will have a standing invitation to all meetings of the committee

- HealthWatch Representative
- Health and Wellbeing Board Representative

Meetings and Voting

The Joint Committee shall adopt the Standing Orders of **NHS Southport and Formby CCG** insofar as they relate to the:

a) Notice of meetings;

b) Handling of meetings;

c) Agendas;

d) Circulation of papers; and

Conflicts of Interest

The committee shall, at all times, have regard for NHS Southport and Formby CCG policy on Conflicts of Interest that now incorporates the guidance issued by NHS England in December 2014.

All members are required to maintain accurate statements of their register of interest with the Governing Body and NHSE Area Team. 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 Southport and Formby CCG Conflicts of Interest Policy and any guidance issued by NHS England.

Voting

NHSE Director shall have one vote and the CCG shall have one vote. The Chair shall have a casting vote.

Quorum

The quorum shall comprise the Chair or Vice Chair, at least 2 representatives from NHSE Cheshire and Merseyside Sub Regional Team, and at least 2 representatives from NHS Southport and Formby CCG one of which must be a Primary Care clinician.

Frequency of meetings

Meeting shall be held weekly for the first month following the establishment of the Joint Committee. Thereafter the Committee shall meet no less than **8** times per year.

Meetings of the Joint Committee:

Meetings of the Committee shall be held in public.

The Joint Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

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

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

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

Administration

Administrative support will be provided by TBA

The Administrator to the Joint Committee will:

a) Circulate the minutes and action notes of the committee with 3 working days of the meeting to all members.

b) Present the minutes and action notes to Cheshire and Merseyside Sub Regional Team of NHS England and the governing body of NHS Southport and Formby CCG

Review of the Terms of Reference

These Terms of Reference will be reviewed from time to time, reflecting experience of the Joint Committee in fulfilling its functions and the wider experience of NHS England and CCGs in primary medical services co-commissioning.

These terms of reference will also be formally reviewed by Cheshire and Merseyside Sub Regional Team of NHS England and NHS Southport and Formby CCG in April of each year, following the year in which the joint committee is created, and may be amended by mutual

agreement between Cheshire and Merseyside Sub Regional Team of NHS England and NHS Southport and Formby CCG at any time to reflect changes in circumstances which may arise.

Decisions

The Joint Committee will make decisions within the bounds of its remit.

The decisions of the Joint Committee shall be binding on NHS England and NHS Southport and Formby CCG

Decisions will be published by both NHS England and NHS Southport and Formby CCG

The Administrator will produce an executive summary report which will presented to Cheshire and Merseyside Sub Regional Team of NHS England and the governing body of NHS Southport and Formby CCG each quarter for information.

Key Responsibilities

The Committee has been established to deliver the main objective of aligning the commissioning of primary care with delivery of the Clinical Commissioning Groups (CCG) Primary Care Quality Strategy to enable transformation within primary care.

The 19 GP practices in Southport and Formby have a track record of working together and are organised into 4 geographic localities with a patient population of around 28 000 per locality. The CCGs Primary Care Quality Strategy in 2014/15 has focused on improving access to general practice, reducing exception reporting, increasing the uptake of MMR and cervical smears and multidisciplinary team meetings with community staff for risk stratified patients.

NHS Southport and Formby CCG and NHSE Cheshire and Merseyside Sub Regional Team are keen to explore alternative models of care such as Primary and Acute Care Systems,

Closer alignment of primary care commissioning with the CCG vision means that patients will benefit from the outcomes delivered which include primary and community care services delivered within localities. During 2015/16 the focus of the Primary Care Quality Strategy will be on supporting over 75's (and care home patients) through proactive management, this will not only improve the patient's' experience of care but also reduce emergency admissions.

Key activities will involve *(but are not limited to):*

- **Overseeing the implementation of the Primary Care Quality Strategy**
- **Ensuring improved access to Primary Care**
- **Ensuring improvements in the uptake of MMR**
- **Ensuring improvements in the uptake of cervical smears**
- **Ensuring improvements in the care for risk stratified patients**
- **Ensuring reductions in emergency admissions**
- **Planning for services**
- **Undertaking reviews as appropriate**

- **Co-ordinating a common approach to Primary Care Commissioning as appropriate**

NHS
South Sefton
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/50	**Author of the Paper:** Name: Jan Leonard Job Title: Chief Commissioning and Redesign Officer Email: jan.leonard@southseftonccg.nhs.uk Tel: 01704 38 7028
Report date: March 2015	

Title: NHS Southport & Formby and NHS England Joint Committee – Terms of Reference

Summary/Key Issues:

NHSE and the CCG have agreed to establish a joint committee to support the implementation of the CCGs Primary Care Quality Strategy.

Recommendation

The Governing Body is asked to ***approve*** the establishment of the Joint Committee and the Terms of Reference.

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.
X	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.

15/50 Joint Committee TOR

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

Links to National Outcomes Framework *(x those that apply)*	
X	Preventing people from dying prematurely
X	Enhancing quality of life for people with long-term conditions
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

NHS Southport and Formby CCG and NHSE Joint Commissioning Committee

Terms of Reference

Background

Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting Clinical Commissioning Groups (CCGs) to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG's preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England and CCGs would jointly commission primary medical services.

Area covered by Joint Commissioning arrangements

The NHS England and **NHS Southport and Formby CCG** joint commissioning committee is a joint committee with the primary purpose of jointly commissioning primary medical services for the people of Southport and Formby.

Statutory Framework

The National Health Service Act 2006 (as amended) ("**NHS Act**") provides, at section 13Z, that NHS England's functions may be exercised jointly with a CCG, and that functions exercised jointly in accordance with that section may be exercised by a joint committee of NHS England and the CCG. Section 13Z of the NHS Act further provides that arrangements made under that section may be on such terms and conditions as may be agreed between NHS England and the CCG.

Role of the Joint Committee

The role of the Joint Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England

This includes the following activities:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);

- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

In performing its role the Joint Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Southport and Formby CCG, which will sit alongside the delegation and terms of reference.[1]

Geographical coverage

The Joint Committee will comprise NHS England Cheshire and Merseyside Sub Regional Team and the NHS Southport and Formby CCG. It will undertake the function of jointly commissioning primary medical services for Southport and Formby.

Membership (to be completed following discussion and agreement with Area Team)

The Joint Committee shall consist of:

- Lay Chair
- Director - NHSE Cheshire and Merseyside Sub Regional Team Director (or other Senior Manager as nominated by the Cheshire and Merseyside Sub Regional Team) with delegated authority to make decisions
- Primary Care Lead – NHSE
- S&F CCG Chief Commissioning and Re-design Officer
- GP Clinical Lead – S&F CCG
- GP Clinical Lead – S&F CCG

The membership will meet the requirements of NHS Southport and Formby CCG's constitution.

The Chair of the Joint Committee shall be the Lay Chair for Governance of the NHS Southport and Formby CCG

The Vice Chair, who shall be a Lay Member[2] of the Joint Committee will be determined by the Committee at the inaugural meeting

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Voting

NHSE Director shall have one vote and the CCG shall have one vote.

For matters relating to statutory duties of the CCG, the CCG shall have a casting vote.

For matters relating to statutory duties of NHS England, NHS England shall have a casting vote.

The one organisational vote for each organisation shall be exercised by the nominated lay or executive member.

Quorum

The quorum shall comprise the Chair or Vice Chair, at least 2 representatives from NHSE Cheshire and Merseyside Sub Regional Team, and at least 2 representatives from NHS Southport and Formby CCG one of which must be a Primary Care clinician.

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- **Ensuring reductions in emergency admissions**
- **Planning for services**
- **Undertaking reviews as appropriate**
- **Co-ordinating a common approach to Primary Care Commissioning as appropriate**

NB: The definitive list of responsibilities and activities will be agreed at the inaugural meeting of the joint committee.

Signature provisions

[Schedule 1 – Delegation by CCG to joint committee – CCG functions - The CCG is not delegating any of its statutory functions to this joint committee

Schedule 2 - List of Members –

TBA populate once membership agreed

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/51

Report date: March 2015

Authors of the Paper:
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Tel: 0151 247 7000

Title: Breast Care Services Engagement and Equality Report and Recommendations

Summary/Key Issues:

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

The detail and outcomes of the engagement and the associated recommendations are outlined in this report.

Recommendation

The Governing Body is asked to approve this report.

Receive	x
Approve	x
Ratify	

15/51 Breast Services

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.
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	Agreed three year integration plan with Sefton Council and implementation of year one (2014/15) to include an intermediate care strategy.
	Review the population health needs for all mental health services to inform enhanced delivery.

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

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

Report to the Governing Body
March 2015

1. Executive Summary

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

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

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

2. Introduction and Background

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

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

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

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

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

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

3. Key Issues

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

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

4. Conclusions

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

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

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

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

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

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

(Appendix 2);

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

5. Recommendations

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

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

Appendices

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

Jan Leonard
March 2015

NHS
West Lancashire
Clinical Commissioning Group

NHS
Southport and Formby
Clinical Commissioning Group

Breast Care Services
Southport and Ormskirk Hospital

Engagement Report

March 2015

CONTENTS

1. EXECUTIVE SUMMARY

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

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

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

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

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

2. BACKGROUND

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

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

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

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

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

3. ENGAGEMENT PROCESS

3.1 Aims of Engagement

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

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

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

3.2 Methodology

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

The key aspects of the methodology were as follows:

3.3 Focus and Methods of Engagement

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

3.4 Equality Analysis

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

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

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

3.5 Capturing Feedback

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

3.6 Analysing Engagement and Feedback

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

3.7 Stakeholders

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

3.8 Engagement/Communication Timeline

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

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

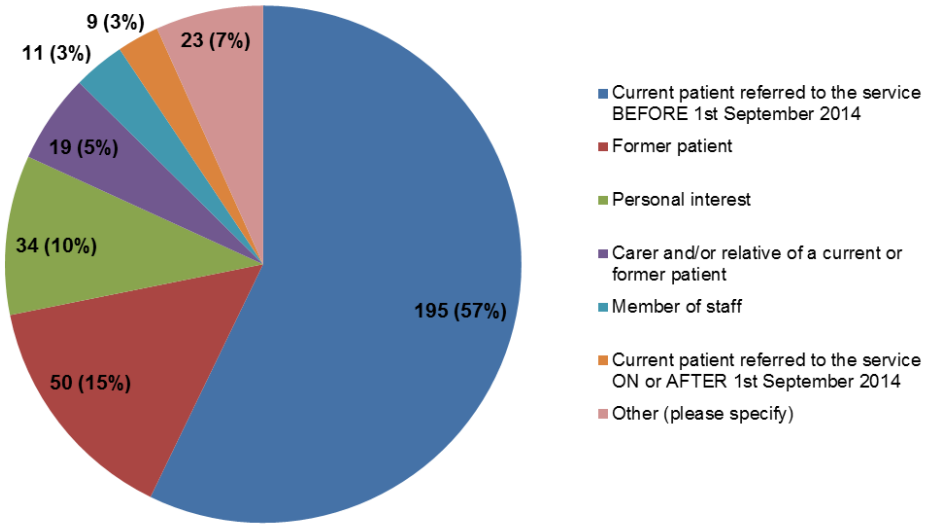
4. ENGAGEMENT OUTCOMES

4.1 Survey responses and questions

A total of 342 survey responses were received.

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

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



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

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

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

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

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

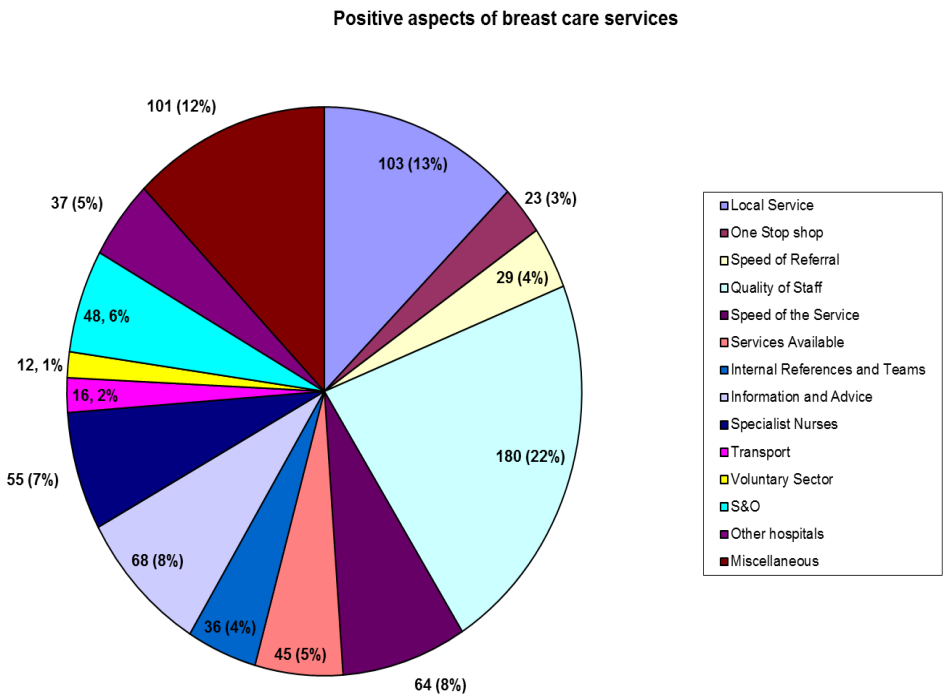
The majority of respondents had experience/knowledge of Ormskirk (79%) and Southport (64%) hospitals, and 52% of the Clatterbridge centre.

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

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

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

Diagram 1:



Local service and a "one stop shop"

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

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

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

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

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

Speed of referral and quality of staff

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

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

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

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

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

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

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

Speed of the service and services available

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

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

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

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

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

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

Internal communications and team working

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

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

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

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

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

Information and advice

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

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

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

"Easy read breast screening booklet"

Support from the voluntary sector

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

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

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

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

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

Specialist nurses

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

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

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

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

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

Transport

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

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

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

Hospital sites

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

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

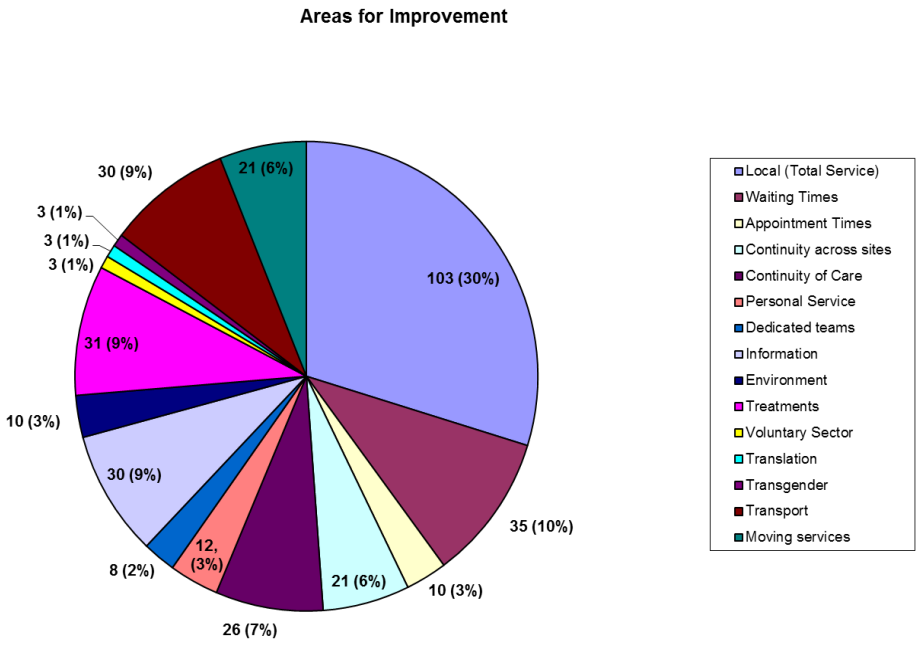
Miscellaneous

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

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

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

Diagram 2



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

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

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

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

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

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

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

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

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

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

Waiting times and appointment times

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

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

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

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

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

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

Continuity, personalised service and dedicated teams

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

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

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

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

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

More follow ups/contact/ appointments with breast nurse.

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

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

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

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

Information and environment

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

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

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

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

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

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

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

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

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

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

"to have all units wheelchair accessible"

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

Personalised support and issues relating to translation, gender and sexuality

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

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

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

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

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

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

Transport

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

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

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

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

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

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

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

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

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

"Should be available in Southport."

Treatments

Respondents made the following suggestions for improvement to treatments:

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

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

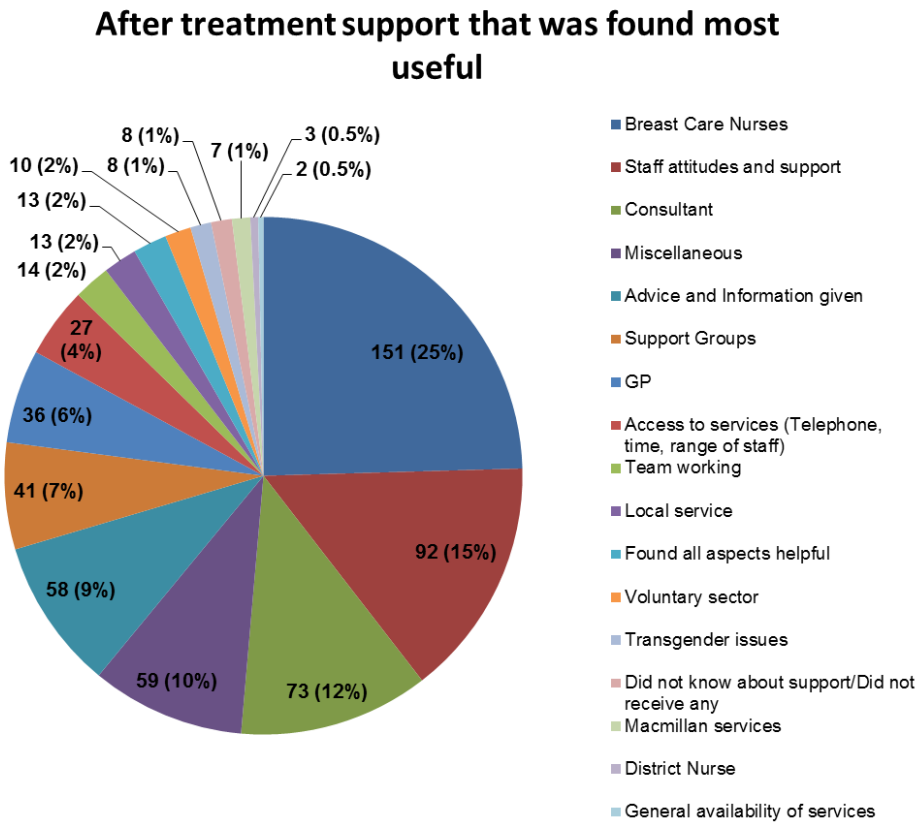
"More urgent care in A&E at Southport when neutropenic. Someone in A&E who can use a picc line. Separate ward in hospital for cancer patients. 24hr 7 days specialist cancer nurse."

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

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

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

Diagram 3



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

Breast care nurses

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

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

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

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

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

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

Team working

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

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

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

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

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

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

Support groups

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

"Support group Sarah's Stars".

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

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

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

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

"Starting Over course at Halton Hospital.GP support"

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

GP

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

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

"GP support from my local GP practice."

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

Other and miscellaneous

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

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

Volunteer drivers for transport to Clatterbridge/radiotherapy invaluable."

Members of the In-Trust transgender support group commented:

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

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

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

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

Specific examples of the above themes are as follows:

A local service

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other supporting/complementary services:

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

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

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

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

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

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

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

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

The importance of continuity

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

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

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

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

Concerns around the lack of information:

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

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

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

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

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

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

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

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

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

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

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

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

Suggestions for improvement:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.2 Profile of survey respondents

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

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

4.3 Meeting and event feedback

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

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

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

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

4.4 Patient Experience Team

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

4.5 Website comments

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

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

4.6 Petition

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

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

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

4.7 Equality Analysis

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

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

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

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

4.8 Other considerations

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

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

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

5. CONCLUSION

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

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

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

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

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

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

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

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

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

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

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

6. APPENDICES

Appendix A

Timetable of public meetings/events/clinics and feedback

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

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

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

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

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

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

Timetable of clinics and feedback (existing patients only)

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

Appendix B

Breast care services engagement stakeholders

West Lancashire

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

Southport and Formby

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

Appendix C

Breast Care Services engagement feedback report

Diversity and Equality monitoring data

What is your age?

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

How would you describe your gender?

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

Is this the same gender you were born with?

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

Which area do you live in?

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

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

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

Are you a carer?

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

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

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

What is your ethnic group/background?

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

Please choose a category that best describes your level of disability

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

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

What is your religion/faith?

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

What is your sexual orientation?

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

Equality Analysis Report
Breast Care Services, Southport and Ormskirk Hospital

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

Locality Development Manager (North Southport)

NHS Southport and Formby Clinical Commissioning Group (CCG)

Details of service / function

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

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

Evidence

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

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

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

The breakdown of patient ages is as follows;

- 35-40 years old 5 patients 3 %

- 41-50 years old 31 patients 18%

- 51-60 years old 28 patients 16%

- 61-70 years old 30 patients 17%

- 71-80 years old 48 patients 27%

- 81-90 years old 27 patients 16%

- 91-99 years old 5 patients 3%

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

Asian).

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

a) Identify in the proposal any inherent indirect discrimination

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

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

What is changing?

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

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

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

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

i) Existing S&O patients

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

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

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

- Timescales of review and clarity of message

iii)) wider public

Timescales of review and clarity of message:

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

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

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

Is this service specific to a protected characteristic?

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

Public Sector Equality Duty:

Objective 1: Eliminate discrimination.

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

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

Objective 2: Advance Equality of Opportunity

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

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

Objective 3: Foster good relations

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

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

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

Recommendation moving forward:

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

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

understands their duties under PSED and can demonstrate compliance.	

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

NHS
Southport and Formby
Clinical Commissioning Group

MEETING OF THE GOVERNING BODY
March 2015

Agenda Item: 15/52	**Author of the Paper:** Billie Dodd Head of CCG Development Email: billie.dodd@southportandformbyccg.nhs.uk Tel: 01704 387028
Report date: March 2015	

Title: Care Closer to Home Strategy 2013 – 2018 (refreshed in 2015)

Summary/Key Issues:

This paper presents the Governing Body with a refreshed Care Closer to Home Strategy 2013 – 2018.

Recommendation

The Governing Body is asked to approve the refreshed Care Closer to Home Strategy.

Receive	
Approve	x
Ratify	

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

Process	Yes	No	N/A	Comments/Detail
Patient and Public Engagement	x			
Clinical Engagement	x			

Process	Yes	No	N/A	Comments/Detail
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

Care Closer to Home Strategy 2013 -2018(refreshed in 2015)

Southport & Formby and West Lancashire Health Economies

Approved by the Southport and Ormskirk Strategic Partnership Board on ……..

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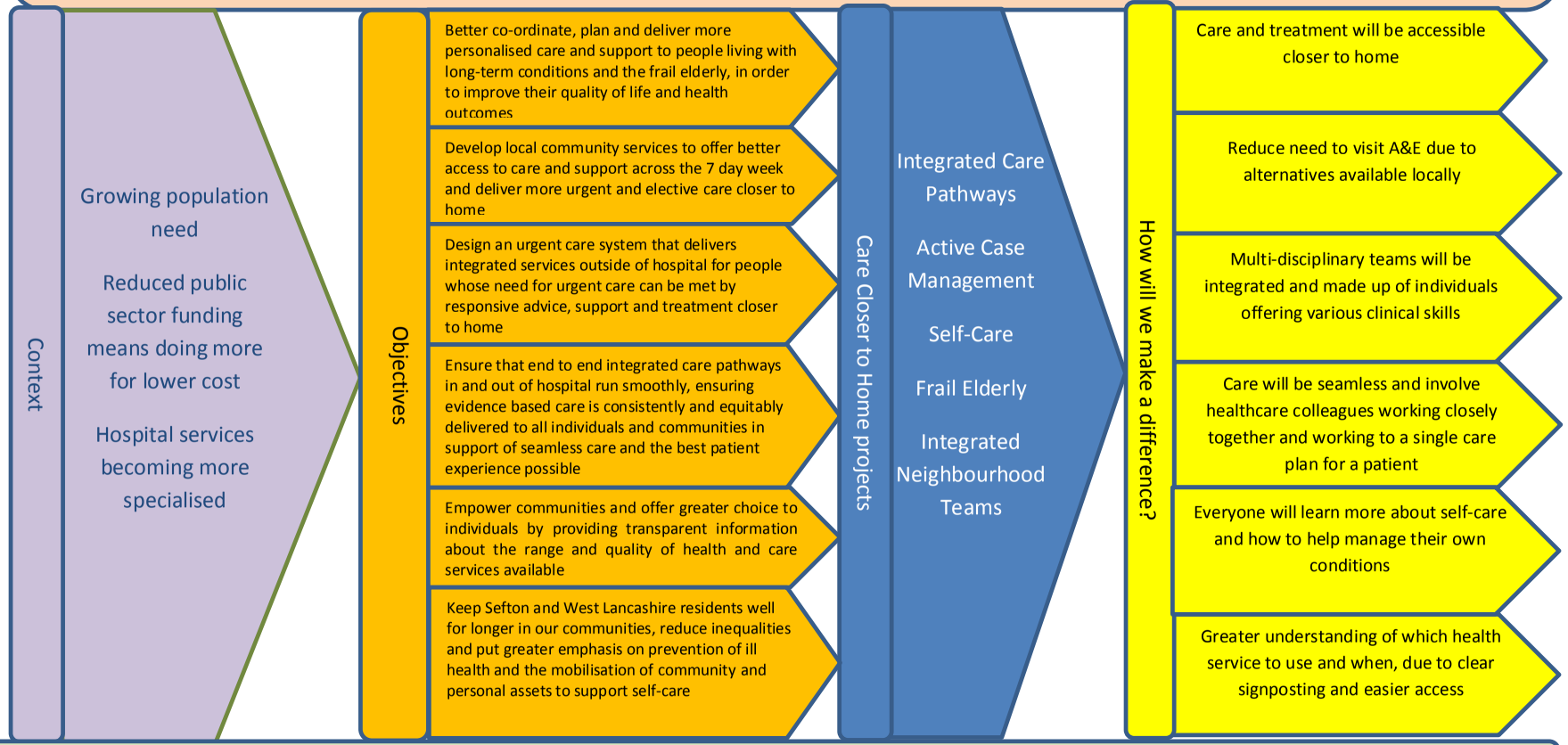
Diagram 1: The Care Closer to Home plan on a page

"This (Care Closer to Home) programme is about allowing everyone to live fulfilling, independent lives, which are supported by safe, quality, patient centred, accessible and seamless services. This will be delivered by a skilled, committed, satisfied and integrated workforce, who together with the public and colleagues across the health, social care and voluntary sectors, take pride in providing quality care. We will achieve this by being innovative and having the vision and courage to do the right thing, building trust and co-ownership with care providers, partners and patients through effective two way communication and listening to experiences of care."



Demonstrating our commitment to improving the quality of Care Closer to Home

National measures: Access to service data, e.g., A&E performance; Referral to Treatment Times; Admissions to residential and nursing homes per 100,000; Proportion of older people (65+) who are still at home 91 days post discharge from hospital into reablement/rehabilitation	**Local measures**: Urgent care attendances; 30 day readmissions; bed days; Community Matron contacts; % of patients who die in their recorded preferred place of care; bed capacity; unplanned admissions; referral rates by GP practice; NWAS REAP level status	**Patient experience** – LTC6, EQ-5D and patient satisfaction surveys; Patient feedback - complaints and compliments; Friends and family test

1. INTRODUCTION

The Southport and Ormskirk Strategic Partnership lead organisations are committed to working together to improve the health and wellbeing of our citizens and communities, through collegiate action at a system level. Accordingly, the 'Care Closer to Home Strategy 2013 – 2018' was commissioned and the Care Closer to Home (CCtH) Programme instigated. Initially the CCtH programme objectives focused on improving the performance of the Southport Accident and Emergency department and reducing demand for urgent care services, but leaders recognised that this was a system issue and required a whole-system transformational response.

In the meantime, Southport and Formby (S&F) and West Lancashire (W Lancs) Clinical Commissioning Groups (CCGs) submitted 5 year strategic plans to NHS England in June 2014 and Southport and Ormskirk NHS Trust (hereafter referred to as 'the Trust') submitted an Integrated Business Plan to the Trust Development Agency in July 2014. Health and Wellbeing Boards have developed action plans to deliver the Better Care Fund requirements, which will also contain a number of key objectives for the CCtH programme.

Consequently this strategy is being refreshed and will be:

- designed to align the local CCG and Trust strategies with the Sefton and the Lancashire Health and Wellbeing Board Strategies and Better Care Fund plans;
- focused on delivering a set of aims and objectives, which arise from the strategies stated above; and
- orientated to lever the maximum benefit from the local health economy pound, both in ensuring the delivery of effective, safe, high quality services, designed to deliver better health outcomes and experience of care, but also through prioritising and investing in activities/projects/services that will deliver the desired benefits

In essence, this strategy tells the story of our local journey of system transformation and service improvement. It describes where we are, our vision for future health and social care services, sets out some of the key reasons explaining why we need to change and specifies the measures we will use to demonstrate that we have achieved what we set out to do – which is to ensure better health outcomes and improved health and wellbeing of our patients, citizens and communities.

2. VISION

The current vision statement has been developed in partnership with people and organisations from across the health economy and was approved by the Strategic Partnership Board in February 2014, as follows:

"This (Care Closer to Home) programme is about allowing everyone to live fulfilling, independent lives, which are supported by safe, quality, patient centred, accessible and seamless services.

This will be delivered by a skilled, committed, satisfied and integrated workforce, who together with the public and colleagues across the health, social care and voluntary sectors, take pride in providing quality care.

We will achieve this by being innovative and having the vision and courage to do the right thing, building trust and co-ownership with care providers, partners and patients through effective two way communication and listening to experiences of care."

The core benefits of delivering this vision for the community and patients will include:

- Care and treatment will be accessible closer to home, or in the most appropriate setting
- Reduce need to visit A&E due to alternatives available locally
- Multi-disciplinary teams will be integrated and made up of individuals offering various clinical skills
- Care will be seamless and involve healthcare colleagues working closely together and working to a single care plan for a patient
- Everyone will learn more about self-care and how to help manage their own conditions
- Greater understanding of which health service to use and when, due to clear signposting and easier access
- Improved health and wellbeing of our citizens and communities by building capacity and resilience so that people become proactive participant in their health and social care, rather than recipients

To illustrate how this vision might be experienced by people receiving services we have penned some illustrations below.

Alice Parbold – a 12yr old living well with asthma

My asthma started when I was little and my parents made sure that I had my inhalers at the right times, but now I do it myself.

I have a special asthma action plan just for me with all of the things I need to do if my asthma gets worse. It also has the number of my asthma nurse, Jill, who I can call for advice but I don't usually need to call because my asthma is OK. Taking my inhaler at the right times and not forgetting it is important, so I get a text to remind me to take my inhaler and to wrap up warm when it's a cold day.

Gary Southport – a 45yr old living well with type 2 diabetes

I have worked as a mechanic at a garage in Formby for the last 26 years and have two children. I was diagnosed with type 2 diabetes three years ago. Being labelled with a lifelong disease was daunting at first. I think I tried to pretend there wasn't a problem and carried on with old lifestyle of drinking a little too much and eating fast food too often.

However, my GP and practice nurse gave me lots of support and sent me off to a course about how to cope with the disease. The specialist diabetes team helped me to understand my illness. I learnt about the importance of a good diet and regular exercise; the value of keeping my cholesterol low; the need to keep my blood pressure monitored; about getting my eyes checked each year; and the importance of looking after my feet and keeping them warm and protected at work.

I was amazed to find out how many people are living well with diabetes, it gave me hope, especially when one of the other blokes on the course talked about how he has joined a gym. This encouraged me to change my life style. I'd put on a few pounds gradually over the years from my 'chip shop' diet, and hadn't done any sport since I gave up Sunday league football when my kids were born.

Now I only need to see my diabetes team for my annual check-up and review of my personal care plan, because I am in control and know what problems to look out for.

It's been quite a lot to take in and I although I had a tough time coming to terms with it initially, I found the support I had from my neighbourhood health team helped me come to terms with my condition, and get on with my life.

Mary Ainsdale – an 80 year old lady living well with dementia

I live with my pet dog Charlie in the house I have lived in for most of my adult life. My husband died of cancer 8 years ago and I started noticing that my memory was getting worse shortly after. I'd seen information in the local paper about dementia, which directed me to a website where I did a quick quiz to check for symptoms. When I finished the quiz and saw the results, it gave me an option to arrange for a memory test, which I agreed to have and I got a call from my GPs surgery to arrange it.

Being told I had dementia was scary; thankfully my daughter came with me and wrote everything down so we were all clear about the disease and how it would get worse over time. I had a visit from a nice young woman from a local charity to help me get out more and explain which services I can use and make sure I'm getting all

the help I am entitled to.

I have a care plan which outlines what to do if there are problems, with information about my treatment and support package….I have my own care budget, so I get to choose who comes to see me and what I want them to do to help me. I even have a future plan agreed for when my dementia gets worse and I can't make decisions for myself; setting out the way I want to be cared for and what's important to me.

Dementia is not an easy thing to thing to live with for me and my family, my daughter is worried about my safety because I got confused recently and ended up being taken to hospital by the police in the early hours of the morning. Thankfully the hospital was able to look at my care plan and got a special emergency team in to take me home and give me the antibiotics (through a drip) for the bladder infection, which had caused the confusion.

After this episode I agreed to have monitoring equipment put into my home. Now carers are alerted if I wander out at night and my daughter can Skype my home and check to see if I am OK.

The vision is consistent with the NHS Constitution and HealthWatch England's Eight Consumer Principles ('Loud & Clear: Making Customers' Voices Heard', HealthWatch England Annual Report 2013/14), which feature throughout this document in the format below.

"I want the right to a set of essential prevention, treatment and care services, provided to a high standard, which prevent me from being in crisis and lead to improvement in my health and care".

"I want the right to access services on an equal basis with others, without fear of prejudice or discrimination, when I need them and in a way that works for me and my family".

"I want the right to high quality safe confidential services that treat me with dignity, compassion and respect".

"I want the right to clear and accurate information that I can use to make decisions about health and care treatment. I want the right to education about how to take care of myself and about what I am entitled to in the health and social care system".

"I want to be an equal partner in determining my own health and wellbeing. I want the right to be involved in decisions that affect my life and those affecting my local community".

"I want the right to have my concerns and views listened to and acted upon. I want the right to be supported in taking action if I am not satisfied with the service I have received".

"I want the right to choose from a range of high quality services, products and providers within health and social care".

"I want the right to live in an environment that promotes positive health and wellbeing".

3. CONTEXT

"In 2014 the NHS is facing a very different disease challenge from the one that existed at its inception in 1948. Broadly, the main challenge in 1948 was infectious disease; now it is people with multiple long term conditions, poor mental health, disabilities and frailty. Over two thirds of the money spent by the NHS and social care is on this group of people, who for the most part (but by no means exclusively) are experiencing the diseases of old age. Most people over 65 have more than one long term condition, over 75 two or more. In short you collect more as you get older. Sometimes people's problems are just a consequence of getting very old. Good care for these citizens requires us to look at them and their health and care needs as a whole.

Yet in many ways the health and care system still behaves very similarly to that of 1948; based on hospitals and focused on specialties that look after a person's body parts, not the person as a whole."
Sir John Oldham Chairman, Independent Commission on Whole Person Care

3.1 Population Demographics

The number of people in Britain aged over 85 increased from 416,000 in 1971 to over 1.1 million in 2009, and is expected to reach 2.6 million in 2021. It is worth noting, however, that increasing life expectancy has been accompanied by increasing healthy life expectancy, although the length of unhealthy life has increased overall – in other words, length of healthy life has not increased as much as total length of life. Analysis of the drivers of cost pressures facing the NHS over the coming years suggests the growth in demand for care because of long term conditions is at least equal to, if not more than, the pressure from a growing and ageing population in and of itself. And on top of this pressure from the growth in demand, there will be funding pressures too from the rising costs of providing healthcare, such as costs of drugs and technology.

Older people use health and care services heavily. People over 65 consult general practitioners (GPs) generally five times more than the average for the population. They account for 62% of total bed days in hospitals in England, 68% of emergency bed days, and 80% of deaths in hospital[i].

The average age of people in hospital is over 80. More than three quarters of people receiving care in registered residential and nursing accommodation in England funded by councils are aged 65 and over, with 43% aged 85 and over. Four of five people receiving community based home-care services are aged 65 or over[ii].
The number of people aged 65 and over in England with care needs, such as, washing and dressing, has been projected to growfrom2.5 million in 2010 to 4.1 million in 2030[iii].

In common with other areas of the country, the changes in the population demographics are impacting on the demand for health and social care support. Locally, although the population size is remaining stable, the proportion of the population aged over 75 years of age is predicted to increase significantly in the coming years, and causing a subsequent increase demand on the available resources.

Already the increased number of elderly patients within the localities is manifested within the care home sector. The combined population of West Lancashire and Southport & Formby is 225,000; in West Lancashire, Southport and Formby there is one care home bed for 69 people as opposed to a national figure of one bed to 150 people.

In West Lancashire we know:

- **Our population is ageing**. 9,122 or 8.2% of the West Lancashire population is over the age of 75. By 2022 we expect this will rise to 11.6%.
- **Our diversity**. 95.6% of the West Lancashire population describe themselves as White British, 0.5% as White Irish and 0.5% as White Polish.

- **Our levels of deprivation**. West Lancashire has a significant number of people living in deprivation. 20% of the West Lancashire population lives in areas classified as being amongst the most deprived in the country.

- **Our life expectancy**. The life expectancy of men in West Lancashire is 78.0 years compared to a national average of 78.6 years and women 81.3 years compared to 82.6 years. Life expectancy for men and women in West Lancashire, overall, has been increasing in line with the national picture although there is a 6.3 year gap in life expectancy for women and an 8.7 year gap for men between the most affluent and the most deprived areas. In West Lancashire, this gap in life expectancy has widened.

- **The main causes of death.** In 2011 the main causes of death for people of all ages in West Lancashire were cancer and CVD.

"I want the right to live in an environment that promotes positive health and wellbeing".

In Southport and Formby we know:

- **Our population is ageing.** In 2011 there were estimated to be more than 26,000 residents aged 65+ and this is expected to increase by as much as 10% within the next five years, and there are 22,100 residents aged under 18 in Southport and Formby – roughly equal to the number of over 67 year olds.

- **Our diversity.** In recent years, there have been growing communities of international workers in and around Southport. Whilst no definitive figures exist, sources indicate there could be as many as 2,000 international workers, 300 school age children and 600 partners/other family members.

- **Our life expectancy.** Life expectancy is similar to the national average at 78.1 years for males and 82.4 for females (2011 estimates). However, there are differences in life expectancy within the Consortia of over 7 years for both sexes.

- In terms of deprivation, the least deprived areas cover large parts of Formby, areas in Hillside and a pocket in Churchtown. The most deprived areas cover Southport town centre, Blowick and pockets in Ainsdale and Kew.

3.2 Our values

Following a consultation in December 2013 across the CCtH partners, The PATHS values and expected behaviours/outcomes were agreed by the CCtH Programme Board as follows:

P- Partnership working

A - Accountability and accessibility

T- Transparency and honesty

H - Helpfulness and responsiveness

S - Solutions focus to support healthy lives

Table 1: Our Values

Values Statement	Descriptors	Behaviours and Outcomes
Partnership working	Collaboration, integration, sharing, together	• Professionals listening to patients' wants and strengths • Shared learning behaviours • Approaching everything with a 'what can we do together' attitude and practice • Clarity about what everyone brings to the table and the benefits that they offer • Developing together
Accountability and accessibility	Responsibility, honesty, ownership, quality, governance	• Being responsible for the best use of resources for patients • Joint ownership and articulated joint responsibilities • Being visible • Being brave • Professionals admitting mistakes and listening
Transparency and honesty	Visibility, openness, integrity,	• Relevance and humility • Failure and success highlighted without judgement • Having clear a governance structure and partnership agreement • Professionals 'saying it like it is' Respecting the rights of our patients and colleagues
Helpfulness and responsiveness	Caring, flexibility, humanity, cooperation	• Being adaptable to the needs of the communities that we serve • Build on skills, don't judge for the past, move to the future • Professional and organisational frameworks are used as enablers not barriers • Professionals being delighted in patients taking control
Solutions focus to support healthy lives	Proactive, well-being, compassionate, caring, empowering	• Focus on public health • Recognise and respond to differences in need • People actively seek to 'live well', and are able and motivated to help themselves or secure help from friends family and the community • Patients 'owning' their lives • Using a range of treatments and approaches to support people to stay well and live as well as possible

3.3 Case for change and policy drivers

In addition to the increased demand arising from changes to the demographic profile of populations, trend analysis shows how changes in policy, behavior and patient choice is driving up the use of urgent care and hospital services. A report by the National Audit Office in 2013[iv]analysed the trends in emergency admissions and concluded the following:

- The increase in emergency admissions over the last 15 years has come almost entirely from patients being admitted from major accident and emergency (A&E) departments who have a short hospital stay once admitted. Over the last 15 years, short-stay (less than two days) admissions have increased by 124%, whereas long-stay (two days or longer) admissions have only increased by 14%.

- More patients who are attending major A&E departments are now being admitted. In 2012-13, over a quarter of all patients attending major A&E departments were admitted to hospital, up from 19% in 2003-04. This increase accounts for three-quarters of the rise in emergency admissions through major A&E departments, while an increase in the number of people attending major A&E departments accounts for the remaining quarter.

- The causes of the increase in emergency admissions include systemic issues, policy changes, changing medical practices, demographic changes and the fact that A&E departments are under increasing pressure.

To cope with this demand, hospitals have been making increasing use of acute assessment units to improve the admissions process. These units are areas where patients from A&E departments can undergo further tests and stabilisation before they are transferred to the relevant ward or discharged. There is evidence that these units can improve outcomes for patients by limiting waiting time in A&E departments, reducing the length of hospital stay and reducing the likelihood of dying. In many trusts, activity driven through these units is treated as emergency admissions, and may be an important factor in the rise in short-stay admissions.

Admissions into units managed by emergency medicine doctors (including assessment units) increased rapidly during the first two years of the enforcement of the four-hour standard, from 70,000 to 320,000 between 2002-03 and 2005-06, a 67% year-on-year rise. By 2012-13, this had risen further to 468,000, of which 443,000 were short-stay admissions.

The average amount of time that hospital beds are occupied has risen, limiting the capacity of some hospitals to cope with fluctuations in emergency admissions in winter. Between 2001-02 and 2012-13, the average occupancy rate of general and acute hospital beds across England increased from 85% to 88%. Over the winter months pressure on beds is even greater; between January and March 2013, bed occupancy rates averaged 89.7%, with over one-fifth of trusts reporting rates over 95%.[v]

The effective management of the flow of patients through the health system is at the heart of reducing unnecessary emergency admissions and managing those patients who are admitted. For example:

• Primary, community and social care can reduce admissions through improving management of long-term conditions;

• Ambulance services can reduce conveyance rates to accident and emergency (A&E) departments, for example by conveying patients to a wider range of care destinations;

• Hospitals can reduce emergency admissions by ensuring prompt initial senior clinical assessment, prompt access to diagnostics and specialist medical opinion; and

• Once admitted, hospitals working with community and social care services can ensure that patients stay no longer than is necessary and are discharged promptly.

Central policy, issued over the last five years, has consistently driven the health and social care system to address the growing demand on the system by introducing initiatives, levers and mechanisms to shift the balance of spend and invest towards more care in the community, a greater focus on people living with long-term health conditions and frail elders and the prevention of ill health.

For example, the **Better Care Fund** provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16. Local Better Care Fund plans must meet a number of national conditions:

• Plans must be jointly agreed and include an explanation of how local adult social care services will be protected;
• Include how 7-day services in health and social care will support patients being discharged and prevent unnecessary admissions at weekends;
• Use the NHS number to enable better data sharing between health and social care;
• Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional; and
• Consider the impact of changes on the acute sector.

NHS England has identified that any high quality, sustainable health and care system in England will have the following **six characteristics** in five years[vi]:

- Wider primary care, provided at scale.
- A modern model of integrated care.
- Access to the highest quality urgent and emergency care.
- A step-change in the productivity of elective care.
- Specialised services concentrated in centres of excellence.

Citizen empowerment is a corner stone of this policy to enable people and communities to take more responsibility for managing their own health needs by:

- Listening patient's views - the Health and Social Care Act 2012 introduced significant amendments to the NHS Act 2006. This guidance supports two legal duties, requiring clinical commissioning groups and commissioners in NHS England to enable:
    - patients and carers to participate in planning, managing and making decisions about their care and treatment through the services they commission
    - the effective participation of the public in the commissioning process itself, so that services reflect the needs of local people.

- Deliver better care through the digital revolution - all people with a long-term condition to have a personalised care plan which is accessible, available electronically and linked to their GP health record. Greater use of telehealth and telecare will also be important in supporting people with long-term conditions to manage their own health and care.

- Transparency and sharing data – by making available the information patients need to understand their condition and make choices about the best treatment for them and by effectively collecting, sharing and interpreting data (based on the NHS number) to inform system transformation.

The **Care Act 2014** sets out the changing role of local authorities to take responsibility for some new functions and states that local authorities must make sure that people who live in their areas:

• receive services that prevent, reduce and delay their care needs from becoming more serious
• can get the information they need to make good decisions about care and support
• have a good range of providers to choose from

> ***"I want the right to choose from a range of high quality services, products and providers within health and social care".***

The **new statutory principle of individual wellbeing** underpins the Act, as the driving force behind care and support. This duty to promote people's wellbeing applies not just to users of services, but also to carers and is the driving force behind the new legislation. One of the factors local authorities will have to consider surrounds identifying carers in the area who might have support needs that are not being met. The new legislation with its emphasis on prevention means that carers should receive support earlier before reaching crisis point.

The Care Act also puts emphasis on greater integration of services for carers provided by the local authority and its relevant partners and a new duty to create a service market of diverse and high quality service providers. This is relevant for carers as the Act requires local authorities to consider the importance of carers and disabled people being able to access work, education and training when they look at whether there are sufficient services in the market.

From April 2016, the Care Act will introduce a cap on care costs and will provide new financial protection for those with modest wealth. The cap means that people will be responsible for their care costs as assessed by the local authority, up to the cap if they can afford it. This follows proposals made by the Dilnot Commission to raise the upper capital limit to £72,000 in April 2016 to reduce the risk of people having to use most of their assets to pay for care. The cap will increase over time.

Additionally, people with modest wealth or around £118,000 worth of assets (savings or property), or less, will start to receive financial support if they need to go to a care home. The amount that the Government will pay towards someone's care and support costs will depend on what assets a person has.

The Care Act also provides a legal framework to ensure that **safeguarding** is properly coordinated and systematically applied in each area. "Adult safeguarding" is working with adults with care and support needs to keep them safe from abuse or neglect. It is an important part of what many public services do, and a key responsibility of local authorities. Safeguarding is aimed at people with care and support needs who may be in vulnerable circumstances and at risk of abuse or neglect. In these cases, local services must work together to spot those at risk and take steps to protect them.

Safeguarding is everyone's business, and it is important that organisations work together to protect people who need help and support. Yet one of the biggest challenges is how to bring together the huge number of teams and organisations involved in keeping people safe. That is why the Care Act requires local authorities to set up a Safeguarding Adults Board (SAB) in their area, giving these boards a clear basis in law for the first time. The Care Act says that the SAB must:

- include the local authority, the NHS and the police, who should meet regularly to discuss and act upon local safeguarding issues;
- develop shared plans for safeguarding, working with local people to decide how best to protect adults in vulnerable situations; and
- publish this safeguarding plan and report to the public annually on its progress, so that different organisations can make sure they are working together in the best way.

The Care Act will significantly increase the workload for social care at a time when central government has drastically decreased funding to local authorities.

The recent publication of the **'Five Year Forward View'** (5YFV) by Simon Stevens, CEO NHS England, in October 2014, acknowledges the need to transform our NHS services to meet future demand. Key aspects in the 5YFV include:

- The need for the NHS to develop a new relationship with communities, including with employers, to enable patients and communities to gain more control of their health and wellbeing
- A 'new deal' for GPs, recognising that the foundation of NHS care will remain list-based primary care over the next five years
- A radical upgrade in prevention of ill health and public health interventions
- Recognition that one size doesn't fit all, when developing NHS organisations, so no top down reorganisations are planned. That said, new detailed care model prototypes will be developed and 'tested' including modern midwifery services, viable smaller hospitals and urgent and emergency care networks.
- Joined up care across health and social care systems and support to break down the barriers, with new national flexibilities to assist transition

The 5YFV describes some of the key challenges as:

- Managing change and transition at scale, pace and at system level
- Bridging the £30bn per year predicted funding gap (by 2020/21), which necessitates action to address demand, efficiency, and funding. The document proposes three combined efficiency and funding scenarios to bridge the gap in funding as follows:
    1. NHS budget remains flat in real terms and maintains current 0.8% a year productivity gain up to 2020/21 – gap cut by ≈ ⅓ to £21b.
    2. NHS budget remains flat in real terms, but stronger efficiencies of 1.5% a year – gap cut by ≈ ½ to £16bn.
    3. NHS gets needed infrastructure and operating investment to accelerate new care models – enables demand and efficiency gains worth 2-3% - combined with staged funding increases close to 'flat real per person' to close the gap by 2020/21.
- Workforce planning and development is critical as there will be:
    - A shortage of GPs and the need to up skill the community and primary care workforce
    - A shortage of midwives
    - Increased demand for services, but fewer clinicians as clinical staff training numbers have not increased at the same rate
    - The need to develop new ways of working and workforce roles and Health Education England will work with partners to address these issues

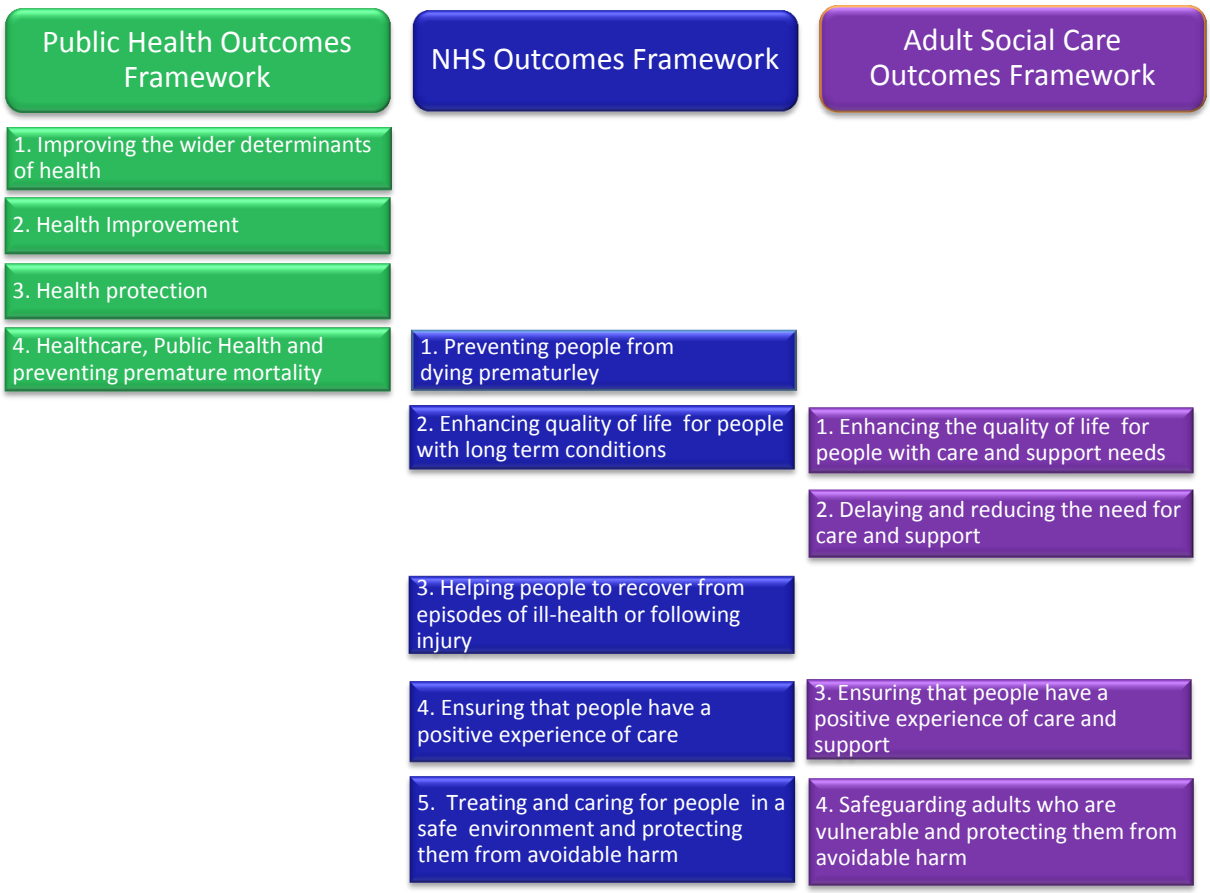
The 5YFV supports and reinforces the need to provide care closer to home and is in complete alignment with the direction of travel described in this strategy.

4. OBJECTIVES& OUTCOMES

Since 2010, the Department of Health has published three outcomes frameworks, one for each part of the health and care system. The outcomes frameworks for Public Health, Adult Social Care and the NHS are intended to provide a focus for action and improvement across the system. Each of the outcomes frameworks include the main outcomes that represent the issues across health and care that matter most to all of us.

The distinct frameworks reflect the different delivery systems and accountability models for the NHS, public health and adult social care. The three frameworks have been further aligned to encourage collaboration and integration, both in terms of how shared and complementary indicators are presented across all three frameworks, and through an increased and more systematic use of shared and complementary indicators in the revised Public Health and Adult Social Care Outcomes Frameworks (ASCOF) for 2013/14.

Diagram 2: National Outcomes Frameworks



More recently these have been expressed in composite as follows:

- Additional years of life for people with treatable conditions
- Improving health related quality of life
- Better and more integrated care in the community
- Increased number of older people living independently after discharge
- Increased positive experience of hospital care
- Increased positive experience of care in general practice and community
- Make progress on eliminating avoidable deaths
- Improving health
- Reducing health inequalities
- Parity of esteem

The national outcomes and policy directives described above are reflected in the objectives of the public sector organisations and associated Health and Wellbeing Boards, active within the CCtH partnership. Since the CCtH programme has been established as a vehicle to deliver some of these intended outcomes and objectives, it is important to consider these both individually and collectively to ensure transparency and assurance of delivery.

4.1 West Lancashire

West Lancashire CCG Integrated Commissioning Plan, states three priorities:

- Right Care, Right Time, Safely Delivered
- Preventing people from dying prematurely
- Integrated working for better patient experience, safety, quality of life and reduced inequalities

Lancashire Health and Wellbeing Board states that by 2020, they will deliver:

- Better health – we will improve healthy life expectancy, and narrow the health gap
- Better care – we will deliver measureable improvements in people's experience of health and social care services
- Better value – we will reduce the cost of health and social care

The objectives of the **Lancashire Health and Wellbeing Board** are described under three headings:

1. **Starting well to:**

- promote healthy pregnancy
- reduce infant mortality
- reduce childhood obesity
- support children with long term conditions
- support vulnerable families and children

2. **Living well to:**

- promote healthy settings, healthy workforce and economic development
- promote mental wellbeing and healthy lifestyles
- reduce avoidable deaths
- improve outcomes for people with learning disabilities

3. **Ageing well to:**

- promote independence
- reduce social isolation
- manage long term conditions and dementia
- reduce emergency admissions and direct admissions to residential care settings
- support carers and families

4.2 Southport and Formby

Southport and Formby CCG has identified three main priorities:

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

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

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

While these three strategic priorities are aligned with the major health needs and issues for the population of Sefton, there is recognition that other significant areas also need to be addressed within the strategic and operational plans.

Sefton Health and Wellbeing Board cite their strategic objectives as follows:

- ensure all children have a positive start in life
- support people early to prevent and treat avoidable illnesses and reduce inequalities in health Support older people and those with long term conditions and disabilities to remain independent and in their own homes
- promote positive mental health and wellbeing
- seek to address the wider social, environmental and economic issues that contribute to poor health and wellbeing
- build capacity and resilience to empower and strengthen communities

4.3 Southport and Ormskirk NHS Hospital Trust

In 2011 the Trust became an Integrated Care Organisation (ICO) by acquiring community services in West Lancashire and North Sefton. Since that time, the Trust has been working to develop an exemplar Integrated Care Organisation, which is reflected in the Trusts vision:

'EXCELLENT, LIFELONG, INTEGRATED CARE'

The Trusts Integrated Business Plan (2014) states the organisations objectives as follows:

- Provide lifelong, integrated care across the local health economy
- Ensure Excellence in treatment and care
- Deliver performance, within resources, comparable with the best the NHS can offer
- Empower and develop staff to achieve their objectives
- Maintain organisational sustainability

The Trust has identified five big enablers to support the delivery of the objectives, which are to:

1. Deliver an exemplar ICO - Our effort to focus on treating patients, wherever possible, outside of hospital.

2. Invest in information technology that supports our vision and strategy - The Trust is investing £9 million over the next 3 years in projects which will both change the way we work and improve patient safety

3. Review all services for productivity, efficiency and cost-effectiveness - Ensuring that both clinical and non-clinical services contribute to the Trust's Business Objectives in the best way possible.

4. Review estate utilisation - Ensuring that our assets are appropriate and used to their utmost potential.

5. Work in partnership with other organisations - Wherever partnership working enhances services locally, improves outcomes for patients or decreases costs, we will examine those opportunities.

4.4 Our Overarching Objectives

Our ultimate aim is to improve the outcomes and experiences of individuals and communities through the delivery of cost effective, integrated seamless care, support and treatment. To achieve this we will work together, effectively engaging individuals, communities and our stakeholders to transform our local health and care services to:

- Better co-ordinate, plan and deliver more personalised care and support to people living with long-term conditions and the frail elderly, in order to improve their quality of life and health outcomes

- Develop local community services to offer better access to care and support across the 7 day week.

- Support the optimal delivery of elective care; utilising community support, where appropriate, to ensure individuals stay in hospital is minimised.

- Design an urgent care system that delivers integrated services outside of hospital for people whose physical or mental health need for urgent care can be met by responsive advice, support and treatment closer to home

- Ensure that end to end integrated care pathways in and out of hospital run smoothly, ensuring evidence based care is consistently and equitably delivered to all individuals and communities in support of seamless care and the best patient experience possible.

- Empower communities and offer greater choice to individuals, by providing transparent information about the range and quality of health and care services available

- Keep Sefton and West Lancashire residents well for longer in our communities, reduce inequalities and put greater emphasis on prevention of ill health and the mobilisation of community and personal assets to support self-care

4.5 Demonstrating improved outcomes

Table 2: Objectives and Outcomes

CCtH objectives	**How we will measure an improved outcome**	**Monitoring benefit realisation**
Better co-ordinate, plan and deliver more personalised care and support to people living with long-term conditions and the frail elderly, in order to improve their quality of life and health outcomes	CCtH dashboard. Use of national and local service user surveys: • EQ-5D • LTC6	CCtH Programme Board
Develop local community services to offer better access to care and support across the 7 day week.	CCtH dashboard	
Support the optimal delivery of elective care; utilising community support, where appropriate, to ensure individuals stay in hospital is minimised.	No measure has been developed or agreed to determine how this objective will be achieved.	
Design an urgent care system that delivers integrated services outside of hospital for people whose physical or mental health need for urgent care can be met by responsive advice, support and treatment closer to home	Urgent Care dashboard	
Ensure that end to end integrated care pathways in and out of hospital run smoothly, ensuring evidence based care is consistently and equitably delivered to all individuals and communities.	Benchmark and audit primary and community services. Evaluate patient and user experience. Primary Care Dashboard	
Empower individuals and communities and offer greater choice to individuals by providing transparent information about the range and quality of health and care services available	Feedback. Monitor and update websites. Annual programme of engagement to test and evaluate experience	
Effectively engage individuals, communities and our stakeholders in working with us to transform and redesign the way in which health and care services are provided to deliver better health and wellbeing for all	Seek stakeholder feedback on awareness of CCtH annually Monitor and capture engagement evidence	CCG and ICO communication leads reporting to CCtH/SPB
Keep Sefton and West Lancashire residents well for longer in our communities, reduce inequalities and put greater emphasis on prevention of ill health and the mobilisation of community and personal assets to support self-care	Joint Strategic Needs Assessment	Public health

The **six characteristics of a transformed service model** are:

I. New approaches to ensuring the citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.
II. Wider primary care provided at scale.
III. A model of integrated care.
IV. Access to the highest quality urgent and emergency care
V. A stepped change in the productivity of elective care.
VI. Specialized services concentrated in centres of excellence

> ***"I want the right to high quality safe confidential services that treat me with dignity, compassion and respect".***

In addition to the characteristics are the **four essential elements of service delivery**:

Table 3: Measuring essential elements of service delivery

Element	How will we measure this?
ACCESS – the NHS Constitution states that access to services must be convenient for everyone. This applies equally to mental health service users, as it does for physical health problems.	Access to Primary Care, particularly for the diagnostic rate of expected dementia against prevalence and access to Memory Assessment Services Access to Intermediate Care Access to Community Services Access to Urgent Care, including A&E
QUALITY - the Francis and Berwick reports amplify a number of essential quality components, such as, patient safety, compassion in practice, safeguarding, 7 day working and staff satisfaction.	All CCG and Provider statutory indicators as a minimum, including Improving health related quality of life for people with long term conditions Proportion of people who use services who say those services have made them feel safe – annual Adult Social Care survey
INNOVATION – through increased research activity and supporting staff to be innovative.	Programme Board to assess individual workstreams in terms of innovation and adaptation of best practice.
VALUE – value for money which is achieved through service efficiency, service effectiveness and procurement.	Assessment of clinical outcomes in comparison to investment

We will achieve this by improving our system delivery and measure the performance of systems in delivering the desired outcomes as follows:

Table 4: Outcomes by Care Systems

Care systems:	Measures	Overall Measure	Secondary Measures	Target for 2014/15
Urgent/Unplanned	4 hour wait	95% of patients wait no more than 4hrs in Urgent Care settings No patients waiting on a hospital trolley for more than 12 hours	Length of Stay Discharges by Specialty per day Ward Rounds taking place by Specialty CERT Team activity and case mix GP referral numbers	Maintain 4hr target performance
Primary	Elective referrals	By 2018 deliver appropriate elective care in GP surgeries.	TBC, pending work up Conversion Rates	GPs move to a paperless referral system – supported by 'choose&book2' Audit of referral practice against protocol
	Access/opening	Appointments Available, including routine Opening Hours OOH availability and contacts	Patient experience Practice Nurse appointments Phlebotomy Access Access to memory assessment	
	End of Life Care	To Increase the number of people identified at end of life. Increase the number people dying in their preferred place of care by 1%		
	Unplanned admissions	Reduction in unplanned admissions by at least 15% by 2018/19 (measured Q4 – Q3); 3.5%	GP referral Rates	Numbers of avoided admissions by CCG to achieve 3.5% target are as follows:
Community	Unplanned		CERT contacts and activity	

	admissions	reduction in 2014/15	Mental Health Nursing and Care Home Liaison (operates currently in in West Lancashire) Admissions from Nursing Homes	W Lancs = 495 p/a S & F = 570 p/a
	Multi-disciplinary teams	By 2015 all integrated neighbourhood teams (INT) in place at locality level New pathways of care for diabetes, cardiology, respiratory, dementia, End of Life, Frail Elderly fully in place by April 2015	Occurrence of MDTs on a regular basis Audit on compliance with pathways	INT fully in place with a plan for roll out across other localities during 2015 – linked with Trust IT project
	Communication	Use of effective community IT system to ensure interoperability with primary care and specialist services by 2015.		Effective community IT system in use by Trust community services as functionality becomes available
	End of Life Care	To Increase the number of people at end of life dying in their normal place of residence by 1% Change to reflect as above		
	Inclusion and social isolation	Reduce isolation of people using adult social care	Proportion of people who use services (adult social care) and their carers who reported they had as much social contact as they would like – annually reported adult social care survey	
Intermediate	Length of Stay Wait times / access	Reduced length of stay Reduction in wait times	LoS in step up and step down separately Wait times for both assessment and admission	

	Discharge outcomes	Increase in discharges to usual place of residence	Breakdown of discharge destinations e.g. to usual place of residence, elsewhere Permanent admissions to residential and nursing homes per 100,000 – adult social care indicator; reported as required Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services – Adult Social Care currently an annual snapshot, but could be as required The outcomes of short-term services: sequel to service – Adult Social Care reported as required when available	
	Step up/down – patient flow	Appropriate increase in use of step up beds particularly requested by GPs	Levels of activity through each level	
	Capacity – numbers of places	CCGs to commission appropriate (according to local as identified by CCG Intermediate Care Strategy) number of intermediate care places by 2015	Wait times, Length of Stay, discharges, numbers of spot purchase beds	
Elective/ Planned	Referral to Treatment times for patients	90% patients requiring admission for treatment seen in 18 weeks 95% patients not requiring admission for treatment are seen in 18 weeks 92% of patients referred are waiting for less than 18 weeks	Conversion rates by specialty Referral rates by practice	Maintain performance against targets

4.5.1 CCtH dashboard

The CCtH dashboard is designed to track the impact of the interventions within the programme on key measures/outcomes identified within the original CCtH strategy. The data captures information about specific cohorts of people (identified by their NHS number) living with long-term health conditions and those people deemed to be frail elders (who often present with one or more long-term conditions). The long-term conditions under scrutiny are associated with the development of integrated care pathways for Diabetes, Cardiology, Respiratory, Frail Elderly and End of Life care.

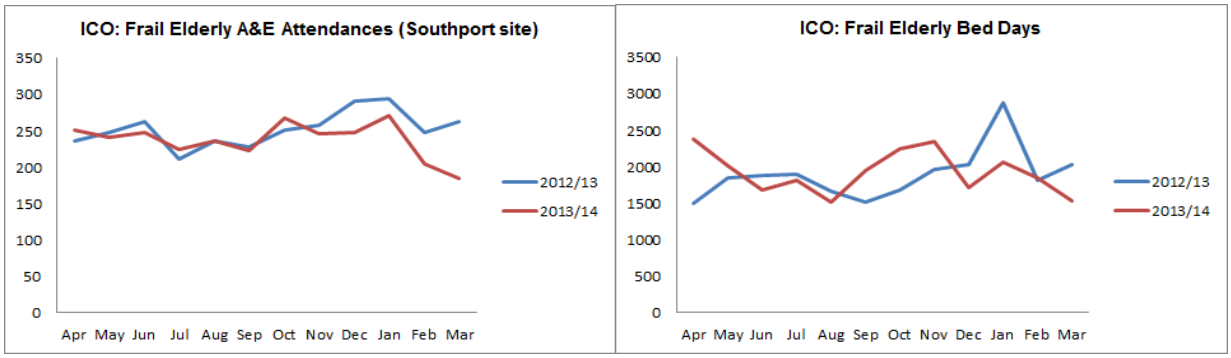
A data dictionary has been devised to ensure that data is collected consistently. Part of the process of establishing and running the dashboard has resulted in closer scrutiny and a 'tightening up' of data inputting and coding. For example, some cardiac activity in the ICO was classed as general medicine.

Reduction in 30 day readmissions	Reduced unplanned admission
Reduce A&E attendances	Reduce bed days
Increase in Community matron contacts	Increase of % of patients who die in their recorded preferred place of care

The dashboard reporting appears to indicate progress in achieving the key objectives for the CCtH programme and the improved performance of Southport District General Hospital's A&E department, during 2013/14 is undeniable.

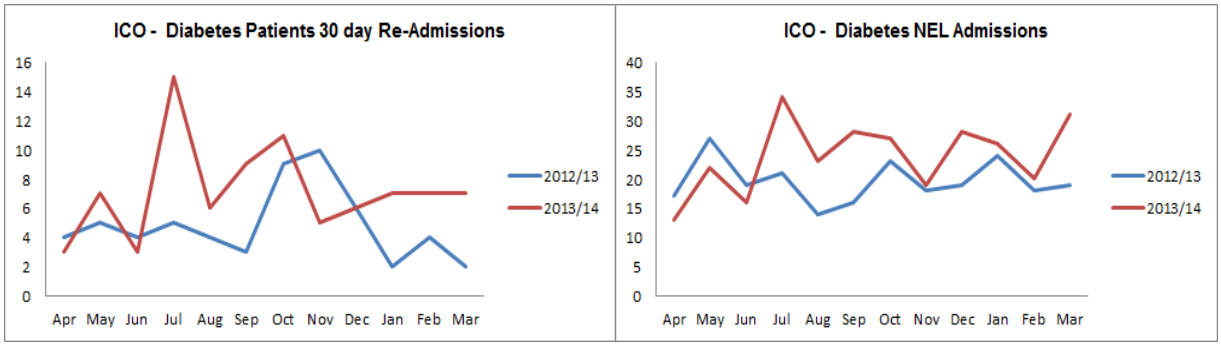
The following charts provide information to support this supposition. The CCtH Frail Elderly project has developed integrated clinical pathways and benefited from dedicated specialist medical consultant input from the ICO to implement the pathway. Furthermore, commissioners have invested additional funds (alongside centrally funded 'winter pressures' funding) to develop a Frail Elderly Short stay Unit and all of these factors have together contributed to the desired reductions.

Graph 1: Illustration of dashboard output – Frail Elderly



However, some dashboard outputs show a mixed picture, which probably reflects the fact that the integrated clinical pathways are not fully implemented for a number of reasons, such as, the need to train the primary care workforce and gaps in service provision that prevent implementation. For example, the 'Foot attack' clinical pathway requires the deployment of a multi-disciplinary team, which is not currently in place; and commissioners are considering how to address this gap. Hence, the benefits for patients on the diabetic pathway have not yet been realised and this can be seen in the charts below.

Graph 2: Illustration of dashboard output - Diabetes



4.5.2 *Urgent Care dashboard*

Holding the local health and care system to account for the performance of urgent care is a requirement of all Urgent Care Network Boards, now known as the System Resilience Group. A whole-system CCtH task and finish group was set up to consider and make recommendations about the most appropriate indicators to the CCtH Programme Board. The following measures were agreed by the CCtH Programme Board in April 2014.

Diagram 3: Proposed Indicators for Urgent Care Dashboard

Primary Care Setting	Hospital setting	Community setting
PRIMARY CARE No of unplanned admissions by A&E – total and by LTC No of referrals to A&E, GPAU and AEC by GP but not admitted – total and by LTC No of referrals to Community Matron – by source of referral No of referrals to Community Emergency Response Team by source of referral No of GP and out of hours GP referrals to urgent care by CCG and day of week	**ADMISSIONS** Unplanned admissions 30 day readmissions **BED CAPACITY** No of bed days lost against bed days available No of Delayed Transfers of Care Bed Occupancy as a % of total open beds Average No of discharges today by day of week Average No of expected discharges	**ICO COMMUNITY** % Occupancy of available community beds – step up/down and commissioned Ability to respond –% due to absence in Community Teams % die in preferred place of care % Community Caseload breakdown by patient location.
NWAS REAP level status – an NWAS internal escalation indicator Number of Ambulance conveyances to Urgent Care Units % of Patients handed over to Hospitals in > 15 mins % of Patients handed over to Hospitals in > 30 mins % of Patients handed over to Hospitals in >60 mins HAS PIN conversion by NWAS/ICO	**URGENT CARE (BY SITE)** Weekly achievement against 4 hour target No of A&E attendances – Major No of A&E attendances – Minor Average wait to be seen **PATIENT EXPERIENCE** Q.1 to be agreed Q.2 to be agreed Q.3 to be agreed	**SOCIAL CARE** Bed occupancy as a total of available – Nursing Home & Residential Elderly Mental illness Ability to respond - % due to absence in Social Care

The purpose of the Urgent Care dashboard, which is in development, is to:

- Produce a monthly report for the System Resilience Group (aka CCtH Programme Board) which will allow the Board to see how the system has performed retrospectively, identify impact of changes within the system and inform future actions
- Enable the System Resilience Group to form strategic plans based on real trend and performance data from across the system
- Enable the Urgent Care Operational Resilience Network to identify key areas for service development
- Publish performance data and make accessible information available to the public in Urgent Care Units

4.5.3 *Measuring peoples' experience of care*

National Voices, a collaboration of 130 third sector member organisations involving people who use services developed the following principles underpinning integrated care and what people expect. They state that integrated care must:

- be organised around the needs of individuals (person-centred)
- focus always on the goal of benefiting service users
- be evaluated by its outcomes, especially those which service users themselves report
- include community and voluntary sector contributions
- be fully inclusive of all communities in the locality
- be designed together with the users of services and their carers
- deliver a new deal for people with long term conditions
- respond to carers as well as the people they are caring for
- be driven forwards by the commissioners
- be encouraged through incentives
- aim to achieve public and social value, not just to save money
- last over time and be allowed to experiment

> ***"I want the right to have my concerns and views listened to and acted upon. I want the right to be supported in taking action if I am not satisfied with the service I have received".***

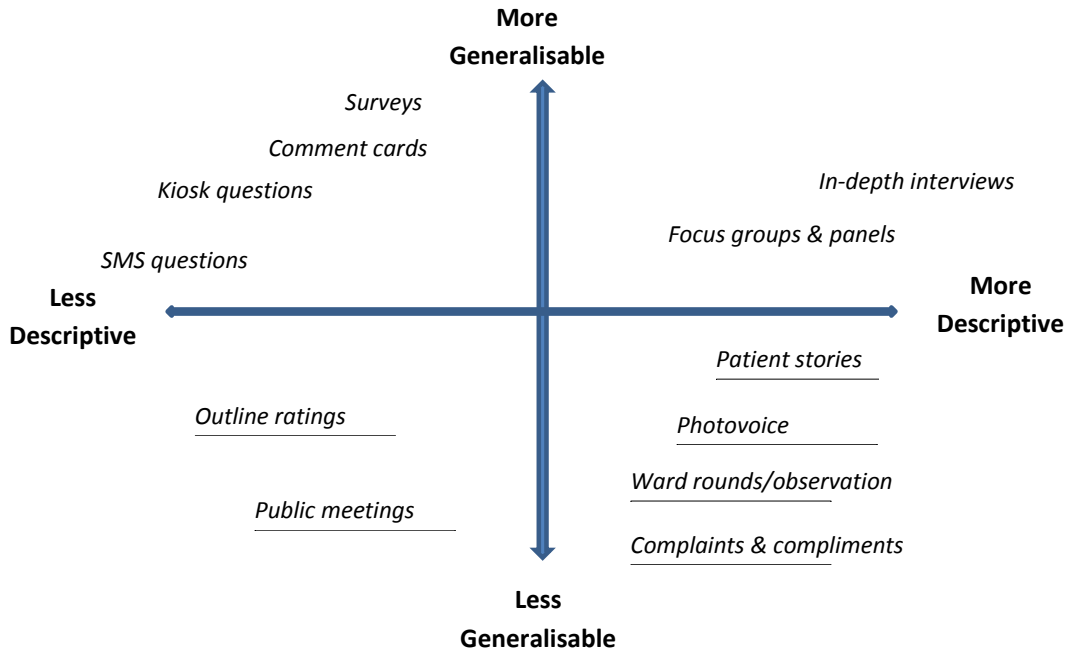
Efforts to measure and improve 'integrated care' have been hampered by the wide range of definitions of the term. Definitions of 'integrated care' often focus on descriptions of what integrated organisations should look like or what they do: in effect, they view integration from the perspective of services. Most of these definitions have come from policy makers, researchers, or health organisations.

Current thinking is shifting towards integrated care being described as 'person-centred coordinated care'. This definition was developed for the NHS Commissioning Board (now known as NHS England) and the Local Government Association by National Voices (a coalition of health and social care charities). The definition – referred to as 'the Narrative' - has been developed by users and is supported by key national stakeholders. It focuses on what is important from a user perspective: namely that care is…

"…planned with people who work together to understand me and my carer(s), put me in control, [and] co-ordinate and deliver services to achieve my best outcomes".

Patient experience is what the process of receiving care feels like for patients. **Understanding patient experience** can be achieved through a range of activities that capture direct feedback from patients, service users, carers and wider communities. These are used alongside information on clinical outcomes and other intelligence to inform quality improvements, the way local services are designed and reshaped, and contractual arrangements with providers. There are many different ways to understand the experiences of patients and carers – from questionnaires or analysing complaints, through to Experience Based Design approaches. Using experience to design better healthcare is unique in the way that it focuses so strongly on capturing and understanding patients', carers' and staff experiences of services, not just their views of the process.

Diagram 4: Examples of methods used to measure patient experiences[vii]



There are a number of national surveys that should be considered and used in support of the local surveys, which are listed as follows:

- GP Patient Survey
- NHS Inpatients Survey – the 'Friends and FamilyTest'
- VOICES national bereavement survey
- Community Mental Health survey
- National Cancer survey
- Personal social services carers survey
- Personal social services adult social care survey
- Overall satisfaction of people who use services with their care and support – annual Adult Social Care survey

"I want the right to high quality safe confidential services that treat me with dignity, compassion and respect".

In addition, the Picker Institute has been commissioned to develop a set of questions (likely to be 18 in number) to measures peoples' experience of integrated care by the Department of Health, with a stated intention that these are used in the future by commissioners as an evaluation tool.

In the meantime and since the CCtH programme prioritises those people living with long term conditions (LTC) and the 'frail elderly', a validated set of six simple questions, known as 'LT6' can be used. LT6 has been developed by the NHS to measure how effective services have been for individuals living with LTCs. It must be noted that most people described as frail elderly will also suffer from LTCs. If these six questions (LT6) were used in combination with space for people to comment on the experiences which shaped their views, the CCtH programme would be able to establish a baseline measurement of how the system is currently experienced by people with LTCs (split by demographic profiles) and be able to generate stories of patient experience. This data, combined with independent external evidence (analysis of CQC and HealthWatch reports) and internal evidence (analysis of complaints and complements) will enable the CCtH Programme Board to understand and act on the experiences of people using services.

It is recommended that the LT6 questions are used to shape a proforma which will be used by those in direct contact with people living with LTCs to capture the evidence of individual experiences.

Key factors that impact on peoples' experience of care.

People's experience of care is influenced by a number of factors, which include the nature and quality of interactions with people providing care. To improve experience of care, we must also attend to the wellbeing of the people providing care, as there are direct correlations. For example, Aston Business School undertook an analysis of the links between patient and staff surveys. The research[viii] found a large number of associations between the NHS Staff and Acute trust in-patient surveys. Further analysis and interpretation of the associations led to the following key findings:

- The more staff who have had health and safety training, the better the patient perceptions of greater conscientiousness and availability of staff.
- Organisations where staff have clear, planned goals are more likely to have patients who report positive experiences of communication; in particular around patients being involved in decisions on care/treatment, family members being able to speak to doctors, the medical information patients were given, and doctors acknowledging the presence of the patient directly when talking about their case with others.
- When employees are considering leaving their organisation, it is more likely that there are poor levels of communication with patients, particularly around medicine.
- Patient perceptions of staffing levels and the respect and dignity shown towards them are correlated to employee's feelings of work pressure and staffing levels
- Prevalence of discrimination against staff is related to several areas of patient experience, particularly their perceptions of nursing staff.
- High levels of bullying, harassment and abuse against staff by outsiders relates to many negative patient experiences.
- Staff views on the confidentiality of patient information are mirrored by patient views of the privacy they are given.

This was supported by further research which showed a relationship between staff wellbeing and various dimensions of staff-reported patient care performance and patient-reported patient experience. Individual staff wellbeing should be seen as an antecedent rather than a consequence of patient care performance[ix].

5. Service model

According to the recently published 'Five Year Forward View' (NHS England Oct. 2014) The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.

It states that, over the next five years and beyond the NHS will increasingly need to dissolve these traditional boundaries. Long term conditions are now a central task of the NHS; caring for these needs requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. As a result there is now quite wide consensus on the direction we will be taking.

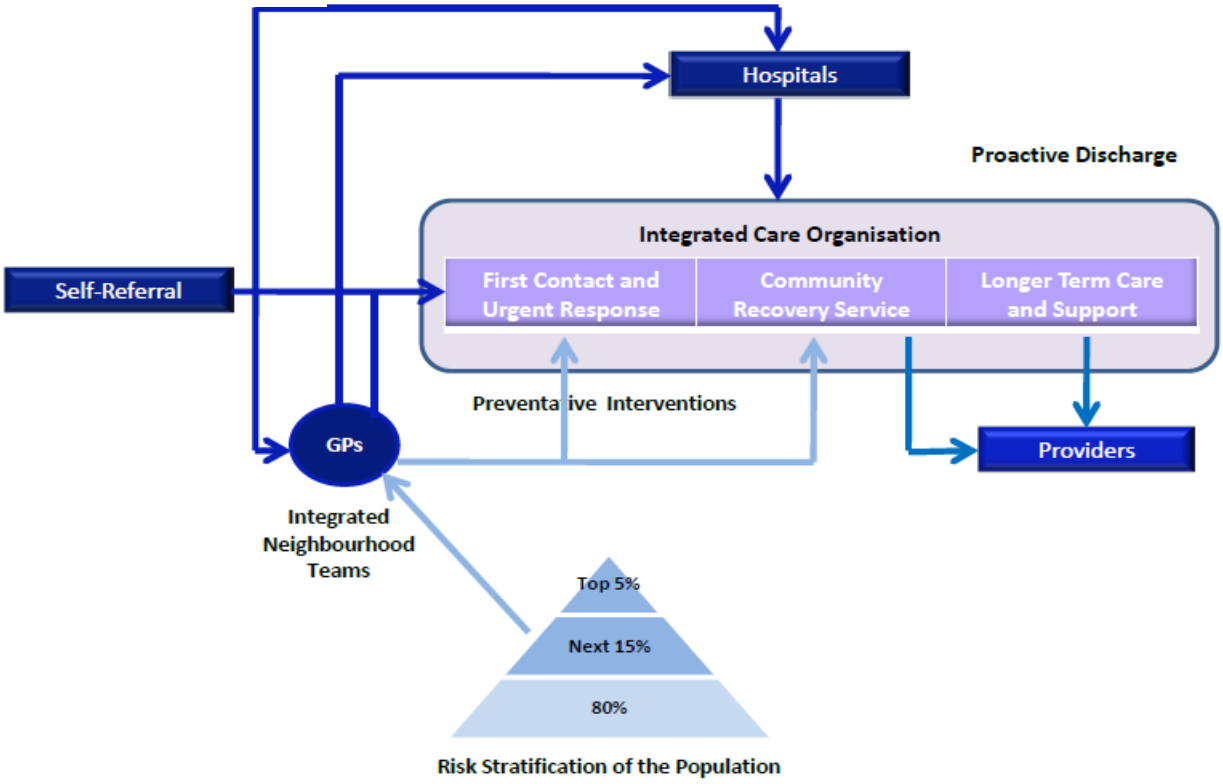
- Increasingly we need to manage systems – networks of care – not just organisations.
- Out-of-hospital care needs to become a much larger part of what the NHS does.
- Services need to be integrated around the patient. For example a patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.
- We should learn much faster from the best examples, not just from within the UK but internationally.
- And as we introduce them, we need to evaluate new care models to establish which produce the best experience for patients and the best value for money.

NHS England plan to develop seven new models, detailing how care could be provided in future. These include:

- allowing GP practices to join forces into single organisations that provide a broader range of services including those traditionally provided in hospital;
- creating new organisations that provide both GP and hospital services together with mental health, community and social care;
- helping patients needing urgent care to get the right care, at the right times in the right place by creating urgent care networks that work seven days a week;
- sustaining local hospitals where this is the best solution clinically and is affordable and has the support of local commissioners;
- concentrating services into specialist centres where there is a strong relationship between numbers of patients and the quality of care;
- improving opportunities for women to give birth outside hospital by making it easier for groups of midwives to set up NHS-funded midwifery services;
- improving quality of life and reduce hospital bed use by providing more health and rehabilitation services in care homes;
- finding new ways to support carers by identifying them more effectively and encouraging volunteering by, for example, offering council tax reductions for those who offer help and more programmes to help carers facing a crisis

Our plans will need to adapt accordingly in due course, utilising the national methodology (to be developed by NHS England) to assess our local pattern of services and determine what the most appropriate configuration of services in the future. Our current forward view of services is that of a network of integrated services, delivered by multi-disciplinary teams who will work in together to ensure the patient pathway is seamless, reduces duplication of assessment and ensures the correct outcomes are achieved. The service will utilise the resources of traditional sets of professionals in a more integrated way to create multi-disciplinary teams to enable them to deliver seamless pathways for the patients. The network will operate as *one service*, from both a clinical and a patient/service user perspective.

Diagram 5: The Care System



Services will maximise patient independence, by supporting and treating individuals in their own home or community thereby preventing and / or delaying admissions into hospital and institutional care placements. Services will deliver tailored packages of support, flexing to people's needs and enabling people to remain at home. Accordingly, the CCtH Programme Board approved the adoption and implementation of person-centred principles, developed by the 'National Voices' – a collaboration of 130 third sector member organisations involving people who use services. These principles were refined further and became more focused on integrated care and what people expect. They state that integrated care must:

- be organised around the needs of individuals (person-centred)
- focus always on the goal of benefiting service users

- be evaluated by its outcomes, especially those which service users themselves report
- include community and voluntary sector contributions
- be fully inclusive of all communities in the locality
- be designed together with the users of services and their carers
- deliver a new deal for people with long term conditions
- respond to carers as well as the people they are caring for
- be driven forwards by the commissioners
- be encouraged through incentives
- aim to achieve public and social value, not just to save money
- last over time and be allowed to experiment

A robust range of measures (by this we mean systems and processes) will be expected to support transition between services for patients. These include:

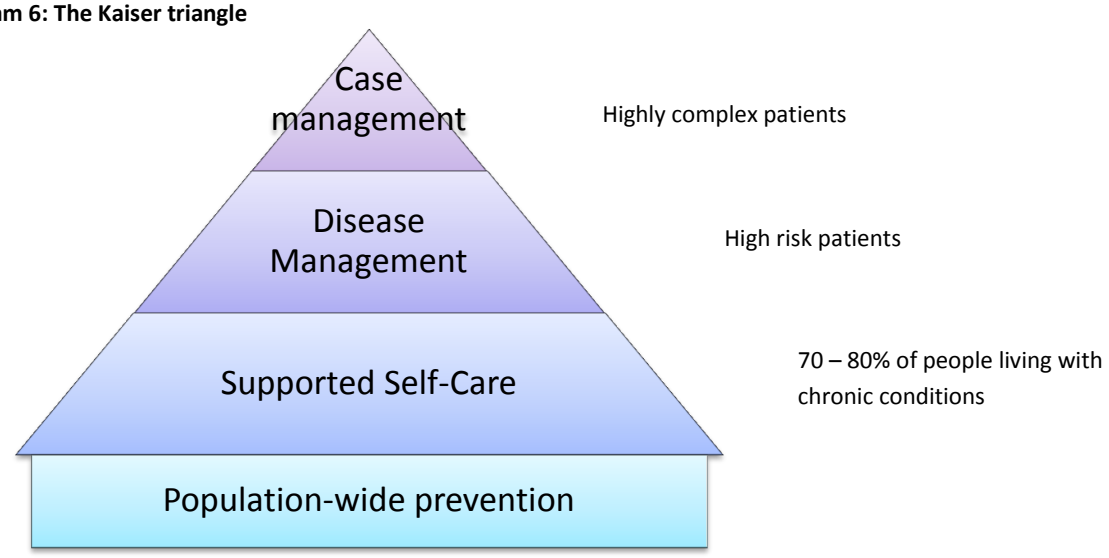
a) Use of a joint single assessment processes
b) Care coordination and single point of access
c) Enhanced data and information sharing arrangements with all partners in care
d) New approaches to addressing cross boundary issues
e) Workforce -Developing extended roles for clinicians and practitioners
f) Use of telehealth and telecare
g) Information technology / Enabling the Vision
h) Improving public health and addressing health inequalities
i) Collective leadership

Coordinated person-centred care is not universally required for all people in contact with our health and social care services. Coordinated person-centred care will target people with the most need and risk of deterioration in their health and social care circumstances. The Active Case Management approach has been adopted to ensure care is delivered as close to home as possible. Active case management is:

- the proactive management of patients with long term conditions,&/or intensive needs. E.g. older people with chronic disease & dementia who live alone,
- a proven model of care which has been successful in reducing readmissions, reducing length of stay, avoiding hospital admissions,
- empowering and supporting patients to effectively self-manage their own long term condition,
- a process that uses comprehensive holistic assessment to identify and implement appropriate health & social care services to optimise an individual's health, quality of life and active participation in the community, and
- includes planning for both current situations and a person's long term needs.

Active Case Management was first developed by Kaiser Permanente as a way of understanding and responding to chronic disease in the USA. The Kaiser 'triangle' (below) is commonly used to explain the approach.

Diagram 6: The Kaiser triangle



This approach is delivered by Case Managers, who work closely with GPs and Community Matrons to provide case management to patients at home.

Case Managers can be a generic role and are:

- experienced health professionals with a background of working with patients with long term conditions within a community setting,
- based in the community, for example, as part of the integrated neighbourhood teams or Community Mental Health Teams and they continue to support people living with long-term conditions, carrying out regular planned telephone/face to face consults, and
- are focused on educating patients to follow rescue plans and on empowering / supporting patients to self-manage their condition.

The term **Clinical Case Manager** is also used, but this description relates to the role of Community Matrons, who provide the elements of the case manager role described above, which, combined with their advanced nursing practitioner skills can work with Three of the most common reasons for unscheduled hospital admission among the most vulnerable group of people are respiratory problems, dehydration and urinary tract infections. A highly skilled nurse can treat all these conditions in the home.

NHS England has identified that any high quality, sustainable health and care system in England will have the following **six system characteristics** in five years[x]:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.
- Wider primary care, provided at scale.
- A modern model of integrated care.
- Access to the highest quality urgent and emergency care.
- A step-change in the productivity of elective care.
- Specialised services concentrated in centres of excellence.

To support the delivery of integrated care, Southport & Formby CCG and West Lancashire CCG **plan to develop a commissioning framework,** which will describe their vision for integrated services. The framework will enable partners to work together, with **collective accountability**, to provide an integrated model of care. West Lancashire CCG has developed a draft document describing the integrated services that they wish to commission entitled, **'Building for the Future: A Clinical Commissioning Strategy to Support the Delivery of Integrated Services'**. The CCGs are working closely together to align plans over the next few months and a delivery plan will be published thereafter.

5.1 Inclusion

We know that citizens want to be fully engaged in making positive choices about their own health and lifestyles; participating in the shaping and development of health and care services; well served by access to transparent and accessible data and advice about health and services; and able to choose which health services they can use and how to access them. We know that the public want a much greater say in how health services are organised, and we know that patients and their carers want much more say in how their personal care is delivered. We also know that patients and the public want much more and better information about how they can stay well or help to manage their own illness and to have information that is of high quality and readily accessible about different services and different treatments so that they can make informed choices about what will be the best for them. Empowered in this way, citizens and patients become co-providers of and active participants in health care.

- Listening to people's views
- Use of technologies
- Transparency and data sharing

"I want the right to clear and accurate information that I can use to make decisions about health and care treatment. I want the right to education about how to take care of myself and about what I am entitled to in the health and social care system".

5.1.1 Self-Care and Self-Management

*'**Self-care** is a part of daily living. It is the care taken by individuals towards their own health and wellbeing … whether in their homes, neighbourhoods, local communities, or elsewhere. Self-care includes the actions individuals and carers take for themselves, their children, their families and others to stay fit and maintain good physical and mental health; meet social and psychological needs; prevent illness or accidents; care for minor ailments and long-term conditions; and maintain health and wellbeing after an acute illness or discharge from hospital'*[xi]

Self-management is often described as a component of self-care that is informed by evidence-based health information.

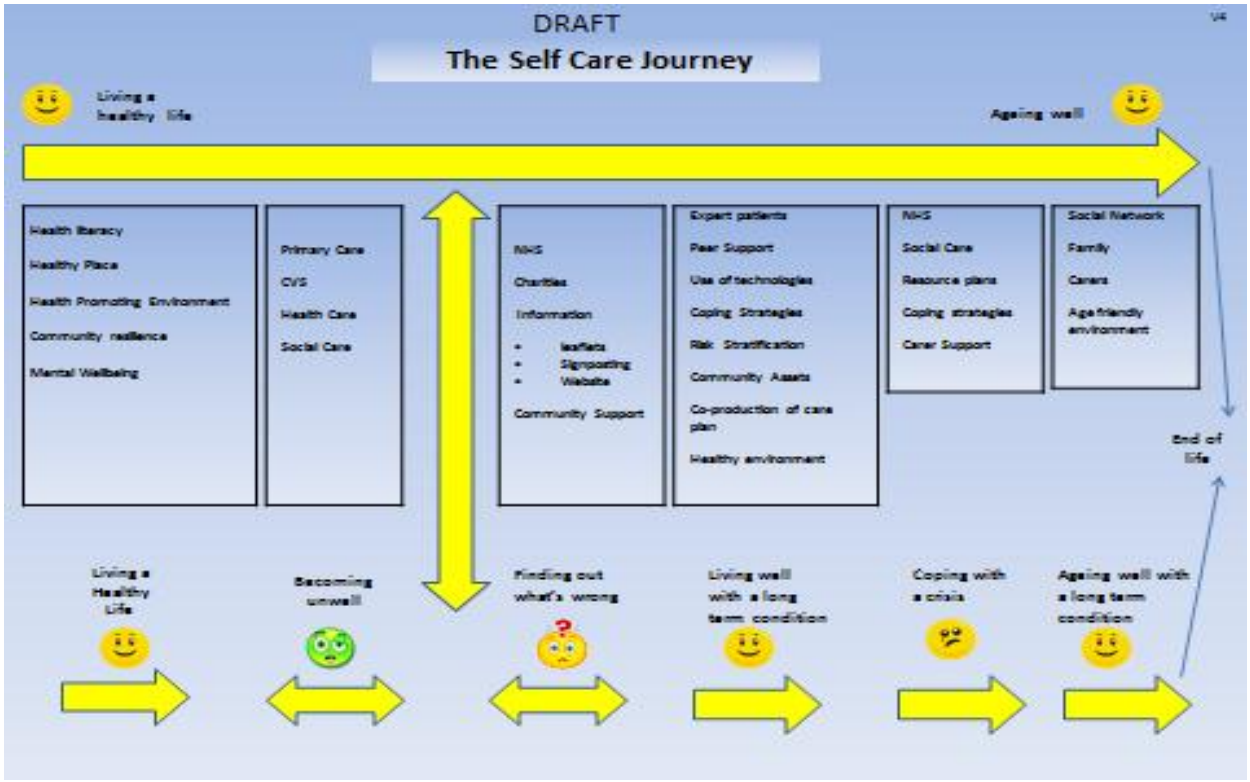
*'**Long-term condition self-management** is a process that includes a broad set of attitudes, behaviours and skills. It is directed toward managing the impact of the disease or condition on all aspects of living by the patient with a chronic condition. It includes, but is not limited to; self-care and it may also encompass prevention. The following are believed to contribute to this process:*

- *Having knowledge of the condition and/or its management*
- *Adopting a self-management care plan agreed and negotiated in partnership with health professionals, significant others and/or carers and other supporters*
- *Actively sharing in decision-making with health professionals, significant others and/or carers and other supporters*
- *Monitoring and managing signs and symptoms of the condition*

- *Managing the impact of the condition on physical, emotional, occupational and social functioning*
- *Adopting lifestyles that address risk factors and promote health by focusing on prevention and early intervention*
- *Having access to, and confidence in the ability to use support services*[xii]

The model below (draft version 4) has been developed by the CCtH Self-Care Task and Finish group to provide an evidence based framework and as a self-care journey across an individual's life course.

Diagram 7: The Self-Care Journey



The Self-Care journey model is under-pinned by the concept of health literacy, which is the ability to obtain process and understand health information in order to make informed decisions about heath choices. American research shows that low health literacy is associated with more hospitalisations, greater use of emergency care, lower use of screening and vaccination programmes and low adherence to treatment recommendations, worse health outcomes and higher mortality rates.

High health literacy helps people to promote the health of themselves, their families and their communities by understanding the causes of disease and the factors that influence health, self-diagnosing and treating minor conditions, knowing when to seek advice, choosing appropriate health care setting and provider, selecting appropriate treatments, monitoring symptoms and treatment effects, coping with the effects of chronic illness and self-managing their care, adopting healthy behaviours to prevent occurrence or recurrence of disease, providing feedback to enable quality improvement and improve governance, engaging meaningfully in ethical dilemmas and greater ownership of how resources are allocated.

People with low levels of health literacy are associated with:

- Poorer overall health status[xiii]
- Higher rates of hospitalisation and death, and longer stays in hospital[xiv]
- Higher rates of hospital readmission within 30 days of discharge[xv]
- Decreased capacity to manage chronic disease[xvi]
- Less ability to recall information after a clinic visit[xvii]
- Are more likely to make errors with medication [xviii]
- Are more ill when they seek medical care[xix]
- Have less knowledge of their illness management[xx]
- Use preventive services less frequently, and have increased patient costs[xxi]
- Are more likely to not keep appointments[xxii]

"I want to be an equal partner in determining my own health and wellbeing. I want the right to be involved in decisions that affect my life and those affecting my local community".

As people who use services are increasingly being expected to become more responsible for their care, it is becoming even more important for doctors to ensure that the health information they are providing is understood and acted on correctly. Low health literacy, simply put, is a barrier to good care. Patients should be encouraged to ask questions and expect answers, rather than expected to passively comply with everything the doctors says. This is important as although patients are far more informed than they were 10 years ago, many express frustration and dissatisfaction with their care because they feel they did not have enough say in the decisions their doctors made for them. Also, some doctors are not supportive of patient involvement in the decision-making process, simply because they believe that the doctor knows best[xxiii].

As well as improving the health literacy of our citizens and communities, we need also to harness the community assets and connect people to these assets, using an asset based approach. 'A glass half-full' (2010) introduced the assets principles:

• Assets are any resource, skill or knowledge which enhances the ability of individuals, families and neighbourhoods to sustain their health and wellbeing. "Assets can include such things as supportive family and friendship networks; intergenerational solidarity; community cohesion; environmental resources for promoting 'physical, social and mental health'; employment security and opportunities for voluntary service; affinity groups; religious toleration; life-long learning; safe and pleasant housing; political democracy and participation opportunities; and, social justice and equity." *(Hills et al. 'Asset based interventions; evaluating and synthesising evidence of effectiveness').*

• Assets approaches make visible, value and utilise the skills, knowledge, connections and potential in a community. They promote capacity, connectedness, reciprocity and social capital. The aim is to redress the balance between meeting needs and nurturing the strengths and resources of people and communities.

• Asset working seeks ways to value the assets, nurture and connect them for the benefit of individuals, families and neighbourhoods. Instead of starting with the problems, it starts with what is working, what makes us feel well and what people care about. The more familiar deficit approach starts with needs and deficiencies and designs services to fix the problem and fill the gaps. This creates dependency and people can feel disempowered. *(In Morgan et al eds Health Assets in a Global Context. Springer 2010).*

These empowering approaches will be particularly important in the development of integrated neighbourhood teams.

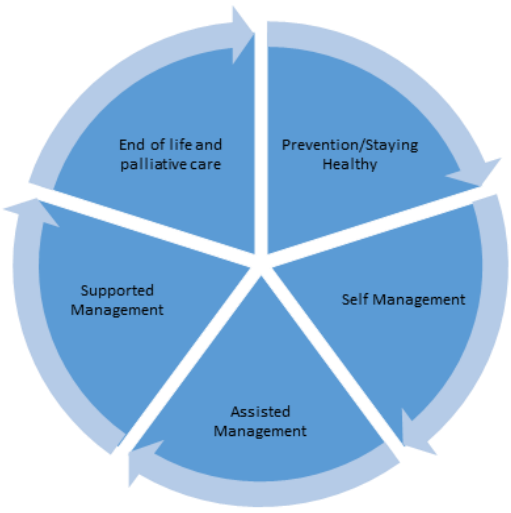
5.1.2 Telehealth and Telecare

Telehealth is the remote exchange of data between a patient at home and their clinician(s) to assist in diagnosis and monitoring, and is typically used to support patients with Long Term Conditions. Among other things it comprises of fixed or mobile home units to measure and monitor temperatures, blood pressure and other vital signs parameters (and the answering of targeted questions) for clinical review at a remote location using phone lines or wireless technology.

Telecare refers to the idea of enabling people to remain independent in their own homes by providing person-centered technologies to support the individual or their carers. Examples of Telecare technologies would typically include, falls sensors; motion sensors; bed mattress sensors; flood sensors etc., all of which can be monitored remotely.

The diagram below, taken from the West Lancashire CCGs IM&T Strategy, shows the areas of long term conditions management that need to be underpinned by technology.

Diagram 8: Areas to be underpinned by technology



Typically the areas of Self-Management, Assisted and Supported Management are those where Tele-Health and Tele-Care technologies are likely to offer the greatest benefit.

The Department of Health (DH) believes that at least three million people with long term conditions and/or social care needs could benefit from the use of Telehealth and Telecare services. Implemented effectively as part of a whole system redesign of care, Telehealth and Telecare can alleviate pressure on long term NHS costs and improve people's quality of life through better self-care in the home setting.

Initial findings from the 'Whole System Demonstrator Programme' showed that ***when used correctly***, Telehealth can benefit a patient's health and quality of life. The early findings from the WSD trial indicated:

- 15% reduction in visits to A&E
- 20% reduction in emergency admissions
- 45% reduction in mortality rates.

There have been many papers written about the benefits of Telehealth and Telecare. The University of Salford (Manchester) have undertaken a systematics overview of literature and evidence (3433 papers were retrieved) on the effects on clinical outcomes, costs effectiveness and the patient experience.

It was found that there was more evidence for some conditions than others, but on the whole trends are largely positive suggesting Tele-health is effective in:

- Reducing patient mortality and hospital admissions for chronic heart failure
- Reducing hospital admissions for COPD
- Reducing blood pressure in hypertension, improving glycaemic control in diabetes and reducing symptoms in asthma.

The CCtH Telehealth, Telecare and Assistive Technology Operational Delivery Group is considering how these technologies might be deployed across the economy and will be making recommendation to commissioners to address gaps in 2014/15.

5.2 Primary Care at scale

For those patients with a moderate mental or physical long-term condition (about 20 per cent of the population) we need to secure access to all the support and care they need from wider primary care, provided at scale. This will mean access to a broader range of services in primary care, in their own homes and in their communities, centred on a much more pivotal and expanded role for general practice to co-ordinate and deliver comprehensive care in collaboration with community services and expert clinicians.

Primary care needs to develop at pace to meet growing demand and change the way in which primary care engages with the rest of the health and social care system, particularly in relation to the development of person-centred integrated care for long-term conditions and frail elders. The priorities for primary care development can be summarised as follows:

- Ensure services are accessible and responsive
- Ensure services are of high quality and are safe
- Actively case manage people with complex needs through risk stratification and multi-disciplinary team working, organised in neighbourhood footprints, delivered close to home
- Empower and enable individuals and communities to be proactive in maintaining wellbeing and be involved as partners in managing their own care

5.2.1 Access to a responsive primary care

National policy is driving towards increased access to primary care services across 7 days a week. This will require consideration of the continuity of care, increased numbers of consultation times and giving better information to patients to enable people to make the right choices in accessing health and care services according to need.

For primary care to be become more responsive a number of developments will need to take place, such as, faster access to diagnostic results, the use of assistive technologies to support more self-care and self-management of long-term conditions, increased capacity to respond to urgent care in order to prevent needs escalating and the ability to mobilise intensive community support through multi-disciplinary neighbourhood working. In addition, GPs and community services need to work more effectively together to support people living in nursing and residential homes and alternative community based step-up and step-down facilities, which will reduce reliance on hospital care.

5.2.2 Community Based Step Up and Step Down Facilities

Alongside the commissioning of the virtual ward, the provision for the need of step up and step down facilities within each area will be assessed. Step up and step down care is part of the intermediate care facilities that sit outside of an acute hospital setting. They enable people who wish to maintain and improve their independence by providing health and social care support that is greater than currently available in their home (step up) or enables them to leave an acute hospital and get ready to return home (step down). Step up and step down beds provide services that can avoid unnecessary admissions and reduce the numbers of delayed discharges from the acute hospital settings.

The provision of these services will reduce length of stay in hospitals, so people can be discharged once their medical condition has been effectively treated, and have their care and support needs assessed at home or in a more 'home-like' environment. This also applies to people with dementia, who would be better assessed in a 'normal' environment than an assessment undertaken when in any type of hospital environment. Along with faster set down to facilitate better appropriate community placement, this would offer greater capacity to support a 'discharge to assess' approach, which may offer a number of benefits, as demonstrated by the Active Recovery Team in Sheffield[xxiv] where:

- Assessment now takes place within an environment familiar to the patient, it is 'context specific' and the patient's immediate and longer term needs can be more appropriately evaluated in their own home
- Issues which may have been developing for some time which precipitated an acute admission will be assessed and plans put in place while the patient is still able to be at home.
- Patients and their relatives report increased satisfaction. AR work until 8pm and are happy to accept evening discharges.
- Removal of steps, processes and delays in the discharge process which consume valuable resources and do not add value for the patient.
- A reduction in length of stay.
- A reduction in the risk associated with vulnerable patients remaining in a hospital environment.
- Increased discharge rates on the ward where this process is now fully implemented.
- Freeing up hospital beds reducing medical outliers.
- Increasing patient flow through the hospital.

> ***"I want the right to high quality safe confidential services that treat me with dignity, compassion and respect".***

5.2.3 Support for patients within Nursing and Residential Care Homes

An audit was carried out in 2011 on all attendances, during a two-month period, at A&E and EAU at Southport & Ormskirk Hospital NHS Trust from patients who resided in Nursing and Residential care homes.

The audit highlighted the greater proportion of nursing and residential care home beds in Southport, Formby & West Lancashire areas as opposed to the national average, with 110 registered care homes, equating to 0.86% of all the U.K total number of care home residents, when the total population of these areas only represents 0.38% of the U.K

population. The audit showed that 46% of patients admitted into secondary care had a length of stay of less than 12 hours, and that there was some care homes that appeared to be significant outliers in terms of the numbers of patients admitted to hospitals. Given some of the details in the audit, a specific project has been initiated to assess the full report, then propose and develop an action plan which will aim to coordinated services in a targeted way to support care homes in reducing the numbers of patients attending or being admitted to secondary care.

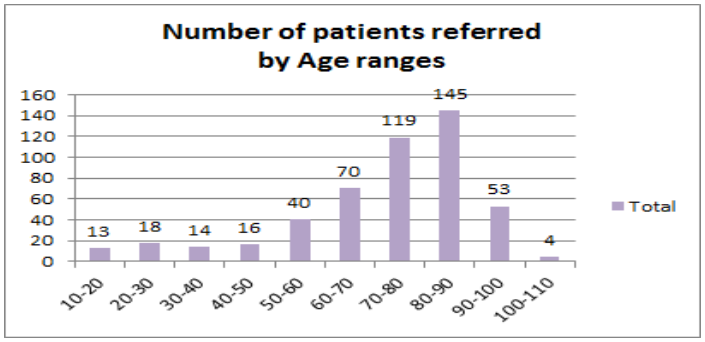
A pilot Acute Visiting Scheme (AVS) project has been operating across West Lancashire since 2nd December 2013, providing an in-hours week day service (Mon – Fri; caller handler service 8am - 6.30pm & onsite doctor 10am - 6.30pm). The service has 2 main aims:

1. Compliment primary care provision with an acute visiting service to patients where an urgent visit from a GP may not be possible or delayed, and a potential 999 call may ensue.
2. Build on previous NWAS work that suggest up to 45% of 999 calls it receives could be dealt with in primary care. During December the Ambulance team commenced using the service using NWAS Pathfinder 24 hours a day, 7 days a week.

The pilot continues with phase 2 of the AVS pilot focused on two local nursing homes. Some key information and findings so far from the audit:

- 492 referrals to the service received (in hours and out of hours). 44% from NWAS and 56% from Primary Care. NWAS colleagues feel there is more opportunity for referral and they are working with the team to improve communication and alerts to staff to utilise.
- The AVS team has visited 353 patients in their home. 259 of these patients were referred directly by primary care. Home visits are time consuming and this support provides primary care colleagues with the opportunity to see other patients.
- There is a mid-morning peak in demand from both sources of referral, with a further mid-evening peak in ambulance calls when GP surgeries closed.

Graph 3



Lancashire Care Foundation Trust provides a Nursing and Care Home Liaison services, which provides dementia education and support to nursing and care settings, aimed at improving the environment for people living in the care home with dementia and preventing admission. This is particularly important where people living with dementia exhibit challenging behaviours, so as to help the care home staff understand and better manage the behaviour to maintain the placement.

5.2.4 Managing ambulatory care-sensitive conditions

Ambulatory care-sensitive (ACS) conditions are chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management, such as vaccination; better self-management, disease management or case management; or lifestyle interventions. Examples include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension.

Despite admission being largely preventable, a significant proportion of all acute hospital activity is related to ACS conditions. In England ACS conditions accounted for 15.9 per cent of all emergency hospital admissions in 2009/10. There is significant variation in how effectively ACS conditions are managed – emergency admissions per head vary more than two-fold between local authority areas after adjusting for the differences in age, gender and deprivation. These admissions are costly. The total cost to the NHS in 2009/10 was estimated at £1.42billion for a core set of 19 ACS conditions[xxv].

Early identification of ACS patients is crucial if their management is to be successful. GPs are well placed to do this through the use of risk stratification tools and clinical decision support software within GP practices. Some progress can be made through relatively simple measures such as expanding vaccination, where available, to prevent the onset of a condition. For other ACS conditions (chronic and acute aggravated conditions), commissioners will need to encourage active disease management.

A review of evidence[xxvi]suggests that the following evidence-based interventions for avoidable admissions should be implemented and evaluated locally:

- disease management and support for self-management for those with long-term conditions
- telephone health coaching
- other behavioural change programmes to encourage patient lifestyle change.

The review also suggested that improvements in the quality of primary and secondary care are needed, for example:

- increase continuity of care with a GP
- ensure local, out-of-hours primary care arrangements are effective for those with acute aggravated conditions, ensure there is easy access to urgent care
- conduct early senior review in A&E, and implement structured discharge planning.

5.2.5 Improving primary care management of end-of-life care

Within primary care, improving the systematic identification of patients who are at the end of life, and then providing the appropriate support; in particular, improving the co-ordination of care, continuity, quality of communication, and the provision of bereavement care is vital because:

- Two-thirds of people would prefer to die at home, but in practice only about one-third of individuals actually do[xxvii]
- The annual number of deaths in England and Wales is expected to rise by 17 per cent from 2012 to 2030, and the average age at death is also set to increase markedly[xxviii]
- The costs of caring for people at the end of their lives is estimated to run into billions of pounds[xxix]
- Care for the 27 per cent who die from cancer is around £1.8 billion in the last year of their life, or £14,236 per patient[xxx]

- Wide variations exist in the quality of end-of-life care across England. Spending by primary care trusts (PCTs) on palliative care has varied from £154 to more than £1,600 per patient[xxxi]

The CCtH End-of-Life Integrated Care Pathway Group (ICPG) had a head start on the other ICPGs as there was already an evidence based pathway that had been developed nationally and was in the process of being implemented locally. The Gold Standard Framework (GSF) was developed as a framework for palliative care in primary care, bringing a proactive approach to end of life care. The GSF recognised that, in order to provide optimal care for any patient nearing the end of their life and not just in the terminal or dying phase, but in their last year, we need to be able to do three things:

- identify where a patient is on their illness trajectory – is it likely that they have years, months, weeks or days to live? This then allows proactive management, calmer planning and less 'fire-fighting' crisis management
- assess their needs, and those of their family/carers, in the light of their advance care plan
- plan (using a management plan) and then provide their care according to the patient's preferences and varying needs, at different times.

Southport & Ormskirk NHS Trust was the first whole hospital to pilot the use of the GSF in the acute hospital setting and, sharing the same framework and vocabulary, has been a catalyst for better cross boundary care for those approaching the end of life. The Trust then mirrored the first wave, and joined the second wave, of the national Transform Programme for end of life care, adding greater personal future planning and dealing with uncertainty of those acutely ill with a poor prognosis, to the three key enablers already in place – GSF, respecting choice at the end of life with rapid transfers to preferred place of care and care of the dying.

A key point is for all hospital and hospice clinicians, who recognise that a patient may be in their last year of life, to notify the patient's GP and recommend that the patient is added to the palliative care (GSF) register. Dr Karen Groves, Consultant in Palliative Medicine, has been working with clinicians, managers and commissioners across the system to support the implementation of the GSF and other good practice initiatives in palliative care.

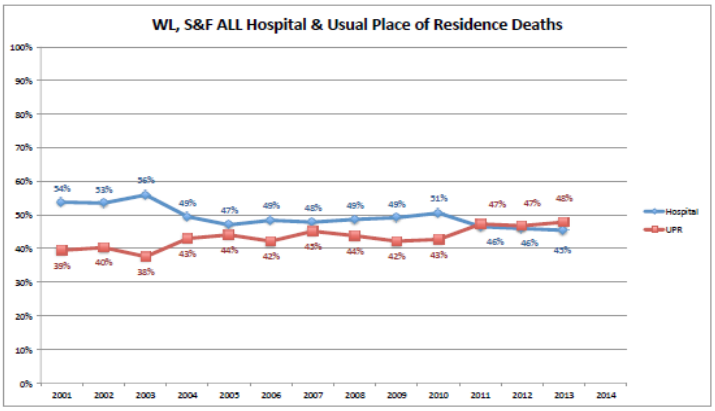
The work has levered a number of benefits:

- Consistent, seamless specialist palliative care across the area with auditable uniform standards of care for those approaching end of life
- Carers' needs appropriately assessed and addressed
- Effective processes in place for respecting choices of those thought likely to be dying

- Increased percentage of patients cared for and dying in their usual place of residence (48% in 2013; 47% in 2012) compared to hospital (45% in 2013; 46% in 2012)
  - 97% of those registered GSF, who died, had a recorded preferred place of care
  - 83% of those registered GSF, who died, and had expressed a preferred place of care achieved it (2013/14)
- Improved hospital support & experience for dying patients and their families

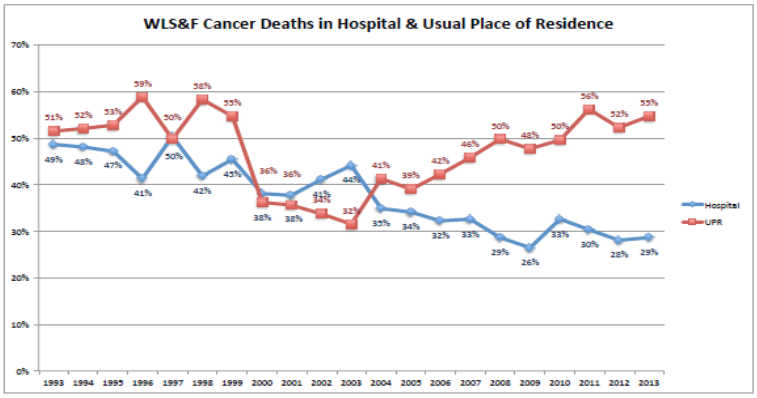
For the third year running, ONS figures for this area, show deaths in usual place of residence (48%) have **exceeded** deaths in hospital (45%). However the gap has increased from 1% in years one & two, to **3%** in year three.

Graph 4



This is a remarkable achievement for all deaths and the picture is even more positive for people dying of cancer, with 55% of people dying in their usual place of residence, rather than in hospital (29%).

Graph 5



The End-of-Life ICPG is no longer operating, but the group are continuing to meet to keep up the momentum of improvement and will be focusing on

- Addressing gaps in provision, such as:
  - Community tissue donation processes
  - Electronic palliative care co-ordinating system
  - Mobile working solution for SystemOne for Specialist Palliative Care services
  - CCG community pharmacy contracts for end of life drugs as yet unresolved
  - Return of District Nurse night service to S&F not yet effected

- Continuing to develop the skills and knowledge of the workforce, across primary, secondary and specialist care services in respect of End-of-Life care.

5.2.6 Mental health and dementia

Our local specialist mental health organisations, Lancashire Care NHS Foundation Trust and Merseycare NHS Trust, provide diagnostic services in line with the best practice dementia pathway. People diagnosed with the condition and their carers are offered education in relation to living well with dementia through memory assessment and Community Mental Health Teams.

Complex care coordination is provided for people with mental health conditions, including dementia and psychotic conditions. Person centered care planning ensures the patient feels part of the care and intervention. Contingency planning for deterioration in psychological (mental) wellbeing and in crisis are formulated by the patient, their carer (if appropriate) and the care coordinator.

Crisis resolution services are available for all ages, with the aim or preventing admission to an acute mental health bed. If admission is required beds are currently available in various sites across Liverpool and Lancashire. From April 2015, Lancashire Care NHS Trust will be opening a new hospital, known as the 'Harbour', which will offer highly specialised excellent mental health in patient care in a purpose built setting in Blackpool. Our mental health providers are developing services for people living with dementia, for example, Lancashire Care Foundation Trust now provides nursing and care home liaison services, where experienced mental health professionals educate and support care home staff in their understanding of dementia and associated behaviors. This liaison service, aims to prevent admission of the patient to hospital services.

In order to further enhance the provision for the frail elderly population and common mental health problems associated with long term conditions, the mental health community provision will need to establish a more coordinated approach to join up care. NHS England's 'Five Year Forward View' (2014) states that, with further investment over the next five years, the NHS must drive towards an equal response to mental and physical health, and towards the two being treated together, in order to achieve genuine parity of esteem between physical and mental health by 2020.

The 'Five Year Forward View' also heralds the expansion of access standards to cover a comprehensive range of mental health services, including children's services, eating disorders, and those with bipolar conditions and signals the need to develop and invest in local mental health services for young people as a priority.

5.3 Modern model of integrated care

For the 5 per cent of patients with multiple, complex, mental or physical long-term conditions, often compounded by being elderly and perhaps frail, we need a modern model of integrated care with a senior clinician taking responsibility (through a personal relationship) for active co-ordination of the full range of support from lifestyle help to acute care.

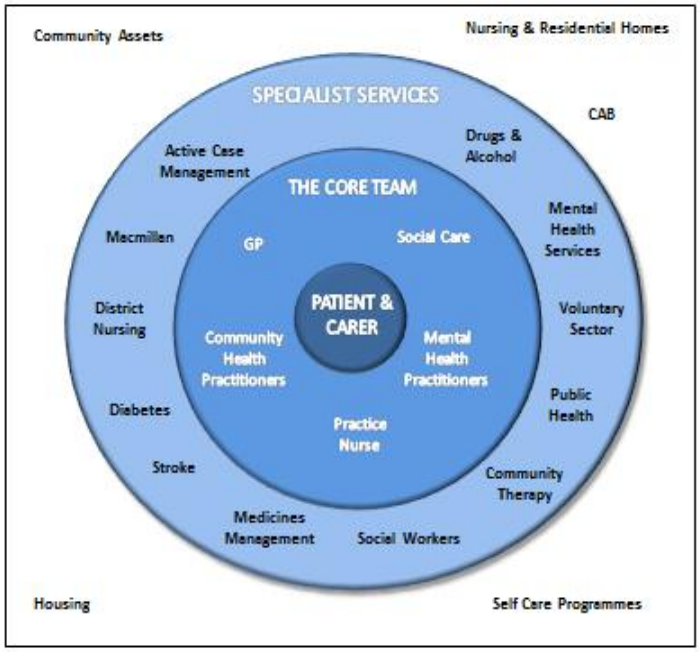


Diagram 9: Draft Integrated Neighbourhood Team model

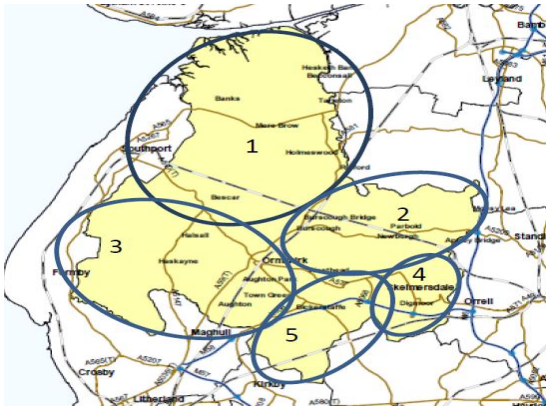
Each integrated care team will look different depending on the community served, but is likely to include the following features: senior clinicians (within a team) taking full responsibility for people with multiple long-term conditions; full responsibility lasting from presentation to episodic care, including personalised care planning for those who would benefit; and co-ordination of care including lifestyle support and advice, social care, general practice care and hospital episode co-management.

To support this development new service 'footprints' have been agreed, known locally as neighbourhoods, to align primary, secondary and specialist health and social care services. These neighbourhoods have also been configured around the prevailing needs of the local populations, which will enable a more proactive public health approach to tackle inequalities in health outcomes, which are largely driven by demographic determinants. So we will organise the integrated care teams in this way and they will be known as **Integrated Neighbourhood Teams** (INTs).The following diagrams show the configuration of these neighbourhood footprints.

"I want to be an equal partner in determining my own health and wellbeing. I want the right to be involved in decisions that affect my life and those affecting my local community".

Diagram 10

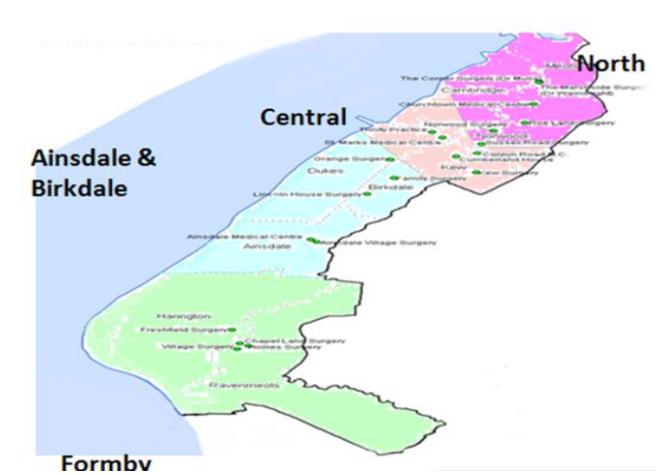
West Lancashire CCG neighbourhood configurations



1. Tarleton, Hesketh Bank and Banks
2. Burscough and Parbold
3. Ormskirk and Aughton
4. Hillside
5. Sandy Lane

Diagram 11

Southport & Formby CCG neighbourhood configurations



Formby	North Southport	Central Southport	Ainsdale & Birkdale
Chapel Lane Surgery	Norwood Surgery	Cumberland House Surgery	Ainsdale Medical Ctr
The Village Surgery	Churchtown Medical Ctr	Curzon Road Medical Practice	Ainsdale Village Surgery
Freshfield Surgery	Sussex Road Surgery	St Marks Medical Centre	Grange Surgery
The Hollies	Roe Lane Surgery	Kew Surgery	Lincoln House Surgery
	The Corner Surgery	Trinity Practice	The Family Surgery
	The Marshside Surgery		

The INTs will not only join up primary, secondary and specialist services, they will be designed to include mental health practitioners, which will join up approaches to mental and physical health. We know that dementia and common mental health problems, such as, anxiety and depression, are increasing in prevalence. At least half of all people with long-term conditions suffer from multiple co-existing conditions and between 12% and 18% of all NHS expenditure on long-term conditions is estimated to be linked to mental health problems[xxxii].

INTs, through the social care service offer, will **work holistically with people to address social needs**, such as isolation and local area coordination will be in place to facilitate access to a much wider resource directory that goes beyond the usual statutory offer, which will ensure that people are supported with trusted assessment and open access to the

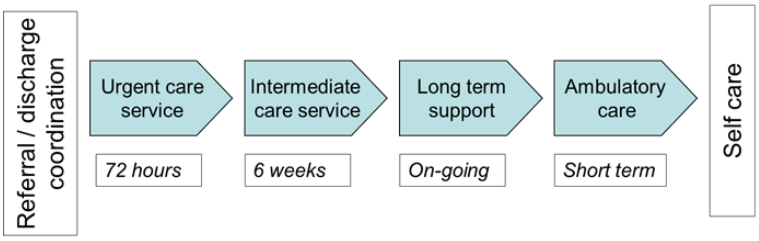
transitional services, for example, better transition arrangements as people move between services will improve people's experience of care and reduce hand offs in the system .

As previously stated in this document, the future integrated primary, community and social care services will be orientated to providing as much care closer to home as is possible, particularly for people living with long-term conditions and the ability to quickly mobilise **flexible, high quality urgent and enhanced care services** will be an essential component of the future model.

Community urgent and enhanced care services will:

- Provide viable, safe alternatives to attending A&E and subsequent admission when clinically appropriate
- Provide the appropriate level of skilled and competent staff clinically assess, differentially diagnose, prescribe if necessary and complete an episode of care, demonstrating autonomous practice
- Provide up to 72 hours of intensive support for a targeted population
- Work seamlessly with community matrons to support case managed patients if intensive support is needed to avoid an admission
- Integrate with adult social care to provide a step up, step down facility (home or within a bed base)
- Provide targeted anticipatory, preventative care in partnership with others
- Facilitate timely transfer of care when clinically appropriate
- Deliver on-going care within specified care pathways in community settings
- Operate 24/7 services as appropriate with full integration with other providers of urgent care and walk in services (OOH and walk in services are under review this includes the CERT and Acute Visiting Service)
- Work in partnership with NWAS Pathfinder scheme

Diagram 12: Duration of support by service components



The urgent response function is an essential component of the whole system approach to admission avoidance in preventing the urgent becoming an emergency and discharge facilitation. The urgent care element of the service will provide a nurse led multi-disciplinary, community based service which is proactive, dynamic and skilled in first contact assessment and care, demonstrating autonomous practice with the primary aim of (wherever possible), preventing unnecessary hospital admissions and admissions into long term care. The team can also facilitate more pressing, safe, early transfer from a hospital setting. It is the crisis arm of the community services offer and is central to the success of the proposed model. How the service operates across the neighbourhood multi-agency teams is set out in Diagram 13 (below).

Providing initial and on-going clinical and social care assessment, observation, co-ordination of care, support and a management plan, patients will then be managed within appropriate pathways. It is accepted that in that 72 hour period the patient may:

- be stabilised with an episode of care completed
- require hospital admission
- further rehabilitation/reablement
- transfer into the neighbourhood long term/complex care service
- transfer into ambulatory care services

The 72 hours of intensive assessment and support will allow time for future care needs to be considered, providing an alternative to acute admission as a default. It is also recognised that 72 hours is a maximum period of stabilisation or transfer on, however it may be clinically appropriate to complete an episode of care earlier depending on patient need. The current Community Emergency Response Team operates extended hours across the full 7 day week and provides some of this model, responding to people experiencing urgent care needs within two hours of referral and provides a foundation to build on.

Integrated Neighbourhood Team Model

Diagram 13