A meeting of NHS North Tyneside Clinical Commissioning Group Governing Body is to be held in Public on Tuesday 22 November 2016, 9.15am-11.15am at Hedley Court, NE29 7ST

Members of the public are invited to meet members of the Governing Body informally prior to the meeting, from 9am-9.15am.

Agenda

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Exclusion of the press and members of the public:

To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.
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<th>Forename</th>
<th>Employed Status</th>
<th>Self/ Relationship</th>
<th>Company/Organisation</th>
<th>Brief Details of Interest</th>
<th>Member or Attendee?</th>
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<td>Clinical Chair</td>
<td>Matthews</td>
<td>John</td>
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<td>Self</td>
<td>Park Road Medical Practice</td>
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<td>Health Education North East</td>
<td>Trustee, Community Development Charity</td>
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<td>Consultant in Palliative Care</td>
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<td>Burke</td>
<td>Wendy</td>
<td>LA employee</td>
<td>Self</td>
<td>North Tyneside Council</td>
<td>Employee of North Tyneside Council</td>
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<td>Lay Vice Chair</td>
<td>Coyle</td>
<td>Mary</td>
<td>Lay Member</td>
<td>Self</td>
<td>Newcastle University Pension</td>
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<td>Trustees Limited</td>
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<td>Fox</td>
<td>Pauline</td>
<td>CCG employee</td>
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<td>Secondary care doctor</td>
<td>Han</td>
<td>Kyee</td>
<td>Clinician</td>
<td>Self</td>
<td>Great North Air Ambulance Service</td>
<td>Medical Director (pt)</td>
<td>Member</td>
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<tr>
<td>Interim Chief Officer</td>
<td>Hayburn</td>
<td>Jim</td>
<td>Interim</td>
<td>Self</td>
<td>Haku consultancy ltd</td>
<td>Director</td>
<td>Member</td>
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<td>Interim Chief Finance Officer</td>
<td>Hayman</td>
<td>Deborah</td>
<td>Interim</td>
<td>Self</td>
<td>O Hayman Associates Ltd.</td>
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<td>Husband</td>
<td>NHS South, Central and West CSU</td>
<td>Associate Director of Procurement</td>
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<td>Lay member</td>
<td>Hayward</td>
<td>Eleanor</td>
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<td>Self</td>
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<td>Interim Chief Finance Officer</td>
<td>James</td>
<td>Paul</td>
<td>Interim</td>
<td>Self</td>
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<td>Interim Chief Operating</td>
<td>Soo-Chung</td>
<td>Janet</td>
<td>Interim</td>
<td>Self</td>
<td>JSC Management Consulting Ltd</td>
<td>Independent member of Audit Committee</td>
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<td>Officer from</td>
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<td>Declaration awaited</td>
<td>Trust Board Member</td>
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<td>Walker</td>
<td>Irene</td>
<td>CCG employee</td>
<td>Self</td>
<td>Northumberland County Council</td>
<td>HR Manager</td>
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<td>Officer from 8/7/16</td>
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<td>Bedlington Community Centre Partnership</td>
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<td>Head of Governance</td>
<td>Willis</td>
<td>David</td>
<td>Lay Member</td>
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<td>Wicks</td>
<td>John</td>
<td>Interim</td>
<td>Self</td>
<td>John &amp; Wicks Healthcare Management Ltd</td>
<td>Director</td>
<td>Attendee</td>
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<td>Officer</td>
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<td>Wright</td>
<td>Martin</td>
<td>Clinician</td>
<td>Self</td>
<td>Portugal Place Health Centre</td>
<td>Partner - advisory body (not fee earning)</td>
<td>Member</td>
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<td>Connect Physical Therapy</td>
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<td>Executive Director of</td>
<td>Young</td>
<td>Lesley</td>
<td>CCG employee</td>
<td>Self</td>
<td>University of Northumbria at Newcastle</td>
<td>Visiting fellow</td>
<td>Member</td>
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<td>Nursing and Transformation</td>
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DEFINITION OF CONFLICT OF INTEREST

A conflict of interest occurs where an individual’s ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. In some circumstances, it could be reasonably considered that a conflict exists even when there is no actual conflict. In these cases it is important to still manage these perceived conflicts in order to maintain public trust.

Conflicts of interest can arise in many situations, environments and forms of commissioning, with an increased risk in primary care commissioning, out-of-hours commissioning and involvement with integrated care organisations, as clinical commissioners may here find themselves in a position of being at once commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment, to procurement exercises, to contract monitoring.

Interests can be captured in four different categories:

**Financial interests:** This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:

- A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.

- A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.

- A management consultant for a provider. This could also include an individual being:
  - In secondary employment (see paragraph 56-57);
  - In receipt of secondary income from a provider;
  - In receipt of a grant from a provider;
  - In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider;
  - In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
  - Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
**Non-financial professional interests:** This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular group of patients;
- A GP with special interests e.g., in dermatology, acupuncture etc.
- A member of a particular specialist professional body (although routine GP membership of the RCGP, British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE);
- A medical researcher.

GPs and practice managers, who are members of the governing body or committees of the CCG, should declare details of their roles and responsibilities held within their GP practices.

**Non-financial personal interests:** This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider;
- A volunteer for a provider;
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;
- Suffering from a particular condition requiring individually funded treatment;
- A member of a lobby or pressure group with an interest in health.

**Indirect interests:** This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above) for example, a:

- Spouse / partner
- Close relative e.g., parent, grandparent, child, grandchild or sibling;
- Close friend;
- Business partner.

A declaration of interest for a “business partner” in a GP partnership should include all relevant collective interests of the partnership, and all interests of their fellow GP partners (which could be done by cross referring to the separate declarations made by those GP partners, rather than by repeating the same information verbatim).

Whether an interest held by another person gives rise to a conflict of interests will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the CCG.
OFFICIAL

North Tyneside CCG Governing Body

Minutes of the North Tyneside CCG Governing Body meeting held in public Tuesday 25 October 2016, 9.15am-10.40am, at Hedley Court.

Present:
Dr John Matthews  Clinical Chair (Chair)
Mary Coyle  Deputy Lay Chair
Janet Soo-Chung  Interim Chief Officer
Paul James  Interim Chief Finance Officer
Eleanor Hayward  Lay Member
Dave Willis  Lay Member
Dr Martin Wright  Medical Director

In Attendance:
John Wicks  Interim Chief Operating Officer
Mathew Crowther  Commissioning Manager
Dianne Effard  PA (Minutes)

NTGB/16/103  Welcome & Introductions (Agenda Item 1)

Dr Matthews welcomed members of the public to the North Tyneside CCG meeting in public and invited Governing Body members to introduce themselves. He went on to clarify that members of the public were in attendance as observers, which differed from a public meeting where the public would have the opportunity to participate in the discussion.

Dr Matthews acknowledged that the “Right Care, Time & Place – A Review of the Commissioning of Urgent Care Services in North Tyneside" item was of considerable interest to the residents of North Tyneside. Given the interest in the review, Dr Matthews asked whether members of the public in attendance wished to raise any points of clarification or questions.

Kate Simpson of Newcastle upon Tyne Hospitals had a query regarding the operating hours of the proposed new urgent care centre as to whether it would be open between 12midnight and 8am. Mr Crowther advised that this would be covered in his presentation.

NTGB/16/104  Apologies for Absence (Agenda Item 2)

Apologies for absence were noted from Dr Young-Murphy, Mr Kyee Han, Ms Irene Walker, Ms Christine Keen and Ms Wendy Burke.

NTGB/16/105  Confirmation of Quoracy (Agenda Item 3)

The meeting was confirmed as quorate.
Declarations of Interest (Agenda Item 4)

The standard register of interests is published on the CCG’s website.

Drs Matthews and Wright declared their interest in relation to agenda item no 9.1 “Right Care, Time & Place – A Review of the Commissioning of Urgent Care Services in North Tyneside”. Dr Matthews advised that Ms Coyle, Deputy Chair would chair the meeting for that item. He and Dr Wright would participate in the discussion, but would not take part in making the decision.

Minutes of the Previous Meeting held on 27 September 2016 (Agenda Item 5)

An error was noted in minute no NTGB/16/090, paragraph 2, bullet point1, line 2: the figure of “£2.3” should have read “£2.3m”.

Subject to that amendment, the minutes were agreed as an accurate record.

Matters Arising from the Previous Meeting held on 27 September 2016 (Agenda Item 6)

There were no matters arising from the previous minutes.

Action Log from Meeting held on 27 September 2016 (Agenda Item 7)

NTGB/16/042, Action 1: Quality & Safety Committee Report: This will be reported to the Quality & Safety Committee first and will then be brought to the Governing Body.

NTGB/16/073, Action 2: Finance Contracting & Performance Report: This is included in the FRP refresh for presentation to the Private Governing Body meeting.


Report from the Chair and Interim Chief Officer (Agenda Item 8)

Dr Matthews reported the recent interest in the referral management scheme, and the concerns which had arisen because of a similar scheme being introduced in North Durham. North Tyneside CCG (NTCCG) has been referenced as it has been operating referral management for some 18 months. It was noted that in implementing this scheme that NTCCG had
benefitted from the support of the Patient’s Forum in helping to design patient information leaflets, and local MPs had been fully briefed.

The scheme has worked effectively in North Tyneside and had reduced the CCG’s average number of referrals compared to other CCGs and was now just below average. Dr Matthews thanked the team for managing the implementation and for improving the consistency of referrals to hospital services.

Dr Matthews advised that Tim Rideout, NHS England Director of Commissioning Operations, has been appointed as NHS Improvement Director of Improvement and Delivery. NHS Improvement has taken over from Monitor for oversight of hospital activity and performance, so the whole healthcare system is being overseen by one person. Alison Slater has been appointed as his Deputy in his NHS England role.

Ms Soo-Chung gave an update on the NHS Directions placed on NTCCG from 1 September 2016, following the annual CCG assurance process. The CCG was working actively to address the requirements, and will work through the specific points set out in the Directions. The main requirements are to refresh the FRP to address the scale of the financial problem, undertake a governance review to stabilise the management of the CCG and strengthen financial management and programme management. Good progress was being made so that the CCG will be able to make its request to NHS England to have the Directions lifted. The timing of this will be discussed with the Area Team.

Ms Soo-Chung advised that the CCG’s Quarter 1 assurance meeting with NHS England was held on 11 October 2016, to assess the CCGs performance across a range of indicators and constitution standards. The CCG had reported positive progress against a range of measures. NHS England will write to the CCG to record their view of the CCGs position at Quarter 1. The Governing Body acknowledged that there had been a lot of hard work done to reach the current position, and congratulated the team. The Area Team had also recognised that the CCG had gone through a very challenging time, and the progress made was acknowledged.

Mr Wicks gave an update on the Sustainability & Transformation Plan (STP). This is a high level strategic plan for Northumberland, Tyne & Wear (NTW) covering a population of 1.5m. The final draft had been submitted to NHS England/NHS Improvement on 21 October 2016.

The health and wellbeing gap in NTW had to be addressed, in particular the higher than average deaths from cancer, higher prevalence of people with diabetes, more obese people, more women who smoke and higher deprivation levels. Because of
those factors, people can expect 10% fewer health years of life in NTW than the England average.

In terms of care and quality, the CCG commissions from outstanding Trusts who deliver most of the NHS services. There is however, still some variation and inconsistency in demands for hospital services. All services need to be clinically and financially sustainable. Over five years the gap across the NHS in this area could be £641m against a do nothing scenario.

The plan is in draft form and when finalised, the CCG will ensure engagement with partner organisations to explain how the plan will be developed. Mr Wicks was thanked for his work on the STP.

Right Care, Time & Place – A Review of the Commissioning of Urgent Care Services in North Tyneside (Agenda Item 9.1)

Dr Matthews invited Ms Coyle, Deputy Lay Chair of the Governing Body, to take the chair for agenda item 9.1.

Ms Coyle introduced the item by clarifying that:
- Drs Matthews and Wright had declared their interest in this item as local GPs;
- Drs Matthews and Wright would be permitted to participate in the discussion of this item but would not participate in making the final decision;
- Given that the Governing Body would not be quorate at the point of making the decision it would need to be ratified by the full Governing Body, including Drs Matthews and Wright.

Ms Coyle invited Mr Crowther to present the report.

It was noted as part of the presentation that the current system of urgent care was potentially confusing for patients with service provision duplicated within a relatively small geographical area. The urgent care system should meet national commissioning standards and the CCG at the same time needed to ensure that urgent care services were cost effective.

The CCG had embarked on a significant piece of work to review the current provision, and as part of this, had undertaken extensive engagement and consultation.

The CCG’s proposals were that existing urgent care services within the scope of the review would be decommissioned, and replaced by a single urgent care service for integrated access to in-hours and out-of-hours urgent care. Consultation had been based on four options, and from the work done the preferred option was a single North Tyneside urgent care centre based at North Tyneside General Hospital. Although this preference was noted and provided an important input to the review, it would need to be considered with other information in finalising a decision.
It was further noted that the consultation process had been independently audited on three occasions and was consistent with best practice.

The proposed North Tyneside integrated urgent care service will:
- Open on a 24/7 basis (although opening times may be subject to further review);
- Treat patients of all ages;
- GP-led;
- Minor injuries/minor ailments;
- Patients with minor ailments who self-refer will receive a triage on arrival and may be offered a booked appointment in primary care;
- Patients calling NHS 111 will be offered a booked appointment with the service.

In response to a query from the Governing Body, Mr Crowther explained that the process would be an open procurement which would invite tenders from providers who would be able to suggest alternative sites for the new service. Although there had been a preference expressed for Rake Lane as part of consultation, Northumbria Healthcare NHS FT (NHC) had confirmed that they did not wish to allow other service providers to operate from that location.

In response to a question from Mr Willis it was clarified that had this been allowed the procurement would have invited tenders for the provision of service from Rake Lane. However, given the Trust position, the procurement would not mandate a specific location.

Mr Willis raised a further question about the length of the contract. This was confirmed as initially three years with an option to extend the contract.

Overall the aim of the procurement was to secure the best possible outcome in terms of accessibility, quality of service and cost effectiveness.

Mrs Hayward asked for further detail on the financial assumptions made in the business case. Mr. Wicks drew attention to pp.63 of the business case which gave further detail on how the affordability envelope had been arrived at taking a starting point of £4.4m and after adjusting for a number of factors arriving at a recommended figure of £3.3m. It was noted that the cost envelope was comparable with the costs of similar service models elsewhere.

Mr Willis raised a point about the possibility of unintended financial pressure arising from the new service. It was noted that a financial contingency had been built into the costings and that work was in progress to reduce demand on these services. This included the
implementation of the Primary care strategy which would develop services to support this.

In response to Mrs Hayward’s question about transport Mr Crowther confirmed that a transport analysis had been undertaken and that this had shown that the two sites were similar in terms of accessibility. It was also thought that public transport tended to change over time to reflect new service locations. This issue could be considered more easily when it was known where the service was to be located.

In concluding the discussion Ms Coyle asked the Governing Body members but not including Dr Matthew and Dr Wright whether they wished to support the recommendations in the report which were to:

1. Decommission the existing urgent care services at NTGH, Battle Hill, Shiremoor Health Centre and the GP OOH service from 30 September 2017;
2. Commission a single integrated urgent care centre providing in-hours and out-of-hours care for patients with minor injuries and minor ailments from 1 October 2017;
3. Commission the new service on a block contract at a maximum cost of £3.3m;
4. Undertake a competitive procurement process. This is the best means of ensuring that the CCG delivers both the new clinical model and the required financial savings;
5. Undertake a competitive procurement in which providers will be able to identify any suitable site for the new service within North Tyneside.

These were agreed and this decision then confirmed by the full Governing Body including Dr Matthews and Dr Wright.

NTGB/16/112 Date of Next Meeting (Agenda Item No 10)

In closing the meeting Dr Matthews thanked members of the public for attending.

The meeting closed at 10.40am

The next meeting of NHS North Tyneside Clinical Commissioning Group Governing Body in public is to be held on:
Tuesday 22 November 2016, 9.15am-11.15am, at 12 Hedley Court, Orion Business Park, Tyne Tunnel Trading Estate, North Shields NE29 7ST
<table>
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<tr>
<th>Date</th>
<th>Minute</th>
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<tbody>
<tr>
<td>24 May 2016</td>
<td>NTGB/16/042</td>
<td>1</td>
<td><strong>Quality and Safety Committee Report:</strong> Dr Young-Murphy and Dr Wright to prepare a report such as this for the independent sector providers. Quality reports to the Governing Body on NHS providers and other providers to alternate, so that in the course of the 6 meetings each year, the Governing Body would receive three of each.</td>
<td>Dr Young-Murphy and Dr Wright</td>
<td>November 2016</td>
<td>On agenda for GB meeting 22.11.16 Complete</td>
</tr>
<tr>
<td>26 July 2016</td>
<td>NTGB/16/073</td>
<td>2</td>
<td><strong>Finance Contracting &amp; Performance Report:</strong> JS-C/PJ/JW: Information on additional saving schemes to be provided to the Governing Body.</td>
<td>Ms Soo-Chung/Mr P James/Mr J Wicks</td>
<td>October 2016</td>
<td>This will be included in final FRP refresh. Outstanding</td>
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<tr>
<td>27 Sept 2016</td>
<td>NTGB/16/090</td>
<td>3</td>
<td><strong>2016/17 Finance and Contracts Report Month 5 – August:</strong> PJ to review report presentation in tables 4a and 4b in future reports to ensure clarity, reconciliation and to provide a breakdown of other services.</td>
<td>Mr P James</td>
<td>November 2016</td>
<td>To be corrected in the next Financial Report. Outstanding</td>
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Report to: Governing Body

Date: 22 November 2016  Agenda item: 9.1


Sponsor: Dr Lesley Young-Murphy, Executive Director Nursing and Transformation

Author: Julie Bee, Senior Clinical Quality Officer, North of England Commissioning Support (NECS)

Purpose of the report and action required:

This report provides the Governing Body of North Tyneside Clinical Commissioning Group (NTCCG) with a summary of activity in July, August and, where available, September 2016 in those areas of clinical quality not covered by the Integrated Quality and Performance Report. A full Integrated Governance Report is provided to the Quality and Safety Committee and exceptions are reported here.

Executive summary:

- A total of 75 serious incidents (SIs) were reported by all four Trusts between July and September 2016.
- Northumberland, Tyne and Wear Foundation Trust (NTWFT) scored ‘outstanding’ following its recent CQC inspection.
- Friend and Family Test (FFT) response rates for Northumbria Healthcare FT (NHCFT), Newcastle upon Tyne Hospitals FT NuTHFT) and NTWFT continue to be below the national average, although improved performance can be seen in recommendation rates.
- In the latest National Reporting and Learning System (NRLS) data released in September, the number of incidents reported by NTWFT relating to self-harming behaviour is significantly higher compared to other mental health Trusts. NHCFT continue to perform well and is in the middle 50% of reporters, however NuTHFT’s reporting rate places it back in the bottom 25% of reporters.
- NuTHFT is undertaking a large amount of work in relation to reducing Healthcare Acquired Infections (HCAIs) and this will continue to be a key area in the Trust’s quality priorities for 2017/18. NHCFT is the only local Trust showing improving C-Difficile rates; this has been particularly notable since the move to the Northumbria Hospital (NSECH).
- North East Ambulance Service FT (NEASFT) Emergency Care Performance continues to be extremely challenging especially with regards to handover delays experienced at NSECH. Additionally workforce continues to be an issue, however staffing levels continue to improve and sickness levels have fallen.
- NHCFT continues to undertake falls reduction work and has developed a bespoke falls dashboard to monitor performance.
- There was a significant ‘spike’ in incident reporting by North Tyneside GP practices with 45 being reported on SIRMS in September compared to eight in August.
Governance and Compliance

1. Links to corporate objectives

<table>
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<th>2016/17 corporate objectives</th>
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<tr>
<td>3. Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside</td>
<td>✓</td>
</tr>
<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
<td>✓</td>
</tr>
</tbody>
</table>

2. Consultation and engagement
   Not applicable

3. Resource implications
   Not applicable

4. Risks
   Patient safety risks following serious incidents, process in place to undertake root cause analysis following SI to ensure lessons learned

5. Equality assessment
   Not applicable

6. Environment and sustainability assessment
   Not applicable
Quality and Safety Committee Report

November 2016
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Provider Quality Updates

Northumbria Healthcare NHS Foundation Trust

- A Falls Update presentation was delivered to the QRG in September outlining the challenges facing the Trust particularly patients with delirium and dementia. The Trust has developed its own dashboard based on falls data where it tracks the number and severity of falls. The data shows that the number of hip fractures that were as a result of an inpatient fall has improved.

- A presentation was given on serious incidents (SIs) and associated significant learning events (SLEs) including the recent ‘never event’, with the Trust demonstrating a range of service improvements from lessons learned.

- The Trust is also undertaking process development work to link the mortality review process to the SLE and SI review processes to ensure that cases previously investigated under the ‘routine’ root cause analysis reviews are escalated to a more comprehensive review where needed.

- The Trust had reported poor performance in hip fracture sepsis and mortality areas across the last four quarters to quarter 2 of 2016/17, however the Trust reported that their overall position had improved and that they were looking at further areas of work to continue to improve their performance.

- With FFT the Trust continues to commit to delivering an improvement to 6% in their A&E FFT response rates by the year-end, alongside the already significant patient experience programme delivered by the organisation.

- The most recent National Reporting and Learning Service (NRLS) data was released in September 2016 which detailed patient safety incident reports in England and Wales occurring between 1 October 2015 and 31 March 2016. NHCFT is placed at the top of the middle 50% of reporters, the top incident type reported was ‘patient accident at 28.5% which is higher than other acute Trusts in the cluster.

- The NHS Quality Dashboard for July shows that NHCFT is not an outlier in any areas, and there has been a significant improvement in the cancer 62 day waits (urgent GP referrals).

- There was one reported case of MRSA in July and three cases of C-Diff reported in both August and September taking the Trust above its monthly trajectory.
Northumberland, Tyne and Wear NHS FT

- The CQC inspection report for NTWFT was published on 1 September 2016 with the Trust scoring 'outstanding' overall. NTWFT is one of the first mental health trusts to be rated outstanding under the CQC’s programme of comprehensive inspections. Some areas of improvement were advised in the areas of restraint and mental health resuscitation.

- The most recent National Reporting and Learning Service (NRLS) data was released in September 2016 which detailed patient safety incident reports in England and Wales occurring between 1 October 2015 and 31 March 2016. NTWFT is placed within the middle 50% of reporters. Self-harming behaviour accounted for 43% of incidents reported, almost twice that of all other mental health Trusts (22%). This is due to the specialist nature of the services provided by the Trust such as children and young people / adolescent inpatient forensic services.

- A Sign up to Safety closedown report was presented. It was confirmed that falls work will continue with the Trust-wide falls group and that physical health is formally reported Trust-wide. The work on physical assault management will continue with the “talk first approach”.

- The Trust has benchmarked against the 39 recommendations in the Mazars Report and has found that it is achieving the majority of them. It was confirmed that the report has given the Trust a valuable resource to use within the mortality review and investigation process.

- The Trust’s training packages in regard to restraint have been revamped and it is in the process of re-training trainers on the new programme. The Trust is moving away from a physical restraint approach to one of violence reduction.

- An update was provided on the prescribing of anti-psychotic drugs for learning disabilities patients. A task and finish group has been formed and it acknowledged that the Trust is struggling to take change forward in isolation and that the role of local implementation groups is key. Medicines optimisation teams will need to be included in any new processes and the Trust needs to be sure of what the overall package will be. The appropriate infrastructure must be in place as it is not just a case of simply ceasing medication for a vulnerable cohort of patients.

- FFT recommendation rates continue to remain below the England average in August 2016, although there has been some improvement from previous months.

- NTWFT also showed as being above the national average in falls with harm for the second consecutive month, but with an improving performance in September. As a mental health Trust, the actual numbers of patients affected are low, however the Trust will provide an update on individual cases and action being taken at the next QRG.
Newcastle upon Tyne Hospitals NHS FT

- Following the 'outstanding' status awarded by the CQC in June, several areas were identified as needing improvement and plans are being implemented in the area of syringe drivers and patients 'preferred place of death' (PPOD). The End of Life Care (EoL) Care team outlined the 3 year strategy, the challenges they face and their intended action on areas for further improvement at the September QRG.

- A patient safety quality report was presented and the steady improvement in the Trust's DNACPR audit results was noted.

- Complaints numbers have reduced despite much work being undertaken to ensure patients are given the opportunity to make a complaint should they need to. The Trust hope that this is due to early intervention by the management teams and clinical staff capturing the issue and resolving it through local resolution before it becomes a complaint.

- The most recent National Reporting and Learning Service (NRLS) data was released in September 2016 which detailed patient safety incident reports in England and Wales occurring between 1 October 2015 and 31 March 2016. The Trust is in the bottom 25% of reporters, which is deterioration compared to the previous release which showed the Trust in the middle 50% of reporters. ‘Patient accidents’ accounted for the highest number of incidents reported (24.9%). An incident reporting education programme is continuing.

- There were no reported MRSA cases in August and September, however there were 10 reported cases of C-Diff each month taking the Trust above its monthly trajectory of 7 and 6 respectively. The Trust is undertaking a large volume of work in relation to reducing HCAIs.

- The Trust was flagged as an outlier in the North Region Quality Dashboard published September across two areas relating to potential under reporting of serious incidents and Monitor continuity of services rating. This is an improvement on the previous report where five outliers were identified; with PROMS (knee replacement oxford score and groin hernia health gain), number of never events and Patient Safety Alerts no longer showing as outliers.

- FFT inpatient and A&E response rates continued to be below the national average in August 2016. In A&E, the Trust’s combined score of 7.8% has increased since July (3.4%), however it continues to remain significantly below the England average of 13.7%. Inpatient response rates have a combined score of 16.7% in August, an increase on July’s figure of 12.8%. This remains below the England average of 25.5%.

- The Trust is below the national average on rates of all reported pressure ulcers, grades 2-4, however it should be noted that on reported rates of new pressure ulcers, NuTHFT is now above the national average following three months of deteriorating performance.
North East Ambulance Service

- NEAS scored ‘good’ as a result of the recent CQC inspection whose report was published on 1 November 2016.
- NEAS Red 8 minute response times improved slightly to 65.5% and Red 19 also improved to 91.08%. Both remain below the national targets of 75% and 95% respectively.
- Workforce continues to be an issue for the Trust, and paramedic vacancies currently run at 80.81wte. This figure excludes advanced technicians working as lead clinicians. Approximately 84 students will graduate from Teesside University between September 2016 and April 2017. It is anticipated that NEAS will have 5 vacancies remaining by the end of the financial year, which is a significant improvement from the starting point.
- The most recent National Reporting and Learning Service (NRLS) data was released in September 2016 which detailed patient safety incident reports in England and Wales occurring between 1 October 2015 and 31 March 2016. The data shows that NEAS only reported incidents for 3 out of the 6 months between 01/10/15 to 31/03/16 and 50% of incidents were submitted more than 102 days after the incident occurred. This delay is due to incidents not being reported at the time of occurrence as they tend to be identified as a result of another investigative process. A ‘deep dive’ investigation is currently being undertaken in respect of incident reporting by NEAS across the North East region.
- The number of patient safety incidents reported has steadily fallen over the past 12 months which NEAS state is as a result of the Police no longer reporting ambulance delays to them. It is however important to note that these are still logged by the Police and shared at the regular joint meetings and any serious cases are formally reported and investigated.
- A number of improvements have been seen in reported downtime. For April to August 2016/17, there have been over 4,000 less hours of downtime, which equates to an 8% reduction, when compared to the same five month period in 2015/16. Most notably, ‘single man’ downtime has reduced by over 3,000 hours. There has also been efficiency savings of almost 500 hours for ‘vehicle cleaning’.
- Handover delays at the Northumbria Specialist Emergency Care Hospital (NSECH) continue to place significant additional pressures on NEAS performance levels, with a high number of ‘hours lost’ each day as a result of the delays.
- Patient Transfer Services (PTS) - It should be noted that the number of respondents for FFT for both PTS and See and Treat remains low; this appears to be a national problem across all ambulance services. The satisfaction scores for the latest data release shows that NEAS PTS respondents totalled 329 (total eligible 52,166) 95% of which recommended the service which is a pleasing result as this is above the national average of 86%. Of the 43 See and Treat respondents (7,272 eligible), 100% would recommend the service.
- The Trust continues to be a low reporter of incidents with many being reported after a significant number of days had lapsed since the incident occurred. The Trust is undertaking significant work to resolve issues in relation to incident reporting through the use of electronic solutions.
Serious Incidents

Serious incident close down panels were held in July, August and September 2016; 27 cases were presented, with 32 SIs closed. Serious incidents are closed when the panel is assured that the investigation report and resulting action plan is complete and the provider has demonstrated that, lessons have been learned from the incident and associated actions have been taken. The graphs below show:

1) A comparison of North Tyneside CCG SIs reported between Sept 2015 and Sept 2016 and the number of those SIs that were closed by North Tyneside CCG in the same time period.
2) The status of ongoing SIs requiring sign off by North Tyneside CCG.

In the year from September 2015 to September 2016, there were 96 SIs reported that required closure by North Tyneside CCG, of these 64 were closed.

There are 26 SIs awaiting closure, including 12 where the reports are not due, 6 where the SI reports are overdue, including NHCF (n=4), NuTHFT (n=2), 4 reports are awaiting review prior to listing for panel, 2 are listed for the closure panel and there are 2 where additional information has been requested prior to closure by the Panel.
There were two Never Events reported by Trusts between July and September 2016. NHCFT reported one regarding a retained foreign object post-surgery, whilst NuTHFT reported one regarding administration of medication via the wrong route. NuTHFT also reported two Never Events in October and one in November, bringing their year to date total to seven. Newcastle Gateshead CCG is working with the Trust to examine the reasons for this and obtain assurances about future action.

Local quality requirements in contracts require the Trusts to monitor and report their performance against the NHS England SI Framework, for reporting SIs within 2 days of identification and submission of final investigative reports within 60 days, with a target of 95% compliance. Over the reporting period, NHCFT reported 83% of incidents within 2 days and 42% in 60 days. NuTHFT reported 85% in 2 days and 63% in 60 days. NTWFT reported 96% in 2 days and 80% in 60 days. All three Trusts are showing overall improvements in each measure.
All 29 GP practices in North Tyneside are now registered on SIRMS to report incidents. Between July and September 2016, 19 (66%) North Tyneside practices reported a total of 65 incidents.

A full SIRMS report is produced quarterly with details of themes, trends and feedback which is shared across the CCG, Practices and Provider Trusts. The next quarterly report is being compiled for quarter 2 2016/17.
The Newcastle upon Tyne Hospitals NHS FT

Northumberland Healthcare NHS FT

Northumberland Tyne and Wear NHS FT

- NHCFT falls with harm rate performance continues on a downward trend
- NHCFT’s performance against patients with catheters and a UTI continues to decrease
- NHCFT recorded 1 case of MRSA in September 2016, however their performance on C.Difficile cases remain strong

- NuTHFT has seen an increase in pressure ulcers
- NuTHFT reported 10 cases of C.Diff in September 2016

- NTWFT has seen an increase in the rate of falls with harm and catheters with UTIs
- All Trusts continue to perform poorly in FFT response rates

Key:
- Improving/ better than national average/on target
- Performance worse than national average
- Deteriorating performance/ worse than national average

*NTWFT is not required to provide data for the indicators which have not been completed
Other Quality Issues

Complaints

In July 2016, there were two formal complaints, three concerns and one advice request received by the NECS complaints team from North Tyneside CCG residents. All cases were acknowledged within 3 working days.

In August 2016, six formal complaints and one advice enquiry were received by the NECS complaints team in respect of North Tyneside CCG residents. All cases were acknowledged within 3 working days. Five complaints and one advice enquiry were closed and one complaint is ongoing.

In September 2016, five formal complaints, one advice enquiry and one concern were received by the NECS complaints team in respect of North Tyneside CCG residents. All cases were acknowledged within 3 working days. Two complaints, one advice enquiry and one concern were closed and three complaints are ongoing.
Report to: Governing Body

Date: 22 November 2016  
Agenda item: 9.2

Title of report: Integrated Quality and Performance Report

Sponsor: Lesley Young-Murphy, Director of Nursing and Transformation
Author: James Martin, Commissioning & Performance Manager and Clair Carpenter, Information Analyst

Purpose of the report and action required: To report progress against the CCG quality and performance measures. This report has been considered by Quality & Safety Committee and is presented to Governing Body to note current progress in 2016/17 against the listed measures.

Executive summary: The 2016/17 Integrated Quality and Performance Report shows delivery against NHS Constitution, CCG Health Outcomes, Quality Premium, and Quality measures. The CCG is held to account for the delivery of these measures by NHS England.

The performance to note identified in this report is:

NHS Constitution –

→ Newcastle FT has struggled to meet the threshold for diagnostic waits in 2016/17 and is under the standard in July 98.9%. A detailed action plan has been implemented with both medium and long term solutions. The CCG is still meeting the 99% threshold YTD.

→ Cancer waiting times – the CCG came under threshold for July for urgent breast referrals seen within two weeks, treatment within 62 days of GP referral and subsequent surgical treatment within 31 days. Across the three standards there were a total of 7 breaches; the CCG is still meeting all three standards YTD.

→ The number of ambulance handover delays at Northumbria FT has decreased significantly following a peak in March (259 delays in July compared to 597 in March). Although there has been a consistent decrease in the number of handover delays occurring at NSECH in recent weeks, the CCG remains concerned that this is symptomatic of the seasonal drop in attendance levels rather than the resolution of underlying capacity, flow and process issues. North Tyneside and Northumberland CCGs have therefore formally requested support from the Emergency Care Improvement Programme (ECIP), which has been asked to undertake an independent assessment of the NSECH site and formulate further recommendations for action. The CCGs are also considering what commissioning and contracting measures could be employed to reduce the volume of discretionary category 1 and 2 attendances at NSECH and create a simpler system which actively directs patients to the most appropriate point of care. This programme of work will be completed before we enter the winter escalation period.

→ Category ‘Red 1’ and ‘Red 2’ response times below the 75% threshold for July and YTD in North Tyneside. Work continues with Northumbria FT to reduce ambulance handover delays and release ambulance resource sooner. There have been signs of improvement for the 19 minute transportation time when compared to earlier in 2016, with the 95% threshold being met for July and also YTD.
NHS Outcomes Framework:

→ 16 indicators are currently performing above their thresholds and are rated as green.

→ Although the standardised rate for unplanned hospitalisation for asthma, diabetes and epilepsy in U19s is above threshold, the number of admissions July 2016/17 YTD is the same as for the parallel period in 2015/16. Improvements were observed throughout 2015/16 on this measure. This will be monitored to observe whether increases continue into Q2.

→ The rate of emergency admissions for children with lower respiratory tract infections for June is above that recorded for the same period in 2015/16 at 76.3 (compared to 22.7). This difference to the 2015/16 rate equates to less than 12 admissions. The measure will be monitored to observe whether this has been due to a round of respiratory infections in Q1 or whether increases continue.

→ IAPT recovery rate in July at 44.9% against a 50% threshold. Due to the implementation of the Step 3 Waiting List Initiative and a considerable increase in patients receiving treatment it was expected there would be a dip in performance for Q1 2016/17. Monitoring will continue to ensure expected improvements come to fruition.

→ The latest data (released July 2016) shows a decrease in satisfaction across all three GP patient experience indicators when compared with the previous release. Review of survey data at practice level has been completed and specific practices have been identified for targeted improvement. Further funded work is planned with GP practices to review current capacity and demand and put in place practice level plans to improve access.

NHS Quality Premium – of the measures in the Quality Premium currently 4 out of 8 measures are on target, however data for one measure is not currently available. Due to the current financial position of the CCG the NHS England qualifying criteria for payment of Quality Premium funding may not be met.

Other Quality Measures - The NHS Quality Dashboard has highlighted one never event at Newcastle FT involving medication given via wrong route. This is being managed via the CCG SI process and the usual contractual penalty will apply.
Governance and Compliance

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<td>✓</td>
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</table>

2. Consultation and engagement
   Not applicable

3. Resource implications
   Not applicable

4. Risks
   Not applicable

5. Equality assessment
   Not applicable

6. Environment and sustainability assessment
   There are no environmental or sustainability issues arising from this report.
Quality and Performance Report

August 2016
This quality and performance report is based upon data available up to 23rd September 2016.

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<td>• Enhancing quality of life for people with LTC</td>
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</tr>
<tr>
<td></td>
<td>• Helping people to recover from episodes of ill health</td>
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<td></td>
<td>• Ensuring people have a positive experience of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Ensuring a safe environment</td>
<td></td>
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<tr>
<td>Healthcare Associated Infections – C. Difficile</td>
<td>• Trend monitoring of C. Difficile infections for North Tyneside CCG, Northumbria FT and Newcastle FT</td>
<td>13</td>
</tr>
<tr>
<td>Quality Premium</td>
<td>• National measures</td>
<td>14 – 15</td>
</tr>
<tr>
<td></td>
<td>• Local measures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• NHS constitution measures</td>
<td></td>
</tr>
<tr>
<td>Other Quality Measures</td>
<td>• NHS England Quality Dashboard</td>
<td>16 – 17</td>
</tr>
</tbody>
</table>
## NHS Constitution

<table>
<thead>
<tr>
<th>Key Performance Area</th>
<th>Indicator</th>
<th>Domain</th>
<th>Period</th>
<th>Threshold</th>
<th>CCG Actual</th>
<th>YTD Actual</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to Treatment</td>
<td>% patients waiting for initial treatment on incomplete pathways within 18 weeks</td>
<td>3</td>
<td>Jul-16</td>
<td>92.0%</td>
<td>94.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of patients waiting more than 52 weeks for treatment</td>
<td>3</td>
<td>Jul-16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% patients waiting less than 6 weeks for the 15 diagnostic tests (including audiology)</td>
<td>3</td>
<td>Jul-16</td>
<td>&gt;99%</td>
<td>99.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% patients spending 4 hours or less in A&amp;E or minor injury unit</td>
<td>3</td>
<td>Jul-16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Over 12 hour trolley waits</td>
<td>3</td>
<td>Jul-16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer waits</td>
<td>% of patients seen within 2 weeks of an urgent GP referral for suspected cancer</td>
<td>2</td>
<td>Jul-16</td>
<td>93.0%</td>
<td>97.0%</td>
<td>96.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of patients seen within 2 weeks of an urgent referral for breast symptoms</td>
<td>2</td>
<td>Jul-16</td>
<td>93.0%</td>
<td>91.3%</td>
<td>94.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of patients treated within 62-days of an urgent GP referral for suspected cancer</td>
<td>2</td>
<td>Jul-16</td>
<td>85.0%</td>
<td>81.8%</td>
<td>87.9%</td>
<td></td>
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<tr>
<td></td>
<td>% of patients treated within 62-days of urgent referral from an NHS Cancer Screening Service</td>
<td>2</td>
<td>Jul-16</td>
<td>90.0%</td>
<td>100.0%</td>
<td>96.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of patients treated for cancer within 62-days of consultant decision to upgrade status</td>
<td>2</td>
<td>Jul-16</td>
<td>N/A</td>
<td>75.0%</td>
<td>75.0%</td>
<td></td>
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<tr>
<td></td>
<td>% of patients treated within 31 days of a cancer diagnosis</td>
<td>2</td>
<td>Jul-16</td>
<td>96.6%</td>
<td>99.0%</td>
<td>98.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of patients receiving subsequent treatment for cancer within 31-days - Surgery</td>
<td>2</td>
<td>Jul-16</td>
<td>94.0%</td>
<td>90.9%</td>
<td>96.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of patients receiving subsequent treatment for cancer within 31-days - Drugs</td>
<td>2</td>
<td>Jul-16</td>
<td>98.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of patients receiving subsequent treatment for cancer within 31-days - Radiotherapy</td>
<td>2</td>
<td>Jul-16</td>
<td>94.0%</td>
<td>97.6%</td>
<td>98.6%</td>
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<tr>
<td>Category A ambulance</td>
<td>Category ‘Red 1’ 8 minute response time</td>
<td>3</td>
<td>Jul-16</td>
<td>75.0%</td>
<td>69.2%</td>
<td>73.3%</td>
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</tr>
<tr>
<td></td>
<td>Category ‘Red 2’ 8 minute response time</td>
<td>3</td>
<td>Jul-16</td>
<td>75.0%</td>
<td>68.5%</td>
<td>89.7%</td>
<td></td>
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<tr>
<td></td>
<td>Category ‘Red’ 19 minute transportation time</td>
<td>3</td>
<td>Jul-16</td>
<td>95.0%</td>
<td>95.7%</td>
<td>95.1%</td>
<td></td>
</tr>
<tr>
<td>Mixed sex accommodation</td>
<td>Mixed sex accommodation - number of unjustified breaches</td>
<td>4</td>
<td>Aug-16</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cancelled operations</td>
<td>Cancelled operations for non-clinical reasons to be rescheduled within 28 days</td>
<td>4</td>
<td>Q1 16/17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent operations cancelled for a 2nd time</td>
<td>4</td>
<td>Q1 16/17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Programme Approach</td>
<td>% people followed up within 7 days of discharge from psychiatric in-patient care</td>
<td>2</td>
<td>Q1 16/17</td>
<td>95.0%</td>
<td>95.7%</td>
<td>95.7%</td>
<td></td>
</tr>
<tr>
<td>Ambulance handovers</td>
<td>Ambulance handover 30 mins - 60 mins</td>
<td>2</td>
<td>Jul-16</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Ambulance handover &gt;=60 mins</td>
<td>2</td>
<td>Jul-16</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Note: QP - Linked to Quality Premium
### Issues to Note on Constitution Measures

<table>
<thead>
<tr>
<th>Constitution measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
<th>Timeline</th>
<th>Level of risk</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Waits</td>
<td>Newcastle FT narrowly missed the 99% threshold at 98.9% for patients waiting less than 6 weeks for July. The trust has missed the threshold throughout 2016/17 to date. The CCG is still meeting the 99% threshold YTD.</td>
<td>Newcastle FT: the trust developed an action plan outlining both medium and long term solutions earlier in 2016, identifying a number of specific areas where there are high risks of breaches. The trust have begun outsourcing to additional scanner sites, are recruiting additional staff where there are shortages and providing extended service hours to reduce backlog. Continue to monitor to ensure CCG threshold is still achieved.</td>
<td>Q2</td>
<td>Low</td>
<td>JM</td>
</tr>
<tr>
<td>A&amp;E 4 hour standard</td>
<td>Newcastle FT had failed to meet the 95% target in 2015/16 and into 2016/17 with May performance at 94.7%. The trust performance has recovered to meet the target in Q1 (95.1%) and for July (97.4%).</td>
<td>Newcastle FT: The department have implemented an A&amp;E action plan and are reporting to the Executive Team on a monthly basis. The A&amp;E team and Cardiology piloted a new patient pathway for acute cardiac patients the week of 18th July 2016. The 4-bedded Chest Pain Assessment Unit (CPAU) on A&amp;E was closed with the patients being clinically managed on the Cardiology Unit. Following the pilot, both Cardiology and the Emergency Department cited positive improvements. The next stage is to progress the estates work on the Cardiology unit to formalise this pathway. The CPAU space will be released to ED to provide a dedicated ambulance assessment area. CCG: A regional SRG group has been established to look into patient flows across the regional A&amp;E sites. The CCG is also working with both the provider and social care colleagues to reduce delayed discharges which have been flagged as an issue for North Tyneside patients. Continue to monitor to ensure improvements are sustained across Q2 2016/17.</td>
<td>Q1</td>
<td>Med</td>
<td>MC/JM</td>
</tr>
<tr>
<td>Constitution measure</td>
<td>Synopsis of Issue</td>
<td>Actions taken to resolve issue</td>
<td>Timeline</td>
<td>Level of risk</td>
<td>Owner</td>
</tr>
<tr>
<td>----------------------</td>
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<td>-------</td>
</tr>
<tr>
<td>Cancer waiting time standards – seen within 2 weeks of an urgent referral for breast symptoms.</td>
<td>CCG performance at 91.3% (threshold 93%) for July 2016. Both FTs achieved threshold in July, and the CCG is currently meeting this standard YTD. There were 4 reported breaches, 3 due to patient choice and 1 admin error.</td>
<td>CCG: Performance dips are inconsistent and patient numbers are relatively small. This standard has been met over recent months; continue to monitor performance dip is not sustained.</td>
<td>Q2</td>
<td>Low</td>
<td>JM</td>
</tr>
<tr>
<td>Cancer waiting time standards – treatment within 62 days of urgent GP referral</td>
<td>Northumbria FT failed to meet the 90% standard for July, resulting in the CCG performance dipping to 81.8%. This is down from 85.7% in June. CCG performance is 2 patients short of meeting the standard for July however performance YTD is still being met.</td>
<td>CCG: Underperformance due to small numbers and casemix between tumour types. The standard is being achieved year to date; continue to monitor to ensure underperformance is not sustained.</td>
<td>Q2</td>
<td>Low</td>
<td>JM</td>
</tr>
<tr>
<td>Cancer waiting time standards – subsequent treatment within 31 days (surgery)</td>
<td>Northumbria FT performance at 75% for July, resulting in the CCG performance dipping to 90.9%. This amounts to 2 breaches in total for July therefore 1 breach short of the 94% threshold. YTD performance remains above threshold.</td>
<td>CCG: Performance dips are inconsistent and patient numbers are relatively small. This standard has been met over recent months; continue to monitor performance dip is not sustained.</td>
<td>Q2</td>
<td>Low</td>
<td>JM</td>
</tr>
<tr>
<td>Category Red ambulance response times</td>
<td>Category ‘Red 1’ and ‘Red 2’ response times below the 75% threshold for July and YTD in North Tyneside. NEAS is not meeting any of the standards at organisation level. The Trust have flagged paramedic vacancies, the change in the pattern of demand since embedding NHS 111, reconfiguration of service provision and system pressure as issues behind the reduction in response times. Additionally</td>
<td>CCG: Performance issues have been raised by lead CCGs with NEAS and a detailed action plan for 2015/16 and 2016/17 is in place focusing on recruitment and reduced workforce gap, establishment of a clinical hub and increased hear and treat, and a number of transformational actions. There are a number of winter schemes to increase capacity that are funded through resilience funds that continue to be implemented. Work continues with Northumbria FT to reduce ambulance handover delays and release ambulance resource sooner.</td>
<td>Q4</td>
<td>High</td>
<td>MC/JM</td>
</tr>
</tbody>
</table>
## Issues to Note on Constitution Measures

<table>
<thead>
<tr>
<th>Constitution measure</th>
<th>Synopsis of Issue</th>
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<th>Timeline</th>
<th>Level of risk</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancelled operations for non-clinical reasons to be rescheduled within 28 days</td>
<td>financial pressures have meant a reduction in the use of third party provision.</td>
<td>The 19 minute transportation time has been met for June and July, and the ‘Red 1’ measure was met for June at 79.6%, however ‘Red 2’ response rates have been deteriorating since April. CCG: Issue raised in contract performance meeting with Trust. Expectation is that this was a one off case. Newcastle FT: 1 breach reported in June in Neurosurgery due to consultant leave. Continue to actively monitor to ensure there are no significant increases and apply contract penalties.</td>
<td>Q2</td>
<td>Low</td>
<td>JM</td>
</tr>
<tr>
<td>Ambulance handover delays</td>
<td>In quarter 1 there was 1 operation cancelled for non-clinical reasons at Newcastle FT that wasn’t rescheduled with the required 28 day timeframe.</td>
<td>Following a peak in March 2016, ambulance handover delays have reduced significantly at Northumbria FT (597 delays in March compared to 309 in June). Newcastle FT reported only 8 30-60 minute delays, with 0 over 60 minute delays in June. CCG: Issue raised with provider and action plan in place; the situation is being reviewed on a monthly basis. Due to national changes to the contract the CCG are unable to apply penalties in 2016/17. Provider: Initial action plan completed but actions did not result in the expected improvements. Further monitoring/detail on this measure is provided in the ‘Ambulance Handover Delays’ section of this report.</td>
<td>Q3</td>
<td>High</td>
<td>MC/JM</td>
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</tbody>
</table>
Ambulance Handover Delays

Following the opening of NSECH in June 2015, Ambulance Handover Delays for Northumbria FT have increased significantly, with the emergence of a significant proportion of delays over 60 minutes over the Winter/Spring months.

The problem of ambulance handover delays at NSECH represents one of the foremost risks to system performance and resilience across the North Tyneside – Northumberland CCG footprint. The issue has been under continuous review for a period of almost a year, with numerous local action plans being agreed and implemented in that time. However the various changes which have been made to staffing, processes and communications have all failed to produce a significant and sustained reduction in the number of ambulance delays occurring at the NSECH site.
## CCG Health Outcomes

<table>
<thead>
<tr>
<th>Health Outcome Domains</th>
<th>Indicator</th>
<th>Frequency</th>
<th>Previous Data</th>
<th>Previous Data Actual</th>
<th>Latest Data</th>
<th>Desired Movement</th>
<th>Actual</th>
<th>England Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from dying prematurely</td>
<td>Reduction in potential years of life lost from causes amenable to health care</td>
<td>Annual</td>
<td>2011-2013</td>
<td>2216</td>
<td></td>
<td>2055</td>
<td>2013</td>
<td></td>
</tr>
<tr>
<td>Enhancing quality of life for people with LTC</td>
<td>Health related quality of life for people with long-term conditions</td>
<td>Annual Survey</td>
<td>Target 2014/15</td>
<td>70.2%</td>
<td>2014-15</td>
<td>71.4%</td>
<td>74%</td>
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<tr>
<td></td>
<td>Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions (adults)</td>
<td>Monthly</td>
<td>Jul-15</td>
<td>337.6</td>
<td>Jul-16</td>
<td>264.4</td>
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<td></td>
<td>Unplanned hospitalisation for asthma, diabetes and epilepsy (under 16s)</td>
<td>Monthly</td>
<td>Jul-15</td>
<td>103.0</td>
<td>Jul-16</td>
<td>103.2</td>
<td></td>
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<tr>
<td></td>
<td>Estimated diagnosis rate for people with dementia</td>
<td>Monthly</td>
<td>Target</td>
<td>66.8%</td>
<td>Aug-16</td>
<td>66.8%</td>
<td></td>
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<tr>
<td>Helping people to recover from episodes of ill health</td>
<td>Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td>Monthly</td>
<td>Jul-15</td>
<td>312.2</td>
<td>Jul-16</td>
<td>541.0</td>
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<tr>
<td></td>
<td>Emergency admissions for children with lower respiratory tract infections</td>
<td>Monthly</td>
<td>Jul-15</td>
<td>22.7</td>
<td>Jul-16</td>
<td>76.3</td>
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<tr>
<td></td>
<td>Emergency readmissions within 30 days of discharge from hospital</td>
<td>Monthly</td>
<td>Jun-15</td>
<td>16.7%</td>
<td>Jun-16</td>
<td>14.0%</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Improving access to psychological therapies (IAPT) coverage</td>
<td>Monthly</td>
<td>Target</td>
<td>15.0%</td>
<td>2016/17</td>
<td>17.3%</td>
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<tr>
<td></td>
<td>IAPT recovery rate</td>
<td>Monthly</td>
<td>Trajectory</td>
<td>50.0%</td>
<td>Jul-16</td>
<td>44.0%</td>
<td></td>
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<tr>
<td></td>
<td>6 Week wait IAPT treatment</td>
<td>Quarterly</td>
<td>Target</td>
<td>75%</td>
<td>Jul-16</td>
<td>95.7%</td>
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</tr>
<tr>
<td></td>
<td>18 Week wait IAPT treatment</td>
<td>Quarterly</td>
<td>Target</td>
<td>95%</td>
<td>Jul-16</td>
<td>99.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services</td>
<td>Annual</td>
<td>2013/14</td>
<td>89.6</td>
<td>2014/15</td>
<td>92.7</td>
<td>82.5</td>
<td></td>
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<tr>
<td>Ensuring people have a positive experience of care</td>
<td>Patient experience of GP services - Satisfaction with the overall care received at the surgery</td>
<td>Annual Survey</td>
<td>2015/16 Target</td>
<td>90.5%</td>
<td>July 16 publication</td>
<td>88.3%</td>
<td>86.2%</td>
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<tr>
<td></td>
<td>Overall experience of making an appointment</td>
<td>Annual Survey</td>
<td>2015/16 Target</td>
<td>78.4%</td>
<td>July 16 publication</td>
<td>77.0%</td>
<td>73.4%</td>
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</tr>
<tr>
<td></td>
<td>Patient experience of GP out of hours services</td>
<td>Sep 2014</td>
<td>452.9</td>
<td>70.1%</td>
<td>July 10 publication</td>
<td>75.3%</td>
<td>67.4%</td>
<td></td>
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<tr>
<td></td>
<td>Patient experience of hospital care</td>
<td>2013/14</td>
<td>NUTHFT - 8.2</td>
<td>NUTHFT - 8.3</td>
<td>June 16 publication</td>
<td>NUTHFT - 8.6/10</td>
<td>NUTHFT - 8.5/10</td>
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</tr>
<tr>
<td></td>
<td>Friends and Family Test (NHCFT recommended score)</td>
<td>Monthly</td>
<td>Jul-15</td>
<td>IP - 99.3%</td>
<td>Jul-16</td>
<td>IP - 98.0% A&amp;E - 91.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Friends and Family Test (NUTHFT recommended score)</td>
<td>Monthly</td>
<td>Jul-15</td>
<td>IP - 98.1% A&amp;E - 88.0%</td>
<td>Jul-16</td>
<td>IP - 97.5% A&amp;E - 89.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe environment</td>
<td>Incidence of healthcare associated infection: MRSA</td>
<td>Monthly</td>
<td>Target</td>
<td>0</td>
<td>Jul-16 YTD</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Incidence of healthcare associated infection: Clostridium difficile</td>
<td>Monthly</td>
<td>Trajectory</td>
<td>29</td>
<td>Jul-16 YTD</td>
<td>13</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: QP - Linked to Quality Premium  TBC - To be confirmed  * - North of England Commissioning Support (NECS) calculated data
# Issues to note on CCG Health Outcome Indicators

There are 22 indicators relating to health outcomes. The CCG currently has 16 indicators with a green rating, 6 indicators with an amber rating, 0 with a red rating.

<table>
<thead>
<tr>
<th>Outcome measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
<th>Timeline</th>
<th>Level of risk</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned hospitalisation for asthma, diabetes and epilepsy in U19s</td>
<td>Weighted number of admissions is at 103.2 for July YTD, compared to 103.0 for the same period in 2015/16</td>
<td>Although the standardised rate is above threshold, the number of admissions July 2016/17 YTD is the same as for the parallel period in 2015/16. Improvements were observed throughout 2015/16 on this measure. Continue to monitor to observe whether under-performance continues into Q2.</td>
<td>Q2</td>
<td>Low</td>
<td>JM</td>
</tr>
<tr>
<td>Children with lower respiratory tract infections</td>
<td>Weighted number of admissions is at 40.7 for May YTD, compared to 22.7 for the same period in 2015/16.</td>
<td>Improvements on 2014/15 were observed throughout 2015/16 on this measure. Difference to the 2015/16 rate equates to less than 12 admissions. Continue to monitor to observe whether this has been due to a round of respiratory infections in Q1 or whether under-performance continues.</td>
<td>Q2</td>
<td>Low</td>
<td>JM</td>
</tr>
<tr>
<td>IAPT recovery rate at July 2016 is 44.9% against a national target of 50%</td>
<td>Rolling Quarter Recovery</td>
<td>The provider is continuing to implement actions detailed in the Action Plan agreed with the CCG. It is expected that the Movement to Recovery rate will dip a little in Q1 due to a considerable increase in patients seen and undergoing treatment due to implementation of the Step 3 Waiting List Initiative. However, it is then expected to increase again when the Initiative has completed. It is also expected to increase further when all Step 4 Psychology patients are no longer recorded on IAPTUS. Performance continues to be monitored on a monthly basis.</td>
<td>Q2</td>
<td>Medium</td>
<td>AP</td>
</tr>
<tr>
<td>GP patients experience</td>
<td>2.5% below target for the satisfaction with the overall care measure, 1.8% below target for the overall experience of making an appointment measure 6 points below the satisfaction with the quality of consultation measures</td>
<td>These were new measures for 2015/16 as part of the primary care co-commissioning agenda and therefore joint improvement trajectories with NHS England. Although satisfaction has decreased compared to the previous survey period, it is worth highlighting that all measures are well above the England average. CCG actions: Initial scoping analysis to identify the practices that are low scoring for these measures, and look at correlation of these measures with other questions in the GP patient survey to identify areas for practices to influence to improve overall satisfaction now completed. The Transformation team has undertaken improvement actions with identified practices and are working into 7 practices currently with improvement actions. These include supporting workforce planning, implementation of a new telephone system, review of appointment and admin systems, and the release of an app for patients at two practices. The survey will be conducted on an annual basis going forward, with the survey period becoming January-March each year, with publication of results in July.</td>
<td>July 2017</td>
<td>Medium</td>
<td>JM</td>
</tr>
</tbody>
</table>
North Tyneside CCG has a 2016/17 target of 74 C. diff cases. July YTD the CCG is under the 2016/17 YTD trajectory by 16 infections.

Northumbria FT has a 2016/17 target of 30 C. diff cases. July YTD the trust is 4 infections below trajectory, but over the 2015/16 comparable period by 2.

Newcastle FT has a 2016/17 target of 77 C. diff cases. July YTD the trust is 9 infections below trajectory, and under the 2015/16 comparable period by 4.
## 2016/17 Quality Premium

<table>
<thead>
<tr>
<th>Measure</th>
<th>Requirement</th>
<th>Period</th>
<th>Threshold</th>
<th>Actual</th>
<th>Passing / Failing</th>
<th>Weighting</th>
<th>Value</th>
<th>Funding calculation</th>
<th>Linked to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancers diagnosed at early stage</td>
<td>4 percentage point improvement in diagnosis at stages 1 and 2 in 2016 compared to 2015 &gt; 60% of all cancers diagnosed at stages 1 and 2 in 2018</td>
<td>Data not yet available</td>
<td>Data not yet available</td>
<td>Data not yet available</td>
<td>20.0%</td>
<td>£215,900</td>
<td>£0</td>
<td>OF - Linked to CCG Health Outcomes (Outcomes Framework) NHSE - Linked to Strategic Plan C - Linked to NHS Constitution</td>
<td></td>
</tr>
<tr>
<td>Increase in the proportion of GP referrals made by e-referrals</td>
<td>80% by March 2017 and a year on year increase in the % of referrals made by e-referrals or achieve 100% e-referrals, or March 2017 performance to exceed March 2016 performance by 20 percentage points</td>
<td>Jul-16 YTD</td>
<td>78.0%</td>
<td>58.5%</td>
<td>Failing</td>
<td>20.0%</td>
<td>£215,900</td>
<td>£0</td>
<td>NECS calculated</td>
</tr>
<tr>
<td>Overall experience of making a GP appointment</td>
<td>85% had a good experience, or 3 percentage point increase from July 2016 publication</td>
<td>July 2016 Publication</td>
<td>80.0%</td>
<td>77.0%</td>
<td>Failing</td>
<td>20.0%</td>
<td>£215,900</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td>Improving antibiotic prescribing in primary care</td>
<td>Reduction in the number of antibiotics prescribed in primary care</td>
<td>Jun-16 YTD</td>
<td>1.19 per 1000 STAR-PU</td>
<td>1.13 per 1000 STAR-PU</td>
<td>Passing</td>
<td>10.0%</td>
<td>£107,900</td>
<td>£107,900</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduction in the proportion of broad spectrum antibiotics in primary care</td>
<td>Jun-16 YTD</td>
<td>11.3%</td>
<td>8.9%</td>
<td>Passing</td>
<td>10.0%</td>
<td>£107,900</td>
<td>£107,900</td>
<td></td>
</tr>
<tr>
<td>COPD - Number of patients reviewed by a respiratory consultant or specialist nurse during their admission</td>
<td>75%</td>
<td>Mar-16</td>
<td>75%</td>
<td>60.3%</td>
<td>Failing</td>
<td>10.0%</td>
<td>£107,900</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td>Emergency admissions for alcohol related liver disease</td>
<td>10% reduction 2016/17 target value: 0.5.4</td>
<td>Apr-15 to Mar-16 (Provisional)</td>
<td>63.4</td>
<td>67.5</td>
<td>Passing</td>
<td>10.0%</td>
<td>£107,900</td>
<td>£107,900</td>
<td></td>
</tr>
<tr>
<td>IAPT reliable recovery: % of people who have completed IAPT treatment who achieved &quot;appropriate improvement&quot;</td>
<td>2016/17 target value: 60.8%</td>
<td>Jul-16 YTD</td>
<td>60.8%</td>
<td>68.8%</td>
<td>Passing</td>
<td>10.0%</td>
<td>£107,900</td>
<td>£107,900</td>
<td></td>
</tr>
</tbody>
</table>

**Total Value**

<p>| | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>£1,079,900</strong></td>
<td><strong>£323,970</strong> 30.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pre-conditions</th>
<th>Pass / Fail</th>
<th>Weighting</th>
<th>Value</th>
<th>Funding calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial plans on target</td>
<td>Passing</td>
<td>100%</td>
<td>£1,079,900</td>
<td>£323,970</td>
</tr>
<tr>
<td>Significant quality failure</td>
<td>Passing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NHS Constitution measures</th>
<th>Organisation</th>
<th>Period</th>
<th>Threshold</th>
<th>Year to date</th>
<th>Passing / Failing</th>
<th>Weighting</th>
<th>Adjustment</th>
<th>Fund</th>
<th>Calculation</th>
<th>Linked to</th>
</tr>
</thead>
<tbody>
<tr>
<td>% patients waiting for initial treatment on incomplete pathways within 18 weeks</td>
<td>CCG</td>
<td>Jul-16</td>
<td>92.0%</td>
<td>94.7%</td>
<td>Passing</td>
<td>25%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>C</td>
</tr>
<tr>
<td>% patients spending 4 hours or less in A&amp;E or minor injury unit</td>
<td>CCG mapped</td>
<td>Jul-16</td>
<td>95.0%</td>
<td>96.0%</td>
<td>Passing</td>
<td>25%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>C</td>
</tr>
<tr>
<td>% of patients treated within 62 days of an urgent GP referral for suspected cancer</td>
<td>CCG</td>
<td>Jul-16</td>
<td>88.5%</td>
<td>87.9%</td>
<td>Passing</td>
<td>25%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>C</td>
</tr>
<tr>
<td>CAT A Red 1 calls responded with 8 mins</td>
<td>NEAS</td>
<td>Jul-16</td>
<td>75.0%</td>
<td>66.0%</td>
<td>Failing</td>
<td>25%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>C</td>
</tr>
</tbody>
</table>

**Adjusted total**

|                     |                   |                   |           |           |                  |           |          | **£89,893**      | **£242,978**            |

Note: OF - Linked to CCG Health Outcomes (Outcomes Framework) NHSE - Linked to Strategic Plan C - Linked to NHS Constitution NECS - North of England Commissioning Support (NECS) calculated
**Issues to note on Quality Premium Indicators**

The CCG currently has four of the eight Quality Premium indicators with a green rating, three indicators with an amber rating, and one measure with data not yet available. The total Quality Premium payment for a CCG is reduced if the listed NHS Constitution rights or pledges for patients. Currently four of the five Constitution measures are being met.

<table>
<thead>
<tr>
<th>QP measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
<th>Timeline</th>
<th>Level of risk</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data availability</td>
<td>Two measures doesn’t have data available for monitoring.</td>
<td>Timely data for stage of cancer diagnosis is not yet available for 2015 or 2016. Additionally 2016/17 data for the COPD measure is not yet available.</td>
<td>Sept 2016</td>
<td>Low</td>
<td>JM</td>
</tr>
<tr>
<td>Increase in the number of GP referrals made through e-referral</td>
<td>A 20% increase on the March 2016 level gives a target of 78% for March 2017. Performance for July 2016 is 58.5%</td>
<td>For referrals to count for this measure the referral needs to remain on e-referral for the full pathway. The process for the local Referral Management System means that the majority of referrals made by GP practices are made through e-referral at the point of referral. This suggests that providers are taking referrals off the e-referral system to process them through local route, leading to them therefore not counting towards this measure. A meeting with the local lead from the e-referral system to understand the data available has taken place and discussion with local providers on the reasons for low usage of e-referral, the barriers to its use, and solutions are planned.</td>
<td>Q4</td>
<td>Medium</td>
<td>SR/JM</td>
</tr>
<tr>
<td>Overall Experience of making an appointment</td>
<td>July 2016 data shows the CCG level at 77% against a target of 80%</td>
<td>Latest patient experience data shows a small decrease in patient experience of making a GP appointment. A funded initiative has been put in place with GP practices for 2016/17 to provide each practice with standardised data on current capacity and demand. Practices will then review this data and put in place a plan to improve current access levels supported as necessary by the local transformation team. This work will also underpin the improving access section of the North Tyneside Primary Care Strategy.</td>
<td>Q4</td>
<td>Medium</td>
<td>JM</td>
</tr>
<tr>
<td>Category Red 1 calls responded within 8 minutes</td>
<td>At provider level NEAS are below the 75% standard for response times to Category Red 1 patients. This measure is based on the region wide performance of NEAS rather than being North Tyneside specific.</td>
<td>Underperformance is being raised with the provider through the regional contract meeting with NEAS as described in the constitution section.</td>
<td>Q2 2016/17</td>
<td>High</td>
<td>JM/MC</td>
</tr>
</tbody>
</table>
### Glossary:

- **DTOC** – Delayed Transfer of Care
- **NRLS** – National Reporting and Learning System
- **VTE** - Venous Thromboembolism

### Quality Dashboard – August 2016

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Acute or Specialist Trust</th>
<th>Northumbria Healthcare NHS Foundation Trust</th>
<th>The Newcastle Upon Tyne Hospitals NHS Foundation Trust</th>
<th>Trust Type</th>
<th>Latest Data</th>
<th>Standard (Best data: Average)</th>
<th>Value</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>Summary Hospital-level Mortality Indicator (SHMI)</td>
<td>Year to Apr-16 Provisional</td>
<td>Not Applicable</td>
<td></td>
<td></td>
<td>108.7</td>
<td>96.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital Standardised Mortality Ratio (HSMR)</td>
<td>Year to May-16 Provisional</td>
<td>Not Applicable</td>
<td></td>
<td></td>
<td>106.7</td>
<td>102.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weekend HSMR - Non-Elective</td>
<td>Year to May-16 Provisional</td>
<td>Not Applicable</td>
<td></td>
<td></td>
<td>114.1</td>
<td>111.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Readmissions</td>
<td>Emergency readmissions rate - Elective</td>
<td>Apr-16 Provisional</td>
<td>Not Applicable</td>
<td></td>
<td></td>
<td>1.35</td>
<td>1.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmissions</td>
<td>Emergency readmissions rate - Non-Elective</td>
<td>Apr-16 Provisional</td>
<td>Not Applicable</td>
<td></td>
<td></td>
<td>0.96</td>
<td>0.93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NRLS - Proportion of reported incidents that are harmful</td>
<td>6 months to Jun-16 Provisional</td>
<td>Not Applicable</td>
<td>28.5%</td>
<td></td>
<td></td>
<td>37.7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NRLS - Potential under-reporting of death and severe harm</td>
<td>6 months to Jun-16 Provisional</td>
<td>Not Applicable</td>
<td>0.17</td>
<td></td>
<td></td>
<td>0.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NRLS - Potential under-reporting</td>
<td>6 months to Jun-16 Provisional</td>
<td>Not Applicable</td>
<td>41.0</td>
<td></td>
<td></td>
<td>27.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NRLS - Consistency of reporting</td>
<td>6 months to Jun-16 Provisional</td>
<td>Not Applicable</td>
<td>6</td>
<td></td>
<td></td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUI</td>
<td>Never events declared - number</td>
<td>Jul-16 Provisional</td>
<td>Zero</td>
<td></td>
<td></td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Serious Incidents declared - potential under-reporting</td>
<td>Jul-16 Provisional</td>
<td>7</td>
<td></td>
<td></td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Sickness Absence Rate</td>
<td>Staff who felt incident reporting procedures fair &amp; effective</td>
<td>Mar-16 Public</td>
<td>Not Applicable</td>
<td>3.9</td>
<td></td>
<td></td>
<td>4.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff who felt incident reporting procedures fair &amp; effective</td>
<td>2015 Public</td>
<td>Not Applicable</td>
<td>3.9</td>
<td></td>
<td></td>
<td>3.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STAFF</td>
<td>Friends and Family Test - Staff recommendation - Care</td>
<td>Quarter to Mar-16 Public</td>
<td>Not Applicable</td>
<td>87.6%</td>
<td></td>
<td></td>
<td>95.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Friends and Family Test - Staff recommendation - Work</td>
<td>Quarter to Mar-16 Public</td>
<td>Not Applicable</td>
<td>77.5%</td>
<td></td>
<td></td>
<td>76.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>R&amp;F Test Staff Survey - recommendation for work &amp; treatment</td>
<td>2015 Public</td>
<td>Not Applicable</td>
<td>93.2%</td>
<td></td>
<td></td>
<td>89.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDS</td>
<td>Central Alerting System - Patient safety alerts</td>
<td>Aug-16 Public</td>
<td>Zero</td>
<td></td>
<td></td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The quality dashboard shows performance indicators for quality measures that have not already been included within the NHS Constitution, Outcomes Framework or Quality Premium.
Other Quality Measures

Quality Dashboard - The quality dashboard is a snapshot of NHS England’s quality dashboard and shows performance indicators for quality measures that have not already been included within the NHS Constitution, Outcomes Framework or Quality Premium.

The NHS England Quality Dashboard for August 2016 is showing one issue of concern.

<table>
<thead>
<tr>
<th>Quality Dashboard measure</th>
<th>Synopsis of Issue</th>
<th>Actions taken to resolve issue</th>
<th>Timeline</th>
<th>Level of risk</th>
<th>Owner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declared never events</td>
<td>1 never event recorded at Newcastle FT in July.</td>
<td>One never event involving medication given via wrong route was reported in July 2016. Since February 2016 there has been a total of four never events reported (two wrong site surgical procedures, one retained swab and one medication incident). These are being managed via the CCG SI process and the usual contractual penalties will apply.</td>
<td>Q3</td>
<td>Low</td>
<td>JM</td>
</tr>
</tbody>
</table>
Report to: Governing Body

Date: 22nd November 2016  |  Agenda item: 9.3

Title of report: CCG Improvement and Assessment Framework Report

Sponsor: Lesley Young-Murphy, Director of Nursing and Transformation
Author: James Martin, Commissioning & Performance Manager and Clair Carpenter, Information Analyst

Purpose of the report and action required: To report progress against the CCG Improvement and Assessment Framework.

Members are asked to receive this report for information.

Executive summary: The CCG Improvement and Assessment Framework (CCG IAF) Report shows the latest reported position against NHs England’s Improvement and Assessment Framework for CCGs.

This new framework replaces both the existing CCG assurance framework and CCG performance dashboard and will be used by NHS England within the CCGs quarterly assurance process.

The CCG IAF contains a set of 57 indicators set out across 29 areas within four domains as set out below. It is intended that the indicators will be reported quarterly. In addition the CCG will receive an annual assessment against 6 key clinical areas - mental health, dementia, learning disabilities, cancer, maternity and diabetes.

The latest data shows that North Tyneside CCG is a positive outlier and in the top quartile of CCGs nationally for 12 (46%) of these measures.

- People with diabetes diagnosed less than a year who attend a structured education course
- People with a long-term condition feeling supported to manage their condition
- People with urgent GP referral having 1st definitive treatment for cancer within 62 days of referral
- Cancer patient experience
- Proportion of people with a learning disability on the GP register receiving an annual health check
- Neonatal mortality and stillbirths per 1,000 births
- Estimated diagnosis rate for people with dementia
- % patients admitted, transferred or discharged from A&E within 4 hours
- Delayed transfers of care attributable to the NHS and Social Care per 100,000 population
- Patient experience of GP services
- Patients waiting 18 weeks or less from referral to hospital treatment
- Staff engagement index
The CCG is a negative outlier and is in the bottom quartile for the following:
- Injuries from falls in people aged 65 and over per 100,000 population
- One-year survival from all cancers
- People with a learning disability and/or autism receiving specialist inpatient care per million population
- Inequality in avoidable emergency admissions
- Inequality in emergency admissions for urgent care sensitive conditions
- Emergency admissions for urgent care sensitive conditions per 100,000 population
- Emergency bed days per 1,000 population
- Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population
- Effectiveness of working relationships in the local system

The CCG has been given a Needs Improvement rating for the following rating for each of the 6 clinical areas.
- Cancer: Needs Improvement
- Diabetes: Performing Well
- Dementia: Needs Improvement
- Mental Health: Needs Improvement
- Learning Disabilities: Needs Improvement
- Maternity: Needs Improvement

Details of the reasons for these ratings are included in the report. Although five of the areas have received a Needs Improvement rating all of these are not far from a Performing well rating and the majority of the individual metrics used to calculate these ratings are in line with or above the national average.
Governance and Compliance

1. Links to corporate objectives

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
<td>√</td>
</tr>
<tr>
<td>2. Deliver the Financial Recovery Plan, leading to the achievement of the CCG's statutory financial duties and future sustainability</td>
<td></td>
</tr>
<tr>
<td>3. Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside</td>
<td></td>
</tr>
<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
<td>√</td>
</tr>
</tbody>
</table>

2. Consultation and engagement
Not applicable

3. Resource implications
Not applicable

4. Risks
Not applicable

5. Equality assessment
Not applicable

6. Environment and sustainability assessment
There are no environmental or sustainability issues arising from this report.
CCG Improvement and Assessment Framework Report

September 2016
Background

For 2016/17 NHS England have introduced a new CCG Improvement and Assessment Framework (CCG IAF) to replace both the existing CCG assurance framework and CCG performance dashboard. This new framework aims to provide a greater focus on assisting improvement alongside the statutory assessment function that NHS England undertakes, and draws together in one place NHS Constitution and other core performance and finance indicators, outcome goals, and transformational challenges.

The CCG IAF aligns with NHS England’s Mandate and planning guidance, and has been designed to supply indicators for adoption in STPs as markers of success. This approach aims to reach beyond CCGs, enabling local health systems and communities to assess their own progress from ratings published online.

The CCG IAF contains a set of 57 indicators set out across 29 areas within four domains as set out below. It is intended that the indicators will be reported quarterly.

- **Better Health**: this section looks at how the CCG is contributing towards improving the health and wellbeing of its population, and bending the demand curve;
- **Better Care**: this principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical areas;
- **Sustainability**: this section looks at how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends;
- **Leadership**: this domain assesses the quality of the CCG’s leadership, the quality of its plans, how the CCG works with its partners, and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest.
Background

- Personalisation and Choice
- Health inequalities
- Clinical priority: Diabetes
- Child obesity
- Smoking
- Falls
- Anti-microbial resistance
- Carers

- Urgent and emergency care
- Primary medical care
- NHS Continuing Healthcare
- Elective access
- 7 day service
- Care ratings
- Clinical priorities:
  - Maternity
  - Dementia, Cancer,
  - Learning disabilities,
  - Mental health

Better Health
Better Care

Improvement

Delivering the Five Year Forward View

Leadership

Quality of Leadership
- Workforce engagement
- CCGs’ local relationships
- Probity and corporate governance
- Sustainability and transformation plan

Sustainability

Estates strategy
- Allocative efficiency
- New models of care
- Financial sustainability
- Paper-free at the point of care
## CCG IAF measures

### Better Health

#### Maternal smoking at delivery
- 2014-15: 12.1%
- 2015-16: 10.6%
- Trend: ↓
- Better is: L

#### % children aged 10-11 classified as overweight or obese
- 2014-15: 33.9%
- 2015-16: 33.2%
- Trend: ↓
- Better is: L

#### Diabetes patients that have achieved all three of the NICE-recommended treatment targets
- 2014-15: 39.1%
- 2015-16: 39.8%
- Trend: ↑
- Better is: H

#### People with diabetes diagnosed less than a year who attend a structured education course
- 2014-15: 10.8%
- 2015-16: 5.7%
- Trend: ↓
- Better is: H

#### Injuries from falls in people aged 65 and over per 100,000 population
- 2015: 2.750
- 2016: 2.027
- Trend: ↓
- Better is: L

#### % people offered choice of provider and team when referred for a 1st elective appointment
- 2015: 0.52
- 2016: 0.5
- Trend: ↓
- Better is: H

#### Personal Health budgets per 100,000 population (absolute number in brackets)
- 2015: 5
- 2016: 14
- Trend: ↑
- Better is: H

#### % deaths which take place in hospital
- 2015: 44.0%
- 2016: 46.8%
- Trend: ↑
- Better is: L

#### % people with a long-term condition feeling supported to manage their condition
- 2015: 69.9%
- 2016: 64.4%
- Trend: ↓
- Better is: H

#### Inequality in avoidable emergency admissions
- 2015-16 Q1: 3.17%
- 2015-16 Q2: 2.73%
- Trend: ↓
- Better is: H

#### Inequality in emergency admissions for urgent care sensitive conditions
- 2015-16 Q1: 5.2 (1.2)
- 2015-16 Q2: 8.4 (1.4)
- Trend: ↑
- Better is: L

#### Anti-microbial resistance: Appropriate prescribing of antibiotics in primary care
- 2015-16 Q1: 8.8
- 2015-16 Q2: 5.7
- Trend: ↓
- Better is: H

#### Anti-microbial resistance: Appropriate prescribing of broad spectrum antibiotics in primary care
- 2015-16 Q1: 8.8
- 2015-16 Q2: 5.7
- Trend: ↓
- Better is: H

#### Quality of life of carers - health status score (ES250)
- 2015: 0.80
- 2016: 0.80
- Trend: ↑
- Better is: H

### Better Care

#### Cancer diagnosed at early stage
- 2014: 49.4%
- 2015-16 Q4: 68.4%
- Trend: ↑
- Better is: H

#### One-year survival from all cancers
- 2013: 67.7%
- 2014: 69.6%
- Trend: ↑
- Better is: H

#### Cancer patient experience
- 2015: 96.0%
- 2016: 90.0%
- Trend: ↓
- Better is: H

#### Improving Access to Psychological Therapies recovery rate
- 2016: 44.4%
- 2017: 47.6%
- Trend: ↑
- Better is: H

#### People with 1st episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral
- Mar-16: 70.8%
- Apr-16: 62.9%
- Trend: ↓
- Better is: L

#### People with a learning disability and/or autism receiving specialist input per 100,000 population
- 2014-15: 56.0%
- 2015-16: 47.0%
- Trend: ↓
- Better is: H

#### Proportion of people with a learning disability on the GP register receiving an annual health check
- 2014-15: 5.22
- 2015-16: 7.10
- Trend: ↑
- Better is: H

#### Neonatal mortality and stillbirths per 1,000 births
- 2014-15: 8.13
- 2015-16: 8.14
- Trend: ↑
- Better is: H

#### Women’s experience of maternity services
- 2015: 81.0%
- 2016: 81.0%
- Trend: ↑
- Better is: H

#### Choices in maternity services
- 2015: 0.67
- 2016: 0.67
- Trend: ↑
- Better is: H

#### Estimated diagnosis rate for people with dementia
- 2015: 74.5%
- 2016: 66.4%
- Trend: ↓
- Better is: H

#### Emergency admissions for urgent care sensitive conditions per 100,000 population
- 2014-15 Q1: 1,290
- 2015-16 Q4: 1,392
- Trend: ↑
- Better is: L

#### % patients admitted, transferred or discharged from A&E within 4 hours
- Apr-16: 95.5%
- May-16: 93.0%
- Trend: ↓
- Better is: H

#### Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population
- 2014-15 Q4: 311.80
- 2015-16 Q4: 318.50
- Trend: ↑
- Better is: L

#### Patient experience of GP services
- 2015: 88.8%
- 2016: 84.9%
- Trend: ↓
- Better is: H

#### Primary care workforce - GPs and practice nurses per 1,000 population
- 2015: 0.96
- 2016: 0.96
- Trend: ↑
- Better is: H

#### Patients waiting 18 weeks or less from referral to hospital treatment
- 2015: 94.6%
- 2016: 91.7%
- Trend: ↓
- Better is: H

#### People eligible for standard NHS Continuing Healthcare per 10,000 population
- 2015-16 Q3: 62.48
- 2015-16 Q4: 62.48
- Trend: ↑
- Better is: H

### Sustainability

#### Financial plan
- 2015: Red
- 2016: Red
- Trend: ↓
- Better is: H

#### Digital interactions between primary and secondary care
- 2015-16 Q4: 56.0%
- 2016-17: 56.0%
- Trend: ↓
- Better is: H

#### Local strategic enablers plan (SEP) in place
- 2016-17: Yes
- 2016-17: Yes
- Trend: ↑
- Better is: H

#### Staff engagement index
- 2015: 3.9
- 2016: 3.8
- Trend: ↓
- Better is: H

#### Progress against workforce Race Equality Standard
- 2016: 0.0
- 2017: 0.2
- Trend: ↑
- Better is: H

#### Effectiveness of working relationships in the local system
- 2015-16: 56.0%
- 2016: 59.0%
- Trend: ↑
- Better is: L

#### Quality of CCG leadership
- 2016-17: Amber
- 2016-17: Amber
- Trend: ↓
- Better is: H
CCG IAF Measures Highlighting Success

The above table shows the reported performance for the CCG IAF measures where data is available. The spine charts on the right hand side show the national benchmarked position for North Tyneside for 26 of the measures. North Tyneside CCG is a positive outlier and in the top quartile of CCGs nationally for 12 (46%) of these measures.

- People with diabetes diagnosed less than a year who attend a structured education course
- People with a long-term condition feeling supported to manage their condition
- People with urgent GP referral having 1st definitive treatment for cancer within 62 days of referral
- Cancer patient experience
- Proportion of people with a learning disability on the GP register receiving an annual health check
- Neonatal mortality and stillbirths per 1,000 births
- Estimated diagnosis rate for people with dementia
- % patients admitted, transferred or discharged from A&E within 4 hours
- Delayed transfers of care attributable to the NHS and Social Care per 100,000 population
- Patient experience of GP services
- Patients waiting 18 weeks or less from referral to hospital treatment
- Staff engagement index

In addition the CCG has seen an improvement in 16 of the 43 reported measures (37%), with no decrease in performance seen for any of the measures.
**CCG Areas for Improvement**

There are nine measures where North Tyneside CCG benchmarks as an outlier and within the worst quartile nationally.

<table>
<thead>
<tr>
<th>IAF measure</th>
<th>Key points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Injuries from falls in people aged 65 and over per 100,000 population</strong></td>
<td>In 2014, North Tyneside CCG worked with local partners to develop a community based falls pathway focusing on multi factorial assessment and a multi factorial clinic and intervention service for 65 years and older. The service commenced in January 2015. The uptake from referral sources was significantly under the expected activity which resulted in the service not delivering value for money. In light of the CCGs Financial position, the CCG Executive Team agreed to cease investment in the Community Falls Pathway and focus instead in ensuring falls assessments are built in to other community based services such as Care Point.</td>
</tr>
</tbody>
</table>
| **One-year survival from all cancers** | North Tyneside CCG is working with local providers on developing survivorship pathways. Evidence suggests many follow up appointments are perfunctory and often have little benefits in terms of supporting patients to develop self-management strategies. The long-term aim is to focus on self-management as early as possible after diagnosis for all cancer pathways. However taking in to account local figures for readmission and premature deaths, North Tyneside CCG will initially focus on developing three new cancer survivorship pathways in breast, prostate and colorectal. Key areas of work include:  
  - Development of Risk Stratification tools.  
  - Health needs assessments and holistic care plans  
  - Introduction of remote monitoring and, |
## CCG Areas for Improvement

<table>
<thead>
<tr>
<th>IAF measure</th>
<th>Key points</th>
</tr>
</thead>
</table>
| • Improved care coordination | Short-term improvements in survival will be negligible due to the nature of the condition. However evidence from Cancer Survivorship: the impact on Primary Care (2011), highlighted the findings of a risk stratification test case study that demonstrated a number of benefits of this approach compared with the current pathway model. This includes:  
  • Reduction in unplanned cancer admissions  
  • Increase in numbers accessing care and support services.  
  • Reduction in outpatient attendances.  
  • Earlier identification and diagnosis of condition. |

| People with a learning disability and/or autism receiving specialist inpatient care per million population | The score for this measure of 92 people receiving specialist inpatient care per million population relates to the North East and Cumbria Transformation area rather than North Tyneside CCG only.  
North Tyneside CCG continues to be part of the North East and Cumbria Transforming Board and a local implementation plan is in place to reduce the use of inpatient beds for this cohort.  
North Tyneside CCG has been successful in reducing bed numbers in CCG commissioned assessment and treatment units by over 50% with only one patient remaining in a long stay hospital unit.  
In addition to this, there are 10 North Tyneside patients residing in Specialist Commissioned beds. Plans are in place between NHS England and the regional specialist commissioning team to reduce dependence of these beds over time.  
Plans are in place to discharge the one remaining patient. The CCG will also work with specialist commissioning on appropriate use of forensic beds for this population. |
## CCG Areas for Improvement

<table>
<thead>
<tr>
<th>IAF measure</th>
<th>Key points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inequality in avoidable emergency admissions</td>
<td>North Tyneside CCG continues to be an outlier for a number of emergency admission indicators.</td>
</tr>
<tr>
<td>Inequality in emergency admissions for urgent care sensitive conditions</td>
<td>The North Tyneside position is artificially inflated by the coding of ambulatory care activity as an emergency admission by Northumbria FT, where for a lot of organisations it’s coded differently and therefore not included in these indicators.</td>
</tr>
<tr>
<td>Emergency admissions for urgent care sensitive conditions per 100,000 population</td>
<td>Following the implementation of QIPP projects in 2015/16 and the opening of NSECH in June 2015 there has been a significant reduction in non-elective admissions of 11.4% in 2015/16. This increased to a 16% reduction for urgent care sensitive conditions and ambulatory care sensitive conditions.</td>
</tr>
<tr>
<td>Emergency bed days per 1,000 population</td>
<td>The time periods used for these measures are either 2014-15 or up to Q2 in 2015/16, therefore these reductions should see an improved position for North Tyneside CCG when the data periods are moved forward.</td>
</tr>
<tr>
<td>Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population</td>
<td></td>
</tr>
<tr>
<td>Effectiveness of working relationships in the local system</td>
<td>This measure is based on the responses to the CCG 360 degree survey to the following two questions</td>
</tr>
<tr>
<td></td>
<td>• Overall, how would you rate your working relationship with your CCG/with CCG?</td>
</tr>
<tr>
<td></td>
<td>• How effective, if at all, do you feel CCG is as a local system leader?</td>
</tr>
<tr>
<td></td>
<td>The CCG score for this measure is 54.3 which is the joint 8th lowest of all of the CCGs nationally.</td>
</tr>
<tr>
<td></td>
<td>The low score will be influenced by a number of middle of challenging schemes affecting both the local foundation trusts and the local authority.</td>
</tr>
<tr>
<td></td>
<td>A full review of the feedback received in the CCGs 360 survey will need to be undertaken and any recommendations for improvement identified</td>
</tr>
</tbody>
</table>
CCG IAF 6 clinical priority areas

In addition to the quarterly reporting against the 57 measures within the CCG IAF framework NHs England have also committed to undertaking an annual assessment against 6 key clinical areas - mental health, dementia, learning disabilities, cancer, maternity and diabetes. The assessments in the clinical priority areas will be overseen by independent groups with a clear rating for each of these six clinical areas being given on a four point ‘Ofsted-style’ scale.

For 2015/16 North Tyneside CCG has been given the following ratings for each of the 6 clinical areas

**Cancer**

<table>
<thead>
<tr>
<th>Cancer</th>
<th>Needs Improvement</th>
<th>CCG: 49.4% Eng avg: 49.7%</th>
<th>CCG:88.4% Eng avg: 81.9%</th>
<th>CCG:67.7% Eng avg: 70.2%</th>
<th>CCG: 96% Eng Avg: 89%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Needs Improvement</td>
<td>New of cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed</td>
<td>Of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral</td>
<td>Of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis.</td>
<td>of responses, which were positive to the question “Overall, how would you rate your care?”</td>
</tr>
</tbody>
</table>

- The Needs Improvement rating is due to the CCG being a significant negative outlier for the one year survival measure.
- The CCG is significantly above the England figure for two measures, and in line with the national average for the other measure included in the assessment.
- A small improvement in the one year survival measure would move the CCG into the Performing Well assessment category.
- As detailed in the above section detailing the one year survival measure plans are in place for 3 survivorship pathways to be implemented in 2016/17.

**Diabetes**

<table>
<thead>
<tr>
<th>Diabetes</th>
<th>Performing well</th>
<th>CCG: 39.1% Eng avg: 39.8%</th>
<th>CCG: 10.8% Eng avg: 5.7%</th>
<th>CCG: 82.8% Eng avg: &lt;60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Performing well</td>
<td>of diabetes patients have achieved all the NICE-recommended treatment targets</td>
<td>of people with diabetes diagnosed for less than a year who attended a structured education course</td>
<td>of GP practices that participated in the National Diabetes Audit</td>
</tr>
</tbody>
</table>

- The CCG has achieved a rating of Performing Well for this clinical area due to there being a significantly higher proportion of people diagnosed with diabetes who attend a structured education course.
CCG IAF 6 clinical priority areas

Dementia

- The Needs Improvement rating is due to the CCG percentage of dementia patients whose care plan has received a review in the past 12 months falling in to the bottom of 4 categories in the assessment of that measure.
- This is a QOF indicator, and the figures used don’t include patients excepted from the process by practices. With these patients remove the CCG percentage is 80.7%. All practices are achieving a full QOF payment for this measure.
- The CCG is well above the national average and the standard target of 66.7% for the diagnosis rate for people with dementia. This puts the CCG into the second of 4 categories in the assessment.
- An improvement of just under 3% to 77.6% in the care plan indicator would move the CCG into the Performing Well assessment category. The CCG will engage with practices, particularly those that have lower scores for this indicator to raise awareness of the importance to ensure all patients have a regular review and that QOF exceptions are minimised.

### Learning Disabilities

<table>
<thead>
<tr>
<th>Learning Disabilities</th>
<th>Needs improvement</th>
<th>CCG: 92</th>
<th>Eng avg: 58</th>
<th>CCG: 56</th>
<th>Eng avg: 47</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate of inpatients per million GP registered adult population for each Transforming Care Partnership. CCGs are then assigned the score of the TCP they belong to</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>of people with a learning disability who are on the GP register and receiving an annual health check during the year. Measured as a percentage of the CCG’s registered learning disability population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- The Needs Improvement rating is due to the Transforming Care Partnership (TCP) the CCG is within being a significant negative outlier for the rate of inpatients per million GP registered adult population. The area covered by the TCP is Cumbria and the North East.
- North Tyneside has been successful in reduction bed numbers in CCG commissioned assessment and treatment units by over 50% with only one patient remaining in a long stay hospital unit.
- The CCG is within the top 25th percentile of CCGs for the proportion of patients with a learning disability receiving an annual health check.
- Improvements will need to be through influencing partners to improve their progress within the TCP.
CCG IAF 6 clinical priority areas

Maternity

<table>
<thead>
<tr>
<th>Maternity</th>
<th>Needs improvement</th>
<th>CCG: 81 Eng avg: 79.6%</th>
<th>CCG: 66.8 Eng avg: 65.4%</th>
<th>CCG: 5.2 Eng avg: 7.1%</th>
<th>CCG: 12.1% Eng avg: 10.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The score out of 100 for women’s experience of maternity services based on the 2015 CQC National Maternity Services Survey</td>
<td>The score out of 100 for choices offered to women in maternity services based on the National Maternity Services Survey</td>
<td>The rate of stillbirths and deaths within 28 days of birth per 1,000 live births and stillbirths, reported at CCG of residence level by calendar year.</td>
<td></td>
<td>of women who were smokers at the time of delivery</td>
</tr>
</tbody>
</table>

- The Needs Improvement rating is due to the assessment for all four indicators being within the ‘No significant difference to the average rate/score’ category. To achieve an assessment of Performing Well the CCG needs at least one indicator to be rated as ‘significantly better than the average score’.
- The CCG is above the national average for three of the four indicators and although there is a higher proportion of women who were smokers at the time of delivery this has seen strong improvements over recent years.
- The Rake lane maternity unit closed in 2015 with the opening of newer NSECH maternity unit which should provide improvements.
- There is a Local system bid to become an early adopter site to implement the outcomes of the national maternity review.
- A process to review these measures with local providers to see where improvements could be made will be undertaken.

Mental Health

<table>
<thead>
<tr>
<th>Mental Health</th>
<th>Needs improvement</th>
<th>CCG: 48.5% Eng avg: 47.6%</th>
<th>CCG: 70.6% Eng avg: 62.9%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>of people who were initially assessed as “at caseness”, attended at least two treatment contacts, are coded as discharged, and are assessed as moving to recovery</td>
<td>of people with first episode of psychosis starting treatment with a NICE-recommended package of care and treated within 2 weeks of referral</td>
<td></td>
</tr>
</tbody>
</table>

- Needs Improvement rating is due to the proportion of people moving to recovery being below 50%. Although the CCG is above the national average for both measures within this assessment.
- There is an agreed action plan with the IAPT provider to improve the proportion of people assessed as moving to recovery with performance monitored and meetings with the provider on a monthly basis.
- It is expected that the Movement to Recovery rate will dip a little in Q1 due to a considerable increase in patients seen and undergoing treatment due to implementation of the ‘Step 3’ Waiting List Initiative. However, it is then expected the rate will increase again when the Initiative has completed. It is also expected to increase further when all Step 4 Psychology patients are no longer recorded on the IAPTUS system.
CCG IAF 6 clinical priority areas

- The data period used for the episode of psychosis indicator is March 2016. Local data shows that the proportion of patients treated within 2 weeks for the CCG is now up to 100%. This would put the CCG into the Performing Well assessment category.
Report to: Governing Body

Date: 22 November 2016  
Agenda item: 9.4

Title of report: CQC inspection – Cobalt Hospital

Sponsor: Lesley Young-Murphy, Executive Director of Nursing and Transformation, North Tyneside Clinical Commissioning Group

Author: Julie Bee, Senior Clinical Quality Officer, North of England Commissioning Support (NECS).

Purpose of the report and action required:

The purpose of this report is to provide the Governing Body of North Tyneside Clinical Commissioning Group (NTCCG) with a summary of the quality report recently published following an inspection of Cobalt Hospital by the Care Quality Commission. The overall rating was subsequently declared as ‘good’.

Introduction:

Cobalt Hospital located at Cobalt Business Park, North Tyneside is part of Ramsay Health Care UK Operations Ltd. It is a purpose built 6-bedded day case facility providing diagnostic and screening procedures, surgical procedures, treatment of disease, disorder or injury to the local populations of Newcastle upon Tyne, North Tyneside and surrounding areas. It does not provide services to under 18 year olds nor does it admit emergency patients. The hospital opened in 2005 and private services commenced in 2006 primarily involving cosmetic surgery services.

There are 43 members of staff, 3 doctors and 15 consultants working at this hospital. The senior management team comprises of the general manager, matron and finance manager.

The inspection took place between 29 – 30 June with a further unannounced visit on 8 July 2016. The two main areas in the report cover surgery and out-patients including diagnostic imaging. Overall, Cobalt Hospital was awarded a ‘good’ rating in the five domains of being safe, effective, caring, responsive and well led in surgical services and out-patients.
Summary:

To obtain details of the patients' experiences of care, the CQC ask five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people’s needs
- Is it well-led?

Overview of ratings:

<table>
<thead>
<tr>
<th></th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Out-patients and</td>
<td></td>
<td>Not rated</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diagnostic imaging</td>
<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Overall</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
</tbody>
</table>

There were several areas of outstanding practice noted. An anaesthetic day surgery study had been presented to the British Association of Anaesthetic Plastic Surgeons (BAAPS) which noted low complication rates and positive patient satisfaction. A deep sedation service was offered to endoscopy patients with low tolerance to discomfort. Finally, a nurse-led out of hours on-call service was available to patients if advice or support was needed.

Safe:

Services were rated ‘good’ because

- Staff were knowledgeable about incident reporting and lessons learned were regularly disseminated
- Policies and procedures were well-embedded and adhered to
- Service level agreements were appropriate and quality monitoring in place for services which were outsourced
- Safeguarding procedures were well managed and staff awareness high
- Staff had a good understanding of the need to comply with duty of candour and the principle of being open when things go wrong
- Nurse staffing was adequate to meet the needs of patients, actual staffing was in line with planned during the inspection and nurse to patient ratios were observed as good with 1:5 or less
- Three medical staff were solely employed by Cobalt and provided all day cover and on-call queries if required
• 15 consultants were employed under the Practising Privileges Policy
• Good teamwork and communication was evident and one medic was an anaesthetist who provided skilled cover in emergencies

Effective:
Services were rated as ‘good’ because

• Processes were in place for implementing and monitoring evidence-based guidelines and standards
• Surgical services participated in national clinical audits and reviews to improve patient outcomes
• Policies and procedures were considered and received sign off approval through the clinical governance committee and medical advisory committee (MAC)
• The hospital benchmarks its practice as part of the private healthcare information network (PHIN)
• 4 unplanned transfer cases were discussed at clinical governance committee and MAC
• All staff received an annual appraisal
• Staff were trained in the Mental Health Act and Deprivation of Liberty Standards

Caring:
Caring was rated as ‘good’ because

• All staff and managers treat patients with kindness, dignity, compassion and respect
• As part of the ‘Friends and Family’ test, 100% of respondents were ‘extremely likely’ or ‘likely’ to recommend the service
• Patient experience was reported on monthly and May 2016 results were ‘good’
• Emotional support was provided to patients and there was access to psychological support for patients undergoing cosmetic surgery
• Specialist advice and support was accessible when required

Responsive:
Responsiveness was rated as ‘good’ because

• The hospital was meeting overall referral to treatment time indicators (RTTs)
• Services were responsive to the needs of patients
• Linked to being ‘effective, robust procedures were in place for safe transfer of patients to acute settings if required
• There were very few formal complaints and those that were received undergo a thorough investigation by the management team

Well-led:
Cobalt is a well-led hospital because

- It has a stable and experienced senior leadership team
- There was a comprehensive governance structure in place to manage corporate/clinical governance risk and quality
- ‘fit and proper person’ requirements were being met
- Medicines management arrangements were in place including appropriate security and competency of staff administering

Areas for improvement:

One action for improvement was recommended – to ensure that the policy for the use of preferred agency providers to cover nurse staffing is followed at all times. This action is now complete.

Conclusion:

Cobalt Hospital has had no ‘never events’ reported and very few incidents resulting in harm. All departments and equipment were visibly clean. Infection control rates were extremely low with no reported cases of MRSA, MSSA and C.Diff reported in 2015/16. The standard of record keeping was high and the implementation of an electronic system is planned to begin in November 2016.

It is a well-run and responsive hospital with high levels of patient and staff satisfaction. It should be commended on the ‘good’ CQC rating and the treatment it provides, also its demonstration of professional and modern practices with safe, effective and efficient use of resources.

Governance and Compliance

1. Links to corporate objectives

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
<td>✔</td>
</tr>
<tr>
<td>2. Deliver the Financial Recovery Plan, leading to the achievement of the CCG’s statutory financial duties and future sustainability</td>
<td>✔</td>
</tr>
<tr>
<td>3. Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside</td>
<td>✔</td>
</tr>
<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
<td>✔</td>
</tr>
</tbody>
</table>
2. **Consultation and engagement**
   Not applicable

3. **Resource implications**
   Not applicable

4. **Risks**
   Not applicable

5. **Equality assessment**
   Not applicable

6. **Environment and sustainability assessment**
   Not applicable
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North Tyneside
Clinical Commissioning Group

Report to: Governing Body

Date: 22 November 2016  Agenda item: 9.5a

Title of report: CQC Inspection – GP Practice Inspections North Tyneside.

Sponsor: Lesley Young-Murphy, Executive Director of Nursing and Transformation
Author: Maureen Grieveson, Head of Quality and Patient Safety and James Martin, Commissioning and Performance Manager

Purpose of the report and action required: The Governing Body is requested to receive this report for information.

Executive summary:

The attached report provides a summary of the GP practices within North Tyneside CCG who have had their services assessed by the CQC and those who are awaiting inspection. The practices are graded under the following domains:

- Safe
- Effective
- Caring
- Responsive
- Well-led
- Overall

Where improvements are required the actions are monitored through the CQC, NTCCG Primary Care Committee and moving forward will be monitored quarterly at the Quality and Safety Committee.

Governance and Compliance

1. Links to corporate objectives

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
<td>✓</td>
</tr>
<tr>
<td>2. Deliver the Financial Recovery Plan, leading to the achievement of the CCG’s statutory financial duties and</td>
<td></td>
</tr>
</tbody>
</table>
## 2. Consultation and engagement
Non applicable.

## 3. Resource implications
Non applicable.

## 4. Risks
Non applicable.

## 5. Equality assessment
A full Equality Impact Assessment has been completed and is included in the revised policy.

## 6. Environment and sustainability assessment
Non applicable.

<table>
<thead>
<tr>
<th>future sustainability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside</td>
<td>√</td>
</tr>
<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
<td>√</td>
</tr>
<tr>
<td>Practice (name registered with CQC)</td>
<td>NHS Code</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>49 Horseme Avenue Surgery</td>
<td>A87004</td>
</tr>
<tr>
<td>Addington Drive</td>
<td>A87009</td>
</tr>
<tr>
<td>Addington Drive (follow-up inspection)</td>
<td>A87009</td>
</tr>
<tr>
<td>Perry Street</td>
<td>A87009</td>
</tr>
<tr>
<td>Perry Street (follow-up inspection)</td>
<td>A87009</td>
</tr>
<tr>
<td>Priory Medical Group</td>
<td>A87004</td>
</tr>
<tr>
<td>Priory Medical Group (follow-up inspection)</td>
<td>A87004</td>
</tr>
<tr>
<td>Appleby Surgery</td>
<td>A87015</td>
</tr>
<tr>
<td>Bramham Park Surgery</td>
<td>A87011</td>
</tr>
<tr>
<td>Westcliffe Medical Centre</td>
<td>A87013</td>
</tr>
<tr>
<td>Collingwood Surgery</td>
<td>A87004</td>
</tr>
<tr>
<td>Dr Blackhamers and Farmers</td>
<td>A87005</td>
</tr>
<tr>
<td>Dr Spraker &amp; Partners</td>
<td>A87006</td>
</tr>
<tr>
<td>Foree Hall Medical Group</td>
<td>A87007</td>
</tr>
<tr>
<td>Morpeth Clinic Limited</td>
<td>D87130</td>
</tr>
<tr>
<td>Eden Park Surgery</td>
<td>A87027</td>
</tr>
<tr>
<td>Mackail Medical Practice</td>
<td>A87015</td>
</tr>
<tr>
<td>Marine Avenue Medical Centre</td>
<td>A87028</td>
</tr>
<tr>
<td>Monkseaton Medical Centre</td>
<td>A87009</td>
</tr>
<tr>
<td>Northumberland Park Medical Group</td>
<td>A87022</td>
</tr>
<tr>
<td>Park Parade Surgery</td>
<td>A87000</td>
</tr>
<tr>
<td>Park Road Practice</td>
<td>A87005</td>
</tr>
<tr>
<td>PGA Health Centre</td>
<td>A87001</td>
</tr>
<tr>
<td>Practice (name registered with CQC)</td>
<td>NHS Code</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Medium Park Medical Centre</td>
<td>A87030</td>
</tr>
<tr>
<td>Berintree Medical Group</td>
<td>A87023</td>
</tr>
</tbody>
</table>
| Spring Terrace Health Centre       | A87002   | 10/03/2015     | Inadequate | http://www.cqc.org.uk/inspection/1-564605152/report                           | Inadequate | Inadequate | Requires Improvement | Inadequate | Inadequate | Inadequate | Inadequate | View requirement notice - Regulation 18 HSCA (RA) Regulations 2014 Staffing, two warning notices - Regulation 12 (safe care and treatment) and Regulation 17 (good governance).
Reassessment now completed and practice rated good (see below) |
<p>| Spring Terrace Health Centre (follow-up inspection) | A87022 | 20/01/2016 | Inadequate | <a href="http://www.cqc.org.uk/inspection/1-564605152/report">http://www.cqc.org.uk/inspection/1-564605152/report</a>                           | Inadequate | Inadequate | Inadequate | Inadequate | Inadequate | Inadequate | Inadequate | None                                                                                                                                            |
| The Village Green Surgery          | A87016   | 24/03/2015     | Good   | <a href="http://www.cqc.org.uk/inspection/1-565405021/report">http://www.cqc.org.uk/inspection/1-565405021/report</a>                           | Good  | Outstanding | Good   | Good       | Outstanding | Outstanding | None                             |                                                                                                                                            |
| Woodgreen Medical Practice         | A8705   | 10/03/2015     | Good   | <a href="http://www.cqc.org.uk/inspection/1-565925262/report">http://www.cqc.org.uk/inspection/1-565925262/report</a>                           | Good  | Good       | Good   | Good       | Good       | Good       | Good       | None                             |                                                                                                                                            |
| West Farm Surgery                  | A8605    | 10/03/2015     | Good   | <a href="http://www.cqc.org.uk/inspection/1-565925262/report">http://www.cqc.org.uk/inspection/1-565925262/report</a>                           | Good  | Good       | Good   | Good       | Good       | Good       | Good       | Good       | None                             |                                                                                                                                            |
| Eldon Park Medical Centre          | A8702   | 25/08/2016     | Good   | Draft report with practice                                                    | Good  | Good       | Good   | Good       | Good       | Good       | Good       | Good       | None                             |                                                                                                                                            |
| Eldon Park Health Centre           | A8707   | 03/12/2015     | Good   | <a href="http://www.cqc.org.uk/inspection/1-567705262/report">http://www.cqc.org.uk/inspection/1-567705262/report</a>                           | Good  | Good       | Requires Improvement | Good   | Good       | Good       | Good       | None                             |                                                                                                                                            |
| Garden Park Medical Practice       | A8704   | 10/03/2015     | Good   | <a href="http://www.cqc.org.uk/inspection/1-565925262/report">http://www.cqc.org.uk/inspection/1-565925262/report</a>                           | Good  | Good       | Good   | Good       | Good       | Good       | Good       | Good       | None                             |                                                                                                                                            |
| TyneHealth Limited                 | To be inspected |                                           | Good   | <a href="http://www.cqc.org.uk/inspection/1-565925262/report">http://www.cqc.org.uk/inspection/1-565925262/report</a>                           | Good  | Good       | Good   | Good       | Good       | Good       | Good       | Good       | None                             |                                                                                                                                            |</p>
<table>
<thead>
<tr>
<th>Report to:</th>
<th>Governing Body - Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>22.11.2016</td>
</tr>
<tr>
<td>Agenda item:</td>
<td>10.2</td>
</tr>
<tr>
<td>Sponsor:</td>
<td>Paul James - Interim Chief Finance Officer</td>
</tr>
<tr>
<td>Author:</td>
<td>Jeff Goldthorpe – Head of Finance</td>
</tr>
</tbody>
</table>

**Purpose of the report and action required:**

- The report details North Tyneside Clinical Commissioning Group’s financial position as at month 7.
- The Governing Body is requested to acknowledge and note the specific issues as set out in the executive summary.
1. Executive Summary

1.1 Key Messages

- The monthly position includes an estimated outturn activity pressure of £2.0m at Northumbria Healthcare Foundation Trust (NHCFT) and £2.3 at Newcastle upon Tyne Hospitals Trust (NUTH) which has been mitigated by the use of reserves and contingencies. Additional pressures have also emerged within Out of Area LD cases and Section 117 cases.

- Month 7 expenditure is in line with the CCG forecast to deliver a £19.3m deficit.

- There also remains significant uncertainty over the financial outturn because the contract discussions with Northumbria are not completed.

- Of the £20.3m gross QIPP target, a few schemes began at the start of the year. The CCG is estimated to have delivered £12.7m to 31 October 16 and is forecast to deliver £16.8m.

- The CCG has refreshed its financial recovery plan in response to its legal directions.

1.2 Overview

North Tyneside Clinical Commissioning Group (CCG) is required to deliver against a number of national and local financial targets as detailed in the Table 1 showing the forecast delivery against these targets.

Table 1 – Key financial targets

<table>
<thead>
<tr>
<th>Metric</th>
<th>Annual/ Year To Date Metric (A/ YTD)</th>
<th>Description of Metric</th>
<th>Mandated Target £’m</th>
<th>CCG Plan £’m</th>
<th>Forecast Delivery against plan £’m</th>
<th>Delivery Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue Limit (Forecast)</td>
<td>A</td>
<td>To deliver a minimum of 1% surplus of revenue limit against expenditure</td>
<td>3.0 (19.3)</td>
<td>(19.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Running Costs</td>
<td>A</td>
<td>To operate within the allocated CCG running cost allowance</td>
<td>4.7</td>
<td>4.7</td>
<td>5.1</td>
<td></td>
</tr>
<tr>
<td>1% Non Recurrent Headroom</td>
<td>A</td>
<td>To hold a 1% reserve for non recurrent use</td>
<td>3.0</td>
<td>3.0</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td>0.5% Contingency</td>
<td>A</td>
<td>To hold a contingency of 0.5%</td>
<td>1.5</td>
<td>1.5</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>QIPP/ Financial Recovery Plan</td>
<td>A</td>
<td>To fully deliver against a QIPP target</td>
<td>0.0</td>
<td>(20.3)</td>
<td>(16.8)</td>
<td></td>
</tr>
<tr>
<td>Cash Limit</td>
<td>A</td>
<td>The maximum amount to be left in the CCG bank account on close of play 31 March 2016</td>
<td>0.50</td>
<td>0.50</td>
<td>0.50</td>
<td></td>
</tr>
<tr>
<td>Better Payment Practice Code</td>
<td>YTD</td>
<td>To ensure that 95% of invoices are paid within 30 days of receiving invoice</td>
<td>95%</td>
<td>95%</td>
<td>98.2%</td>
<td></td>
</tr>
<tr>
<td>Capital Limit</td>
<td>A</td>
<td>Not applicable</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Value of Risks before Mitigations</td>
<td>YTD</td>
<td>Gross risks before mitigations</td>
<td>0.0</td>
<td>0.0</td>
<td>(9.3)</td>
<td></td>
</tr>
<tr>
<td>Value of Risks after Mitigations</td>
<td>YTD</td>
<td>Gross risks after mitigations</td>
<td>0.0</td>
<td>0.0</td>
<td>(7.8)</td>
<td></td>
</tr>
</tbody>
</table>
1.3 Context
The CCG reported a deficit position of £19.3m in the 2015/16 financial year resulting in an equivalent £19.3m allocation reduction in 2016/17. Taking this into account the CCG planned to deliver a £19.3m deficit, effectively maintaining the same level of deficit as during 2016/17. To maintain the in-year break-even position the CCG planned to deliver savings of £20.3m.

1.4 Summary Financial Position
As always the results are based on activity data that is not current. The year-to-date position has been adjusted to take account of the working capital benefit transferred from 2015/16 and to date shows a position of £12.282m which is £1036k worse than originally planned.

A more detailed analysis of expenditure is shown below.

2 Detailed financial position

<table>
<thead>
<tr>
<th>Table 2 – Financial Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>**</td>
</tr>
<tr>
<td>Resources Limit</td>
</tr>
<tr>
<td>Healthcare Commissioned Services</td>
</tr>
<tr>
<td>Acute Services</td>
</tr>
<tr>
<td>Mental Health Services</td>
</tr>
<tr>
<td>Community Health Services</td>
</tr>
<tr>
<td>Continuing Care Services</td>
</tr>
<tr>
<td>Prescribing</td>
</tr>
<tr>
<td>Primary Care</td>
</tr>
<tr>
<td>Better Care Fund</td>
</tr>
<tr>
<td>Other Programme Services</td>
</tr>
<tr>
<td>Reserves - Mandated</td>
</tr>
<tr>
<td>Reserves - CCG</td>
</tr>
<tr>
<td>Reserves - In Year Allocations</td>
</tr>
<tr>
<td>15/16 Accruals</td>
</tr>
<tr>
<td>Healthcare Commissioned Services Total</td>
</tr>
<tr>
<td>Running Costs Total</td>
</tr>
<tr>
<td>Total Expenditure</td>
</tr>
<tr>
<td>Total Surplus/Deficit</td>
</tr>
<tr>
<td>15/16 Benefits variance</td>
</tr>
<tr>
<td>Underlying YTD variance</td>
</tr>
</tbody>
</table>

2.1 Revenue Resource Limit
The annual revenue resource limits for the CCG are £307.3m for programme expenditure and £4.7m for running costs. At the end of October 2016 the allocations available totalled £293.8m. Table 3 details the baseline allocation and the year-to-date resource limit adjustments. The deficit of £19.3m incurred in 2015/16 has been deducted from the initial allocation. This is in line with NHS England accounting regulations that mandate that this has to be repaid in the following year.
### 2.2 Acute Services

The acute services financial position shows a year to date adverse variance of £2.75m at month 7. Table 4b shows that the financial over performance against plan relates primarily to A&E, critical care, drugs and devices, elective and non-elective care.

The contract for NHCFT has yet to be finalised and signed. The forecast outturn position for NHCFT has been reported at £2.0m over performance although recent un-validated activity from the Trust has indicated that additional over-performance has occurred in the areas of A&E and Non elective admissions. An activity management review to determine the cause of over-activity and agree a plan with the Trust to bring activity back to contracted levels, has now commenced.

The Month 7 reported position for NUTH has been estimated based on Month 6 freeze data reported by the Trust. The Trust is still experiencing problems with coding data but has made significant improvements over recent months to the volume of un-coded data. The Trust is currently over performing on elective activity and drugs and devices.

Table 4a & 4b provide month 7 year to date positions against all acute contracts, covering both activity by the point of delivery and the financial impacts, the associated contract plan and financial impact.
Table 4a – 2016/17 Overall Acute Contract Performance to Month 7 year to date

<table>
<thead>
<tr>
<th>POD Summary</th>
<th>Plan</th>
<th>Actual</th>
<th>Variance against Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>AandE</td>
<td>36,112</td>
<td>41,906</td>
<td>5,794</td>
</tr>
<tr>
<td>Critical Care</td>
<td>2,232</td>
<td>2,461</td>
<td>229</td>
</tr>
<tr>
<td>Drugs and Devices</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Elective</td>
<td>13,522</td>
<td>15,408</td>
<td>1,886</td>
</tr>
<tr>
<td>Emergency Readmissions</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Threshold</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Excess Beddays</td>
<td>9,546</td>
<td>10,320</td>
<td>774</td>
</tr>
<tr>
<td>Maternity Pathways</td>
<td>2,378</td>
<td>2,341</td>
<td>(37)</td>
</tr>
<tr>
<td>Non Elective</td>
<td>11,510</td>
<td>12,782</td>
<td>1,272</td>
</tr>
<tr>
<td>Other Services</td>
<td>572,205</td>
<td>600,471</td>
<td>28,266</td>
</tr>
<tr>
<td>Outpatient Diagnostics</td>
<td>16,607</td>
<td>15,389</td>
<td>(1,218)</td>
</tr>
<tr>
<td>Outpatient First</td>
<td>36,592</td>
<td>35,973</td>
<td>(619)</td>
</tr>
<tr>
<td>Outpatient Follow Up</td>
<td>104,612</td>
<td>100,398</td>
<td>(4,214)</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>20,519</td>
<td>20,338</td>
<td>(181)</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td>5,781</td>
<td>5,470</td>
<td>(311)</td>
</tr>
<tr>
<td>Penalties</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Challenges</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CQUIN</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NEAS</td>
<td>33,106</td>
<td>32,863</td>
<td>(243)</td>
</tr>
<tr>
<td>Large NHS NCAs</td>
<td>0</td>
<td>1,163</td>
<td>1,163</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balance to CCG Budget</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Month 6 Total</strong></td>
<td>864,722</td>
<td>897,283</td>
<td>32,561</td>
</tr>
<tr>
<td><strong>Estimate for Month 7</strong></td>
<td>144,122</td>
<td>149,534</td>
<td>5,411</td>
</tr>
<tr>
<td><strong>Reported Month 7 Position</strong></td>
<td>1,008,844</td>
<td>1,046,817</td>
<td>37,973</td>
</tr>
</tbody>
</table>

Table 4b – 2016/17 Overall Acute Contract Performance to Month 7 year to date

<table>
<thead>
<tr>
<th>POD Summary</th>
<th>£000s (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AandE</td>
<td>3,681</td>
</tr>
<tr>
<td>Critical Care</td>
<td>2,194</td>
</tr>
<tr>
<td>Drugs and Devices</td>
<td>3,735</td>
</tr>
<tr>
<td>Elective</td>
<td>16,182</td>
</tr>
<tr>
<td>Emergency Readmissions</td>
<td>(303)</td>
</tr>
<tr>
<td>Emergency Threshold</td>
<td>(165)</td>
</tr>
<tr>
<td>Excess Beddays</td>
<td>2,035</td>
</tr>
<tr>
<td>Maternity Pathways</td>
<td>2,195</td>
</tr>
<tr>
<td>Non Elective</td>
<td>20,988</td>
</tr>
<tr>
<td>Other Services</td>
<td>12,200</td>
</tr>
<tr>
<td>Outpatient Diagnostics</td>
<td>1,725</td>
</tr>
<tr>
<td>Outpatient First</td>
<td>4,724</td>
</tr>
<tr>
<td>Outpatient Follow Up</td>
<td>7,495</td>
</tr>
<tr>
<td>Outpatient Procedures</td>
<td>3,304</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td>2,486</td>
</tr>
<tr>
<td>Penalties</td>
<td>0</td>
</tr>
<tr>
<td>Challenges</td>
<td>0</td>
</tr>
<tr>
<td>CQUIN</td>
<td>1,914</td>
</tr>
<tr>
<td>NEAS</td>
<td>3,962</td>
</tr>
<tr>
<td>Large NHS NCAs</td>
<td>1,914</td>
</tr>
<tr>
<td>Other</td>
<td>655</td>
</tr>
<tr>
<td>Balance to CCG Budget</td>
<td>51</td>
</tr>
<tr>
<td><strong>Month 6 Total</strong></td>
<td>89,348</td>
</tr>
<tr>
<td><strong>Estimate for Month 7</strong></td>
<td>14,539</td>
</tr>
<tr>
<td><strong>Reported Month 7 Position</strong></td>
<td>103,887</td>
</tr>
</tbody>
</table>
2.3 Mental Health

The contract with Northumberland Tyne and Wear Foundation Trust (NTW) has historically been a block arrangement. Currently the budget shows a small overspend mitigated slightly by the contractual cap benefit.

Table 5 - Northumberland, Tyne and Wear NHS FT Finance & Activity

<table>
<thead>
<tr>
<th>POD Summary</th>
<th>Activity (YTD)</th>
<th>£000s (YTD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td>Adolescent Bipolar Service</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Affective Disorders - Inpatients</td>
<td>0</td>
<td>58</td>
</tr>
<tr>
<td>Regional Disability Team</td>
<td>229</td>
<td>290</td>
</tr>
<tr>
<td>Tyne - Villa 19</td>
<td>578</td>
<td>387</td>
</tr>
<tr>
<td>Other</td>
<td>10,424</td>
<td>39,107</td>
</tr>
<tr>
<td>COUN</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Contract Total</strong></td>
<td>11,231</td>
<td>39,844</td>
</tr>
<tr>
<td>0.1% contract variance cap</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td><strong>Month 6 Total</strong></td>
<td>11,231</td>
<td>39,855</td>
</tr>
<tr>
<td>Estimate for Month 7</td>
<td>0</td>
<td>1,596</td>
</tr>
<tr>
<td>Reported Month 7 Position</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Non-NHS mental health spend predominately relates to jointly commissioned arrangements with North Tyneside Local Authority. These arrangements cover those patients that have been sectioned under Section 117 of the Mental Health Act (1983) and LD patients who require care to be provided out of area (OOA). Both areas are showing year to date and forecast overspends.

2.4 Community Services

The majority of community services are provided by NHCF and NUTH. Although both contracts have traditionally been block contracts from October 2016 elements of the NUTH community contract is charged based on actual usage. The contract is reporting an adverse forecast outturn of £122k.

2.5 Continuing Health Care

The year-to-date and the forecast position for continuing health care (CHC) (which includes funded nursing care) shows an underspend of £78k. It should be noted however that the management of CHC cases was transferred to North Tyneside Council from 1 May 2016 and the CCG has not yet been provided with robust outturn information. The position has therefore been estimated by reference to budgets and previous period outturn.

2.6 Primary Care Prescribing

The GP prescribing outturn position has been estimated by using the year to date position for August 2016 which has been extrapolated using the 2016/17 actual PPA phasing profile. The current position shows an adverse outturn variance of £112k.

2.7 Primary Care

Primary care budgets include local enhanced services, out of hours, oxygen services and GP IT costs. These budgets are forecasting an overall underspend of £15K.
2.8 Better Care Fund

Of the total BCF (£16.6m) the CCG contributes £9.5m towards social care. This includes re-ablement services, carer’s breaks and the implementation of the Care Act. The health elements of the BCF remain within other CCG budgets.

The Better Care Fund is forecasting a £406k overspend position due to the additional investment agreed for Intermediate Care.

The Section 75 agreement between North Tyneside Council and the CCG which governs the operation of the Better Care Fund has yet to be signed for 2016/17.

2.9 Reserves and Contingency

The CCG holds minimal reserves and these are already fully committed. In line with NHSE requirements a 0.5% contingency was held which is now being used to support the current outturn position. Other reserves relate to specific areas of expenditure and are also fully committed.

2.10 CCG Running costs

The CCG has an annual running cost allowance of £4.7m. The year to date position shows an overspend of £294k. This is mainly due to the full year cost of interim staff covering key vacant substantive posts and costs of support for project management and financial recovery. NECS (North East Commissioning Support Services) have also provided additional services to the CCG to support the delivery of the FRP. The forecast position shows an overspend of £443k.

3. Cash

Table 5 outlines the CCG’s cash drawings and payments for Apr 2016 to Oct 2016.

<table>
<thead>
<tr>
<th>Table 5 – Cash position to date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

At the end of October 2016 the CCG holds a cash balance of £255k. At year end it is expected the CCG will meet the NHSE cash target of a minimum of £50k excess cash over expenditure.
4. Better payments practice code

The better payments practice code stipulates that it is good practice to pay 95% of all invoices within 30 days of receipt of the invoice or goods, whichever is later. Table 6 details the number and value of invoices paid from 1 April to 31 October 2016 for both non NHS and NHS suppliers. The CCG has paid 98.25% of the total number of invoices which equates to 99.72% of the total value of invoices.

Table 6 – Better payments practice code

<table>
<thead>
<tr>
<th>Better Payment Practice Code - 30 Days</th>
<th>NUMBER</th>
<th>£000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-NHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices Paid in the Year</td>
<td>4,371</td>
<td>30,842</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices Paid Within 30 Day Target</td>
<td>4,285</td>
<td>30,434</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade Invoices Paid Within 30 Day Target</td>
<td>98.03%</td>
<td>98.68%</td>
</tr>
<tr>
<td>NHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>1,108</td>
<td>129,547</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid Within 30 Day Target</td>
<td>1,098</td>
<td>129,514</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices Paid Within 30 Day Target</td>
<td>99.10%</td>
<td>99.97%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Trade Invoices Paid in the Year</td>
<td>5,479</td>
<td>160,389</td>
</tr>
<tr>
<td>Total Trade Invoices Paid Within 30 Day Target</td>
<td>5,383</td>
<td>159,948</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices Paid Within 30 Day Target</td>
<td>98.25%</td>
<td>99.72%</td>
</tr>
</tbody>
</table>

5. Statement of financial position

Table 7 shows the month 7 financial position of the CCG.

Table 7 – Statement of Financial Position

<table>
<thead>
<tr>
<th></th>
<th>Oct-16</th>
<th>Sep-16</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000's</td>
<td>£000's</td>
<td>£000's</td>
</tr>
<tr>
<td>Non Current Assets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Intangible Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Financial Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Non Current Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Current Assets</td>
<td>8,946</td>
<td>6,542</td>
<td>2,404</td>
</tr>
<tr>
<td>Trade and other Receivables</td>
<td>429</td>
<td>436</td>
<td>7</td>
</tr>
<tr>
<td>Prepayments &amp; Accrued Income</td>
<td>8,262</td>
<td>6,046</td>
<td>2,216</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>255</td>
<td>60</td>
<td>195</td>
</tr>
<tr>
<td>Total Current Assets</td>
<td>8,946</td>
<td>6,542</td>
<td>2,404</td>
</tr>
<tr>
<td>Total Assets</td>
<td>8,946</td>
<td>6,542</td>
<td>2,404</td>
</tr>
<tr>
<td>Current Liabilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>15,216</td>
<td>15,778</td>
<td>560</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Borrowings</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Current Liabilities</td>
<td>(22,663)</td>
<td>(19,020)</td>
<td>(3,643)</td>
</tr>
<tr>
<td>Non-Current Assets plus/less Net Current Assets/Liabilities</td>
<td>(13,717)</td>
<td>(12,478)</td>
<td>(1,239)</td>
</tr>
<tr>
<td>Non-Current liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Borrowings</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Non-Current Liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL ASSETS EMPLOYED</td>
<td>(13,717)</td>
<td>(12,478)</td>
<td>(1,239)</td>
</tr>
<tr>
<td>Financed by Taxpayers Equity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital &amp; Reserves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Fund</td>
<td>(13,717)</td>
<td>(12,478)</td>
<td>(1,239)</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL TAXPAYERS EQUITY</td>
<td>(13,717)</td>
<td>(12,478)</td>
<td>(1,239)</td>
</tr>
</tbody>
</table>
6. Financial Recovery Plan (FRP)

The financial plan for the year is based on the revised deficit control total of £19.3m. This control total is predicated on delivering £20.3m gross savings.

At month 7 the total estimated FRP savings are £12.7m. It is forecast that £16.8m will be delivered during the financial year.

7. Risks and mitigation strategies

Table 8 lays out potential risks and mitigations.

<table>
<thead>
<tr>
<th>Table 8 - Financial risks</th>
<th>Risk Value £'m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risks</strong></td>
<td></td>
</tr>
<tr>
<td>FRP Risk &amp; Mitigations</td>
<td>(1.0)</td>
</tr>
<tr>
<td>16/17 Performance Risk &amp; Mitigations</td>
<td>(5.5)</td>
</tr>
<tr>
<td>15/16 Outturn Risk &amp; Mitigations</td>
<td>(1.5)</td>
</tr>
<tr>
<td>Other Risks &amp; Mitigations</td>
<td>(1.3)</td>
</tr>
<tr>
<td><strong>Total Mitigations</strong></td>
<td>(9.3)</td>
</tr>
<tr>
<td><strong>Mitigations</strong></td>
<td></td>
</tr>
<tr>
<td>16/17 Performance Risk &amp; Mitigations</td>
<td>0.2</td>
</tr>
<tr>
<td>15/16 Outturn Risk &amp; Mitigations</td>
<td>0.5</td>
</tr>
<tr>
<td>Other Risks &amp; Mitigations</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Total Mitigations</strong></td>
<td>1.5</td>
</tr>
</tbody>
</table>

The risks are additional to the forecast position and further risks may arise against the delivery of QIPP in the remainder of the financial year. To offset these risks the CCG will need to develop additional QIPP schemes and has assumed that additional allocations from NHS England to support the costs of interim staff will be received.

8. Recommendations

The Governing Body are asked to acknowledge the contents of this report, and to take into account the update on risks and mitigations, and the delivery of the FRP.

**Report authors:** Jeff Goldthorpe – Head of Finance

**Report date:** 15 November 2016
Governance and Compliance

1. Links to corporate objectives

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution.</td>
<td>✓</td>
</tr>
<tr>
<td>2. Develop and grow North Tyneside CCG as a patient focused, clinically led commissioning organisation.</td>
<td>✓</td>
</tr>
<tr>
<td>3. Deliver year 2 of the Financial Recovery Plan, leading to sustainable financial balance and delivery of the CCG’s statutory financial duties.</td>
<td>✓</td>
</tr>
<tr>
<td>4. Work collaboratively with partners and stakeholders to be responsive to the population of North Tyneside.</td>
<td>✓</td>
</tr>
<tr>
<td>5. Lead and influence the development of health and social care fit for the future.</td>
<td>✓</td>
</tr>
</tbody>
</table>

2. Consultation and engagement

Not applicable

3. Resource implications

The CCG has a revenue resource limit, and expenditure needs to be managed within this, however the CCG is reporting a £19.3m deficit.

4. Risks

Refer to section 7.

5. Equality assessment

Not applicable.

6. Environment and sustainability assessment

Not applicable.
Members-Influence and Impact

CCG Patient Forum and Working Groups

- North Tyneside Clinical Commissioning Group’s Patient Forum is strong, robust and acts as a critical friend to the CCG and its Governing Body. Members are encouraged to challenge and debate throughout all engagement processes.
- As a constituted group the strength of the Forum is the dedication and commitment within the membership as well as their passion for local health services.
- All Working Groups and related topics were decided by Forum Members and are compatible with NTCCG Strategic Plan and Priorities.

The aim of the Patient Forum is to have membership from each of the 29 GP Practices in North Tyneside and come from practices own patient groups. Most Practices have active patient groups with scheduled meetings throughout the year and others run virtual groups to engage with their patient population. Agenda items for the Forum are a mixture of CCG areas for discussion and member led issues for meetings. As a result of members areas of special interests identified within development sessions and inductions, these are matched with CCG priorities and a series of smaller Working Groups are established to enable more in depth discussion and influence. There are six Working Groups, these are special interest groups and membership has formed as a result of members’ experiences or work related background. All working Groups are chaired by Clinicians or senior personnel.

Older People and Care Plus Working Group

Membership 8-Monthly meetings

Following the recent review it was decided to merge Care Plus into this group, this will enable members to have regular ongoing input in service developments.
- Patient satisfaction work is in the process of being arranged

Next meeting Wednesday 30 November 2016 11am Linskill Centre North Shields

Self Care and Wellbeing Working Group

Membership 11-Quarterly meetings

Following the recent review it was decided to merge the Self Care and Health and Wellbeing Working Groups as both have similar aims.
- The back pain workshops continue and the two most successful venues are the White Swan Centre in Killingworth and the Customer First Centre in North Shields. Posters are being prepared to display in GP Practices and the agreed dates are Friday 24 November North Shields Monday 23 January 2017 Killingworth
Thursday 23 March 2017 North Shields

• Members also discussed Health Pledges an initiative involving patients making pledges to improve their health and wellbeing in small ways such as drinking more water. The group will consider this as a theme for Self Care week in November and will discuss with the CCG.
• National Self Care week is during November

Next meeting to be arranged 2.30pm at Wellspring Practice Killingworth

End of Life Working Group
Membership 10-Quarterly meetings

• Future involvement of members will include discussing the need of processes, protocols and systems within bereavement care.
• Members received information on the enhanced model of palliative care
• It was confirmed the Rapid Response Team is almost at its staffing level and is being well received by patients and their families.

Next meeting-Tuesday 13 December 2016 9.30am 205 Park Road Wallsend

Mental Health Working Group
Membership 6-Quarterly meetings

• Members receive and discuss service information. Local developments in North Tyneside have resulted in changes to psychological therapies. North Tyneside also has a Social Prescribing Service, a Voluntary Sector partnership arrangement, it gives patients presenting to their GP with low mood or anxiety issues the opportunity to be prescribed well being activities as an intervention rather than medication as a solution in the first instance.
• Northumberland, Tyne & Wear (NTW) Transformation Programmes are shared with members on a regular basis with opportunities to be involved
• The North Tyneside Mental Health Strategy is in draft form and has been shared with members.

Next meeting-To be arranged 10.30am 205 Park Road Wallsend

Communications Working Group
Membership 9-Monthly meetings

• North Tyneside CCG website now has a dedicated section for the Patient Forum newsletter and the second edition has recently been published. In addition practices will be encouraged to laminate a copy for their waiting rooms and include it on their own website
• The group has worked hard on this to bring all of the elements together with the aim of raising the profile of the Forum
• Specific meeting dates have now been arranged for drafting and editing future editions-members ideas for topics to be included are welcome and Issue 5, the Christmas issue is in the process of being written.

Next meeting-Thursday 24 November 2016 10.00am Linskill Centre
North Shields-Newsletter final edit session
Shared Decision Making (SDM) Working Group
Membership 8-Frequency of meetings to be arranged

- SDM is an approach where clinicians and patients make decisions together using the best available evidence and considering not only treatment options but also how values and preferences affect choices. During a recent presentation by local GPs they felt that clinicians think they do this anyway but that they need to be challenged and trained as patients don’t feel as involved as they should.
- Publicity material is in the process of being printed for display in GP Practices.
- Members are currently considering evaluation tools

Next meeting-Monday 28 November 2016 10.00am Linskill Centre North Shields

Notes of all meetings are available on request and new members to the Working Groups are welcome

Please note proposed dates for 2017 will be shared with members in due course for agreement
Report to: Governing Body

Date: 22 November 2016

Title of report: Risk Assurance Framework

Author: Irene Walker, Head of Governance

Purpose of the report and action required: Governing Body is asked to review and receive the Risk Assurance Framework (RAF), with a particular focus on extreme and high risks.

Executive summary: The Governing Body has overall responsibility for governance, assurance and management of risk. The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces and that it has controls in place to mitigate those risks to a level consistent with the CCG’s risk appetite.

The Corporate Risk Register is reviewed by the responsible committees (i.e. Finance Committee, Quality & Safety Committee and Clinical Executive Committee). Audit Committee then receives the Corporate Risk Register for review to enable it to provide assurance to Governing Body that risks are properly identified, assessed and effectively managed.

The Corporate Risk Register underpins the Risk Assurance Framework. The RAF presents the corporate risks aligned to the corporate objectives – see Appendix 1.

Action
Governing Body is asked to review and receive the RAF with a particular focus on extreme and high risks (see the heat map on page 2).

Governance and Compliance

1. Links to corporate objectives

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
<td>√</td>
</tr>
<tr>
<td>2. Deliver the Financial Recovery Plan, leading to the achievement of the CCG’s statutory financial duties and future sustainability</td>
<td>√</td>
</tr>
<tr>
<td>3. Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside</td>
<td>√</td>
</tr>
<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
<td>√</td>
</tr>
</tbody>
</table>
2. **Consultation and engagement**  
The Risk Assurance Framework is presented bi monthly to Finance Committee, Quality & Safety Committee, Clinical Executive Committee and 4 monthly to Audit Committee for consideration ahead of submission to Governing Body.

3. **Resource implications**  
The management of risk is continuous and may or may not require additional resource.

4. **Risks**  
The risk of not identifying and managing risk effectively is failure to deliver statutory requirements and the CCG’s corporate objectives.

5. **Equality assessment**  
Consideration of equalities issues is inherent as part of the CCG assessing its risks.

6. **Environment and sustainability assessment**  
Consideration of environmental issues is inherent as part of the CCG assessing its risks.

### Heat Map

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negligible</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Minor</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Moderate</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Major</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

- 1 - 3: Low risk
- 4 - 6: Medium risk
- 8 - 12: High risk
- 15 - 25: Extreme risk
### Corporate Objective 1: Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution

- **CCG Constitution reflects NHS Constitution**
- **Regular Provider performance management meetings**
- **Monthly performance reporting to Clinical Executive, with corrective actions identified and followed up**
- **Regular performance reports to Governing Body**
- **Annual report of year-end performance against NHS Constitution targets**
- **Monthly performance reports to Commissioning, Performance and Finance Committee, to align performance issues with contracting discussions**
- **NHS constitution measures included in the penalty schedule within provider contracts**

### Risk of failure to clearly demonstrate compliance with NHS Constitution and its rights and pledges

<table>
<thead>
<tr>
<th>Date</th>
<th>Score</th>
<th>Responsible</th>
<th>Consequence</th>
<th>Likelihood</th>
<th>Residual score</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/05/2013</td>
<td>75</td>
<td>Chief Finance Officer</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
</tbody>
</table>

- Adult Safeguarding Board and Local Children Safeguarding Boards in place; CCG an active member
- **Regular performance reports to the CCG from NHS Providers to confirm and evidence that they have robust safeguarding arrangements in place**
- **Expertise of designated health professionals - 2 named GPs**
- Child and Adult Safeguarding Policies in place (revised November 2015): CCG staff up to date with Safeguarding training
- Governing Body provided with Prevent and Safeguarding training
- Serious Incident Management system in place, compliant with NHS England framework
- Quality and Safety Committee receive regular reports on Serious Incidents and safeguarding issues
- Governing Body receive regular reports on safeguarding issues

### Risk of adult or child safeguarding incident or other significant quality failure incident

<table>
<thead>
<tr>
<th>Date</th>
<th>Score</th>
<th>Responsible</th>
<th>Consequence</th>
<th>Likelihood</th>
<th>Residual score</th>
</tr>
</thead>
<tbody>
<tr>
<td>21/05/2013</td>
<td>544</td>
<td>Murphy</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

- Adult Safeguarding Board and Local Children Safeguarding Boards in place; CCG an active member
- **Minutes of Adult & Children Safeguarding Board Minutes of LSCB**
- Designated Professionals Job Descriptions and work plans
- Policies in place, on the CCG website and reviewed as appropriate
- CCG annual report and Governing Body records
- SI policy documents and notes of SI closedown panels
- Verbal report to Governing Body
- Monthly report to Quality and Safety Committee.
- Internal Audit review of Safeguarding resulted in significant assurance with no issues of note (2013/14) NTC 3804.
- CCG has been rated as fully compliant with all KLOE/Standards set out in the NHS benchmarking/assurance tool 06/04/2016.
- CCG Constitution reflects NHS Constitution on CCG website, subject to regular review
- Notes of Provider performance management meetings
- Performance reporting to Clinical Executive and minutes of those meetings
- Performance reports to Governing Body and minutes of those meetings
- CCG Annual Report and Annual Public Meeting
- Internal Audit review of Performance Management NTC 15/16/08 gave significant assurance (Jan 16)
- Notes of Commissioning, Performance and Finance Meetings
- Penalty schedule - monthly

### Risk of inadequate procedures for Health Care Acquired Infection (HCAI) resulting in a patient contracting an avoidable infection which could prove fatal

<table>
<thead>
<tr>
<th>Date</th>
<th>Score</th>
<th>Responsible</th>
<th>Consequence</th>
<th>Likelihood</th>
<th>Residual score</th>
</tr>
</thead>
<tbody>
<tr>
<td>20/05/2013</td>
<td>188</td>
<td>Murphy</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>

- NTCGG is an active member of the formal control of infection partnership, covering Gateshead and North of the Tyne
- HCAI is a standard agenda item for Quality Review Groups
- Robust arrangements evidenced in FTs including FT Infection Protection and Prevention Control meetings and HCAI Action Plans
- HCAI has received and reviewed FT HCAI action plans; HCAI is included in provider contract monitoring meetings
- **CCG HCAI action plan in place, approved by Quality and Safety Committee, refreshed as required**
- HCAI regularly reported to CCG Quality and Safety Committee, escalated to Governing Body as required
- HCAI included in quality and performance reports to Clinical Executive and Governing Body
- NECS producing weekly update reports

- **CCG Constitution on CCG website, subject to regular review**
- Notes of Provider performance management meetings
- Performance reporting to Clinical Executive and minutes of those meetings
- Performance reports to Governing Body and minutes of those meetings
- CCG Annual Report and Annual Public Meeting
- Internal Audit review of Performance Management NTC 15/16/08 gave significant assurance (Jan 16)
- Notes of Commissioning, Performance and Finance Meetings
- Penalty schedule - monthly
<table>
<thead>
<tr>
<th>Date</th>
<th>Risk No.</th>
<th>Score</th>
<th>Risk Rating</th>
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<td>598</td>
<td>1.4</td>
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<td>Lesley</td>
<td>31/12/2016</td>
<td>John</td>
<td>31/12/2016</td>
<td>John</td>
</tr>
<tr>
<td>20/05/2013</td>
<td>169</td>
<td>1.5</td>
<td>High</td>
<td>31/12/2016</td>
<td>Lesley</td>
<td>31/12/2016</td>
<td>John</td>
<td>31/12/2016</td>
<td>John</td>
</tr>
<tr>
<td>11/11/2015</td>
<td>543</td>
<td>1.6</td>
<td>High</td>
<td>31/12/2016</td>
<td>Lesley</td>
<td>31/12/2016</td>
<td>John</td>
<td>31/12/2016</td>
<td>John</td>
</tr>
<tr>
<td>04/08/2016</td>
<td>552</td>
<td>1.7</td>
<td>High</td>
<td>31/12/2016</td>
<td>John</td>
<td>31/12/2016</td>
<td>John</td>
<td>31/12/2016</td>
<td>John</td>
</tr>
</tbody>
</table>

**16/11/2015 598 Lesley Young-Murphy**

**Risk of unexpected and unacceptable decline in quality of services due to focus on Financial Recovery Plan**

| Quality and Safety Committee has a robust programme of work to maintain a focus on quality of services |
| Q&S committee provide regular reports to the Governing Body, providing assurance on quality matters |
| CCG is an active participant in Quality Review Groups, Safeguarding Boards and other formal and informal arrangements, continuing to give this work a high priority |
| Director of Nursing and Transformation and Medical Director have a continuing commitment to maintaining and where possible improving quality of services |
| In the FRP, QIPP schemes are subject to a Quality Impact Assessment, with an escalation process in place where concerns are raised about quality issues |
| Completion of a Quality Impact Assessment (QIA) for every QIPP project |

**20/05/2013 169 Lesley Young-Murphy**

**Risk of commissioning services that are not of sufficiently high quality**

| Standard NHS Contracts in place with NHS Providers, joint contract with local authority for domiciliary services & nursing homes |
| Regular Provider performance management meetings |
| CCG is an active member of the Quality Review Groups (QRG) |
| Specific quality issues are actively managed e.g. ambulance handover delays and reported to QRG and CCG Quality and Safety Committee, escalated as appropriate |
| Regular reports to Quality and Safety Committee and to Governing Body |
| Quality issues in Nursing Homes and other CHC care settings are actively monitored and reported to Quality and Safety Committee |
| CCG sign off annual FT Quality Accounts |
| Working in partnership with Local Authority to monitor and improve quality of care in Nursing Homes |
| Working in partnership with Local Authority to monitor and improve quality of services to people with learning disabilities, including implementing the national programme of work on ‘transforming services’ |
| Structured approach to capturing and acting on soft intelligence |
| Programme of announced and unannounced visits to all providers arranged |

**11/11/2015 543 Lesley Young-Murphy**

**Risk of inadequate implementation of Deprivation of Liberty (DoL) criteria leading to the required Court Orders not being in place as required**

| CCG employs professional staff with knowledge of DoL regulations and developing DoL case law |
| CCG staff aware of patient group who are the responsibility of the CCG who may require a DoL assessment |
| Process for checking which patients have had or who need a DoL assessment and who have or need a court of protection order including Orders that have expired or are about to expire |
| Detailed plans being put in place to ensure relevant court applications are made |
| The financial impact on the CCG (e.g. the cost of the Court application and associated legal fees) is being calculated |
| Staff attended MCA/DoLs seminar on 24/5/16 at Ward Hadaway to clarify CCG responsibilities |
| CCG staff have requested a list of CHC patients living at home from NCH - now received (updated 6/7/16) |
| Patients who require DoLs identified at panel on 6.7.16 |

**04/08/2016 552 John Wicks**

**Risk that delayed ambulance handovers impacts negatively on patient safety and patient flow**

| Regular director level meetings with NHGFT and NEAS |
| Action plans developed and implemented |
| ECIST (national expert team for urgent care) appointed to review NSECH process and recommend improvements |
| CCG working collaboratively with Northumberland CCG to reduce walk in activity at NSECH to increase capacity for ambulance conveyed patients |

**Actions**

- Escalated to Emergency Care Improvement Programme (ECIP) for additional support
- CCG considering financial options to reduce discretionary attendance at NSECH
<table>
<thead>
<tr>
<th>Date</th>
<th>Risk Ref</th>
<th>Reference</th>
<th>Directorate</th>
<th>Risk Owner</th>
<th>Consequence</th>
<th>Initial Score</th>
<th>Assurance</th>
<th>Gaps in Assurance</th>
<th>Actions</th>
<th>Residual Score</th>
<th>Action</th>
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<tbody>
<tr>
<td>18/08/2016</td>
<td>553</td>
<td>1.8</td>
<td>CFO</td>
<td>Expenditure increases and forces the CCG to breach its deficit control total</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>Financial expenditure controls</td>
<td>- QIPP schemes (including block contracts)</td>
<td>- Revised FRP and revised deficit control total</td>
<td>Reports to Finance Committee and Clinical Executive Committee QPAC Tracker</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

Audit Committee (16/9/16) suggested that this risk should be removed as it overlaps with other risks and it implies controls are not working. In subsequent discussions the CFO indicated that this is a valid risk. Risk deleted following discussion at Finance Committee 9/11/16 and replaced with risk number 554.
<table>
<thead>
<tr>
<th>Date</th>
<th>Code</th>
<th>Management Team</th>
<th>Action</th>
<th>Time</th>
<th>Status</th>
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<tbody>
<tr>
<td>10/05/2016</td>
<td>548</td>
<td>1.9 Lesley Young</td>
<td>Risk</td>
<td>4</td>
<td>4</td>
<td>SLA with Local Authority • Daily transition calls CHC Policy in place • Head of Quality and Patient Safety on CHC Panel. • Robust governance process. • Gamshare arrangement in place to assist in achievement of financial target. • NECIS Transition Plan. • Contract monitoring meetings. • Regular reports to Quality &amp; Safety Committee. • Monthly finance reports on trajectory. • NECIS performance monitoring meeting. • Outstanding legacy issues with NECIS • COG to hold NECIS to account for the delivery against plan. • Activity management schemes will be developed but unlikely to address the full problem • Reflect activity better in future plans</td>
</tr>
<tr>
<td>30/11/2015</td>
<td>545</td>
<td>2.1 Chief Finan Officer</td>
<td>Risk of activity increasing over contracted or formally planned levels, bringing additional, unplanned financial pressures</td>
<td>4</td>
<td>5</td>
<td>• Contract management meetings with variances against planned contract activity scrutinised forecast out turn summaries updated. • Finance Committee to oversee investigation into priority areas, supported by QIPP Programme Assurance Committee (QAPAC). • Detailed finance and contract report and quality and performance report presented to Clinical Executive. Finance Committee and Governing Body to enable triangulation of information. • Medicines Optimisation Services purchased from NECIS - Medicines Optimisation Committee in place. • Robust CHC assessment processes in place, benchmarked against other CCGs nationally, robust CHC decision making processes and budget forecasts. • High cost CHC packages remain under close scrutiny. • CHC Policy approved by Clinical Executive February 2015, to set out CCG’s role in commissioning CHC. • BCF £75 partnership agreement signed. • Metrics and KPIs agreed for each section in the BCF. • BCF Board in place to oversee monitoring against plan and initiate corrective action if required. • Referral Management System in place (3 specialties). • Discussions with NHFT regarding risk mitigation of specific activity increases in Accident and Emergency. • Notes of contract management meetings and 14 Day reviews and actions arising from those. • Minutes of Finance Committee and QIPP Programme Assurance Committee (QAPAC), including deep dives. • Finance and contract reports and quality and performance reports to Clinical Executive, Finance Committee and Governing Body with exceptions highlighted and actions reported. • Minutes of Medicines Optimisation Committee, medicine optimisation SLA with NECIS and medicine optimisation QIPP schemes. • CHC assessment processes and reports to Clinical Executive and Finance Committee. • CHC Policy. • BCF £75 agreement; signing reported to Governing Body. • BCF Board ToR and meeting papers. • Review by Internal Audit NTC4807 Medicines Management provided limited assurance (2014/15). • Review by Internal Audit NTC4811 Monitoring of Performance against contract - provided limited assurance (2014/15). • Internal Audit report of BCF, NTC 4810 (2014/15) and Internal Audit Report NTC 516/06 both gave significant assurance with no issues of note. • Review by Internal Audit NTC 1516/03 QIPP Assurance gave significant assurance with no issues of note (December 2015). • Review by Internal Audit NTC 1516/08 Performance Management and Board reporting gave significant assurance with no issues of note (January 2016). • Risk of activity increasing over contracted or formally planned levels, bringing additional, unplanned financial pressures</td>
</tr>
<tr>
<td>02/12/2015</td>
<td>546</td>
<td>2.2 John Wicks</td>
<td>Work required to determine QIPP schemes to support FRP 16/17 is delayed, inadequate or not fully implemented resulting in an inadequate or unrealistic plan and savings targets not being achieved.</td>
<td>4</td>
<td>4</td>
<td>Appointment of a Director of Finance who will support development of the QIPP scheme. • Clinical and non-clinical workshops to review the 16/17 QIPP opportunities have taken place. • 23 February 2016 ‘Right Care’ schemes added to QIPP list. • QIPP Projects developed with support of Business Intelligence and Finance to test the robustness of assumptions made. • Submission of Final FRP 16/17 to NHSE 3/6/16. • PMO assurance of QIPP projects. • PMO fortnightly monitoring, reporting and escalation of QIPP progress. • QAPAC receives QIPP monitoring reports and direct remedial actions (where appropriate). • Finance Committee receives regular reports of QIPP and challenges identified. • Each QIPP project has a project plan, savings target, KPIs, Quality and Equality Impact Assessments. • fortnightly monitoring of CCG FRP implementation by NHS England Area Team. • Revised Integrated finance, performance and quality reporting tool developed (FPR) as management of acute activity is key to financial recovery. • Monthly contract management meetings. • Contracts with Acute Trinities include QIPP within value. • Systemwide STP (Sustainable Transformation Plan) being developed that includes N CGG, NT CGG and NHFT to identify joint QIPP programme - 5 year plan. • NTW contract signed. • NUTH contract agreed. • Notes of contract management meetings and 14 Day reviews and actions arising from those. • Minutes of Finance Committee and QIPP Programme Assurance Committee QIPAC, including deep dives. • Finance and contract reports and quality and performance reports to Clinical Executive, Finance Committee and Governing Body with exceptions highlighted and actions reported. • Minutes of Medicines Optimisation Committee, medicine optimisation SLA with NECIS and medicine optimisation QIPP schemes. • CHC assessment processes and reports to Clinical Executive and Finance Committee. • CHC Policy. • BCF £75 agreement; signing reported to Governing Body. • BCF Board ToR and meeting papers. • Review by Internal Audit NTC4807 Medicines Management provided limited assurance (2014/15). • Review by Internal Audit NTC4811 Monitoring of Performance against contract - provided limited assurance (2014/15). • Internal Audit report of BCF, NTC 4810 (2014/15) and Internal Audit Report NTC 516/06 both gave significant assurance with no issues of note. • Review by Internal Audit NTC 1516/03 QIPP Assurance gave significant assurance with no issues of note (December 2015). • Review by Internal Audit NTC 1516/08 Performance Management and Board reporting gave significant assurance with no issues of note (January 2016). • Risk of activity increasing over contracted or formally planned levels, bringing additional, unplanned financial pressures</td>
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<td>546</td>
<td>2.2 John Wicks</td>
<td>Work required to determine QIPP schemes to support FRP 16/17 is delayed, inadequate or not fully implemented resulting in an inadequate or unrealistic plan and savings targets not being achieved.</td>
<td>4</td>
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</tr>
</tbody>
</table>

Corporate Objective 2: Deliver the Financial Recovery Plan, leading to the achievement of the CCG’s statutory financial duties and future sustainability.
<table>
<thead>
<tr>
<th>Date</th>
<th>Line No</th>
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<th>Name</th>
<th>Consequence</th>
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</thead>
<tbody>
<tr>
<td>04/06/16</td>
<td>547</td>
<td>2.3</td>
<td>John Wicks</td>
<td>Risk that the lack of a long term QIPP plan for the CCG will result in unsustainable growth in expenditure in North Tyneside.</td>
<td>4 4 10</td>
<td></td>
<td>Fortnightly meeting with NHS England Area Team to scrutinise and validate credibility of QIPP across NCCG and NTCCG</td>
<td></td>
<td></td>
<td></td>
<td>Further back up STP to determine how plan will be delivered.</td>
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<tr>
<td>09/06/16</td>
<td>550</td>
<td>2.4</td>
<td>Lesley Young</td>
<td>Risk that the delay in Primary Care Support England Services; primary care records delayed transfer - delay in receiving medical supplies causes delays in treatment and investigation of incidents</td>
<td>4 4 10</td>
<td></td>
<td>Updates from NHS England - review of negative reports from GPs</td>
<td></td>
<td></td>
<td></td>
<td>Early planning of 17/18 QIPP to set targets e.g. for Right Care, Urgent Care, M6K2</td>
</tr>
<tr>
<td>07/06/16</td>
<td>549</td>
<td>2.5</td>
<td>John Wicks</td>
<td>Risk that the urgent care consultation and decision is delayed resulting in reputational damage and increased costs.</td>
<td>3 4 10</td>
<td></td>
<td>TCI review of consultation process - revised competitive tender</td>
<td></td>
<td></td>
<td></td>
<td>Risk deleted following discussion at Finance Committee 9/11/16 and replaced with risk register 6</td>
</tr>
<tr>
<td>09/11/16</td>
<td>554</td>
<td>2.6</td>
<td>CFO</td>
<td>QIPP plans, including target contract values, are not delivered and/or progress in rebalancing and reducing expenditure, causing the CCG to breach its control total.</td>
<td>4 4 10</td>
<td></td>
<td>QIPP list rationalised and agreed by Clinical Executive 13/01/16</td>
<td></td>
<td></td>
<td></td>
<td>Following discussion by Clinical Executive, December 2017</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>QIPP plans monitored by the QIPP Programme Assurance Committee, QAP formally reports to Clinical Executive and provides updates to the Finance Committee.</td>
<td></td>
<td></td>
<td></td>
<td>- Arbitration 3/10/16 - Ongoing identification of new QIPP schemes by director team and project.</td>
</tr>
</tbody>
</table>

**Corporate Objective 3:** Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside.
<table>
<thead>
<tr>
<th>Date</th>
<th>Risk No.</th>
<th>Risk Level</th>
<th>Reference</th>
<th>Responsible</th>
<th>Risk Description</th>
<th>Consequence</th>
<th>Likelihood</th>
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<th>Controls Detail</th>
<th>Residual Score</th>
<th>Review Date</th>
<th>Target Risk</th>
<th>Score</th>
</tr>
</thead>
</table>
| 21/05/2013 | 206      | 3.1        | Lesley Young-Murphy        | 4                    | Risk of CCG joint working arrangements with the Local Authority failing to be effective and transparent, resulting in less than optimum use of public funds                                                                                     | 4           | 4          | 16            | • Formal arrangements documented in relevant legal agreements, including s75 and s296 agreements  
• Formal joint working relationships documented and reported to the Health and Wellbeing Board, integration Board and Better Care Fund Partnership Board  
• Integration Board and supporting committees fully supported by all partners, including through the role of joint appointments  
• Partnership governance policy in place - refreshed and approved by the Clinical Executive 25 February 2015.  
• Informal working relationships accorded a high priority by both partners, with regular dialogue  
• BCF 16/17 reviewed by Clinical Executive April 16.  
• Better Care Fund s75 signed June 2015  
• Health and Wellbeing Board, integration Board and Better Care Fund Partnership Board Terms of Reference and minutes  
• Audit of Partnership Governance (ref NTC 1516/04) gave ‘significant assurance’ with two issues of note. Actions of note have been addressed  
• Audit of Better Care Fund (BCF) (ref NTC 1516/06) gave significant assurance with two issues of note. The two issues have been addressed and have been reported to the Audit Committee  
• Regular updates to the Clinical Executive and Quality and Safety Committee include reference to informal working and regular dialogue with LA | 0           | 0          | 2             | 12            | 8           | 31/12/2016 | 8             |
| 20/05/2013 | 193      | 3.2        | John Wicks                | 3                    | Risk of failure to engage with partners and stakeholders in line with CCG statutory duties, resulting in misalignment of plans across the health economy                                                                                      | 4           | 4          | 12            | • CCG an active partner in the North Tyneside Health and Wellbeing Board  
• CCG attends the Overview and Scrutiny Committee, as required, to present and discuss the work of the CCG  
• CCG has regular formal and informal meetings with North Tyneside Council, local NHS Foundation Trusts, HealthWatch, local MPs  
• Stakeholder engagement plan in place, as part of communications and engagement strategy, with specific targeted plans for identified initiatives  
• CCG complies with modified CCG governance arrangements  
• CCG actively engages with stakeholders, public and patients, including commissioning the Community Health Care Forum to facilitate patient voice  
• There are regular communication channels between CCG and the Voluntary Sector  
• Process designed for the development of Commissioning Intentions  
• Operational Plan 16/17 complete and available on CCG website  
• ACO vehicle for closer working & understanding  
• CCG has engaged with the NTW Sustainable Transformation Plan governance arrangements and are planning system wide financial control targets for 17/18.  
• North Tyneside Health and Wellbeing Board and Overview and Scrutiny Committee meeting papers and minutes  
• Minutes and papers of committees of the Health and Wellbeing Board, Integration Board, Overview and Scrutiny Board, Urgent Care Board, Primary Care Commissioning Committee and meetings with MP  
• Communications and engagement strategy  
• Communications and engagement plan for key pieces of work including for example, FRP, commissioning plan, urgent care  
• Reports to CCG Governing Body on plans to consult and outcome of consultation, including, for example; maternity services and urgent care  
• Formal agreement with the Community Health Care Forum  
• Internal Audit review of Strategic Planning NTC 1516/02 provided significant assurance with no issues of note (2015/16)  
• Internal Audit review of Partnership Governance NTC 1516/04 provided significant assurance with issues of note (2015/16)  
• Sustainable Transformation Plan (STP) under development.  
• Operational Plan 16/17 signed off by Clinical Executive, Governing Body and Council of Practices, available on CCG website.  
• STP (final version submitted 21/10/16) | 0           | 0          | 2             | 12            | 6           | 31/12/2016 | 6             |
<table>
<thead>
<tr>
<th>Date</th>
<th>Score</th>
<th>Likelihood</th>
<th>Target Risk</th>
<th>Residual score</th>
<th>Consequence</th>
<th>Risk Description</th>
<th>Actions</th>
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<tbody>
<tr>
<td>13/08/2014</td>
<td>534</td>
<td>3.3</td>
<td>John Wicks</td>
<td>4</td>
<td>4</td>
<td>Operational meeting minutes</td>
<td>Clear staff reporting arrangements; job descriptions, appraisal processes, objectives and work plans, Staff statutory and mandatory training up to date, monitoring arrangements for the SLA with NCCG including HR and IG</td>
</tr>
<tr>
<td>21/05/2013</td>
<td>195</td>
<td>3.4</td>
<td>Lesley Young-Murphy</td>
<td>3</td>
<td>5</td>
<td>CHC restitution process failing to meet national standards, resulting in untimely or inappropriate decisions</td>
<td>CHC restitution team and processes reviewed in line with 2015 'Previously Unassessed Periods of Care' (PUPoC) guidance; Action plan in place to close gap between current and required monthly trajectory to ensure national timetable met; Plans made to transfer responsibility for CHC restitution back to neighbouring CCGs to enable NTCCG to concentrate on their own cases; Benchmarking against national figures from other CCGs; CHC restitution costs calculated and accounted for in CCG financial plans; National risk share in place to manage the financial impact of restitution claims; Agreement process in place to deal effectively with complaints that may lead to CHC restitution claims</td>
</tr>
<tr>
<td>07/05/2013</td>
<td>138</td>
<td>3.5</td>
<td>Chief Operating Officer</td>
<td>4</td>
<td>3</td>
<td>Risk of the work of the CCG and its partners not improving the health and wellbeing of the population in line with statutory duties</td>
<td>CCG Commissioning Plans developed and published; Regular integrated quality and performance reports to Clinical Executive and Governing Body; minutes of those meetings and results of 'deep dive' reviews and discussions with MPs; Notes of Quarterly Performance Reviews with the NHS England Area Team; CCG Annual Report against CCG health outcomes data set; CCG Constitution in place, with Scheme of Delegation and clear governance structures; Staff Service Level Agreement with Commissioning Support Unit in place; CCG capacity to deliver FRP and maintain all other essential business reviewed and staff team strengthened and adjusted; CCG Major Incident &amp; Business Continuity Management Plan in place; CCG complex with Emergency Planning, Resilience and Response (EPRR) requirements under Civil Contingencies Act; Urgent Care Working Group/System Resilience Group in place to monitor capacity and direct investment as required; Membership of Urgent Care Group includes all relevant Commissioners and Providers; Winter plans in place; Clinical Executive reviews capacity plans as necessary; plans also subject to review by partners and by NHS England; System to monitor capacity and pressure in place; Daily teleconference between Commissioners, Acute Providers and NEAS to manage pressure over winter period; Establishment of A&amp;E Delivery Boards for the NFT footprint; Reported results of EPRR self assessment to Governing Body on 27/9/16 (full compliance)</td>
</tr>
<tr>
<td>04/08/2016</td>
<td>551</td>
<td>3.6</td>
<td>Lesley Young-Murphy</td>
<td>4</td>
<td>4</td>
<td>Intermediate Care - level of system resilience, delayed discharges, and not realising their potential for rehabilitation.</td>
<td>Commissioning Plans developed and published; Regular integrated quality and performance reports to Clinical Executive and Governing Body; minutes of those meetings and results of 'deep dive' reviews and discussions with MPs; Notes of Quarterly Performance Reviews with the NHS England Area Team; CCG Annual Report against CCG health outcomes data set; CCG Constitution in place, with Scheme of Delegation and clear governance structures; Staff Service Level Agreement with Commissioning Support Unit in place; CCG capacity to deliver FRP and maintain all other essential business reviewed and staff team strengthened and adjusted; CCG Major Incident &amp; Business Continuity Management Plan in place; CCG complex with Emergency Planning, Resilience and Response (EPRR) requirements under Civil Contingencies Act; Urgent Care Working Group/System Resilience Group in place to monitor capacity and direct investment as required; Membership of Urgent Care Group includes all relevant Commissioners and Providers; Winter plans in place; Clinical Executive reviews capacity plans as necessary; plans also subject to review by partners and by NHS England; System to monitor capacity and pressure in place; Daily teleconference between Commissioners, Acute Providers and NEAS to manage pressure over winter period; Establishment of A&amp;E Delivery Boards for the NFT footprint; Reported results of EPRR self assessment to Governing Body on 27/9/16 (full compliance)</td>
</tr>
</tbody>
</table>
### Objective 4: Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture

<table>
<thead>
<tr>
<th>Date Entered</th>
<th>Reference</th>
<th>Lesley Young-Murphy</th>
<th>Risk</th>
<th>Likelihood</th>
<th>Initial Score</th>
<th>Target Risk</th>
<th>Actions</th>
<th>Consequence</th>
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<tr>
<td>16/11/2015</td>
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<td>12/09/2014</td>
<td>536 4.2</td>
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<tr>
<td>16/11/2015</td>
<td>539 4.3</td>
<td>Chief Officer</td>
<td>3</td>
<td>4</td>
<td>12</td>
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**Risk:**
- Risk that the CCG fails to focus on the needs of patients and fails to commission the right, cost effective services to meet those needs.
- Risk of insufficient clinical input into the work of the CCG if clinical leaders and member practices CCG are not effectively engaged.
- Risk of not being able to implement New Models of Care, with the consequent risk of services not being fit to meet the needs of the ageing population.

**Likelihood:**
- 3
- 4
- 4
- 3

**Initial Score:**
- 12
- 15
- 12

**Consequence:**
- Role of Lay Member for Patient and Public Involvement set out in CCG Constitution and evidenced in her work in the CCG.
- Patient Forum work programme, meeting notes and reports to CCG Governing Body.
- Communications and engagement strategy in place, supported by specific plans for identified work streams.
- CCG operational plan and Commissioning Plans prepared, approved by the Council of Practices and published.
- Value Based Commissioning Policy on CCG website; Medical Director identified as CCG decision maker; reported at Clinical Executive.
- Reports from public and patient engagement in major service reviews (e.g. maturity services review; urgent care review).
- Committee reports and minutes show that Clinical Leaders - nurses and GPs - are involved in all aspects of CCG decision making.
- CCG website shows a number of ways to contact the CCG including ‘contact us’, complaints and compliments, opportunity to meet Governing Body members informally prior to meetings.
- Internal Audit review of Patient Experience NTC4806 provided significant Assurance with no issues of note (2014/15).
- Minutes of Quality Review Groups and reports to Quality and Safety Committee.
- Plans for service redesign, including QIPP plans, maternity services, urgent care include reference to available clinical evidence.
- Advice of Clinical Senate sought on paediatric care pathway and on urgent care plans.
- Internal Audit review of Strategic Planning NTC 1516/02 provided significant Assurance with no issues of note (2015/16).
- External assurance from Andy Mills, Consultation Institute on urgent care process at Governing Body 28.6.16.
- The outputs from these controls will support achievement of the target risk score.
- CCG to ensure service and system changes are based on patient need and VFM in 16/17 contracts and STPs.
- New Models of Care Project Board in place, inclusive of key stakeholders, reports to North Tyneside Integration Board.
- Patient Forum involved in design of New Models of Care, informing its development and enhancing understanding of and commitment to.
- Council of Practices briefed and involved; this discussion minuted.
- Clinical Blueprint facilitated by NHS ICD compile.
- 4 localities signed up as pilot sites and Whitley Bay implementation work streams in place.
- New Models of Care programme part of QIPP work, with supporting documents in place, including KPIs.
- Project Plan and finances signed off by OPAC 27/06/2016.
- New Models of Care Project Board monitors performance.
- Service requires agreement with key partner regarding geriatrician sessions delivery.
- Agreement of staff from NHCT (nursing, geriatrician) escalated to contract meetings.
- Governing Body and Committee Terms of Reference, meeting papers and minutes.
- CCG Constitution and papers and minutes of the meetings of the Council of Practices.
- CCG annual report.
- Practice Nurse Forum notes.
- Monthly newsletters.
- Locality Group meeting notes and reports to the Clinical Executive.
- Clinical Chair and Chief Officer programme of joint practice visits, with follow up actions.
- Practice facilitators work programme and achievements.
- Internal Audit review of Clinical Engagement NTC4805 provided Significant Assurance with one issue of note (2014/15). Issue of note has been addressed.
<table>
<thead>
<tr>
<th>Date</th>
<th>Ref.</th>
<th>Score</th>
<th>Risk Category</th>
<th>Initial Risk</th>
<th>Action</th>
<th>Assurance</th>
<th>Controls Detail</th>
<th>Risk Description</th>
<th>Residual Score</th>
<th>Target Risk Score</th>
<th>Review Date</th>
<th>Target Risk Score Change</th>
<th>Action Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/11/2015</td>
<td>542</td>
<td>4.4</td>
<td>Chief Officer</td>
<td>16/11/2015</td>
<td>542</td>
<td>4.4</td>
<td>16</td>
<td>Risk of the CCG lacking capacity to provide system wide leadership</td>
<td>4</td>
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<td>16</td>
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</tr>
<tr>
<td>19/08/2014</td>
<td>535</td>
<td>4.5</td>
<td>Chief Officer</td>
<td>19/08/2014</td>
<td>535</td>
<td>4.5</td>
<td>16</td>
<td>Risk of a lack of confidence in the CCG as a result of reputational damage, inhibiting the CCG’s role as a system leader</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>16</td>
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<tr>
<td>16/11/2015</td>
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<td>4.6</td>
<td>Chief Officer</td>
<td>16/11/2015</td>
<td>541</td>
<td>4.6</td>
<td>16</td>
<td>Risk of short term finance pressures overriding the need to deliver sustainable solutions</td>
<td>5</td>
<td>4</td>
<td>16</td>
<td>16</td>
<td>None</td>
</tr>
<tr>
<td>Report to:  Governing Body</td>
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<td>Date: 22 November 2016</td>
<td>Agenda item: 12.2a</td>
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<tr>
<td><strong>Title of report:</strong> Information Governance Annual Report 15/16</td>
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<tr>
<td><strong>Sponsor:</strong> Dr Lesley Young-Murphy</td>
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<tr>
<td><strong>Author:</strong> Hilary Murphy, Information Governance Officer, NECS</td>
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**Purpose of the report and action required:**
This report is to provide assurance to the committee that robust systems and process are in place for the management of Information Governance issues. Members are asked to note the contents of the report.

**Executive summary:**

Information Governance is the framework that brings together a number of information related requirements. These legal requirements were developed to ensure confidentiality/protection of information in all formats, electronic and paper and to support appropriate information sharing for patient care.

The attached report provides information regarding information governance activity for 15/16. This includes the results from the IG Toolkit self-assessment, internal audit, compliance with IG training, policies refreshed, Freedom of Information requests and information around identified risks and incidents reported.

Members are asked to note the contents of the report and to receive for assurance purposes.
Governance and Compliance

1. Links to corporate objectives

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
<td>√</td>
</tr>
<tr>
<td>2. Deliver the Financial Recovery Plan, leading to the achievement of the CCG’s statutory financial duties and future sustainability</td>
<td></td>
</tr>
<tr>
<td>3. Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside</td>
<td></td>
</tr>
<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
<td>√</td>
</tr>
</tbody>
</table>

2. Consultation and engagement
CCG staff are engaged with the Information Governance agenda through the sharing of strategy, policies and the completion of IG training on an annual basis.

3. Resource implications
No impact.

4. Risks
Non-compliance with information governance requirements may result in a breach of information confidentiality, security etc.

5. Equality assessment
Not applicable.

6. Environment and sustainability assessment
Not applicable.
Contents

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   2.2 Report Results .............................................................................................................. Error! Bookmark not defined.
   2.3 Audits .......................................................................................................................... 4
   3.1 Information Governance Toolkit ................................................................................ Error! Bookmark not defined.
   3.2 Training ......................................................................................................................... Error! Bookmark not defined.
   3.3 Policy Review .............................................................................................................. Error! Bookmark not defined.
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   3.6 Risks ............................................................................................................................. 7
   3.7 Incidents ....................................................................................................................... 7
   3.8 Reporting ...................................................................................................................... Error! Bookmark not defined.
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1. Introduction

Information Governance is the framework that brings together a number of information related requirements.

These legal requirements were developed to ensure confidentiality/protection of information in all formats, electronic and paper and to support appropriate information sharing for patient care.

The Information Governance Toolkit has been provided by the Health and Social Care Information Centre (HSCIC) to support performance monitoring of progress on Information Governance in the NHS. The HSCIC uses the toolkits to monitor performance and as evidence that organisations are complaint with the IG SoC (Information Governance Statement of Compliance).

Version 13 (2015/16) of the IG Toolkit for Clinical Commissioning Groups is very similar the version 12 (2014/15) Toolkit with minor changes applied. Although the CCG, as a public authority and statutory body, is subject to the provisions of the Freedom of Information Act, HSCIC has not included Corporate Information Assurance in the IG Toolkit. However this report includes CCG performance against its statutory duty to comply with the Freedom of Information Act 2000.

The categories covered are:

- Information Governance Assurance
- Confidentiality and Data Protection Assurance
  - Confidentiality NHS Code of Practice
  - Data Protection Act 1998
- Information Security Assurance
  - Information Security Management NHS Code of Practice
- Clinical Information Assurance
  - Health Records Management
  - Records Management NHS Code of Practice

This report covers the CCG’s performance against its Information Governance responsibilities during its third year.
2. 2015/16 Performance

2.1 Self-Assessment

The CCG self-assessed against the toolkit for 2015/16 and the overall score was submitted at 72% (satisfactory) which is a 3% improvement on the 2014/15 score of 69%. The breakdown below shows the individual initiative areas and their status. 23 requirements within the initiatives achieved a level two and two requirements achieved a level three.

2.2 Report Results

<table>
<thead>
<tr>
<th>Information Governance Management</th>
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<tbody>
<tr>
<td>Assessment</td>
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<tr>
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<tr>
<td>Version 13 (2015-2016)</td>
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</table>

<table>
<thead>
<tr>
<th>Confidentiality and Data Protection Assurance</th>
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<tbody>
<tr>
<td>Assessment</td>
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<tr>
<td>Version 13 (2015-2016)</td>
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<th>Information Security Assurance</th>
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<tr>
<td>Assessment</td>
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<tr>
<td>Version 13 (2015-2016)</td>
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<tr>
<th>Clinical Information Assurance</th>
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<tbody>
<tr>
<td>Assessment</td>
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</table>
Throughout 2015/16 progress was made in the toolkit to address the outstanding evidence. Regular meetings with the Information Governance Lead demonstrated steady progress with the collation of evidence and upload to the online toolkit ready for the final submission in March 2016.

Each component of the toolkit has a number of requirements to meet the standard. These are graded between 0 and 3 as follows:

<table>
<thead>
<tr>
<th>Level of attainment</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Level 0</td>
<td>The organisation has not undertaken any work to support the requirement</td>
</tr>
<tr>
<td>Level 1</td>
<td>The organisation has begun work to support the requirement i.e. draft documentation, resource appointed.</td>
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<tr>
<td>Level 2</td>
<td>As above plus approval has been sought i.e. policy approval, board approval as well as implementation of working policies and procedures.</td>
</tr>
<tr>
<td>Level 3</td>
<td>As above plus regular reporting and audit.</td>
</tr>
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</table>
2.3 Audit

The CCG IG Toolkit was audited in 2015/16 by both an internal auditor and HSCIC and both received satisfactory outcomes.

3. Strategy

An Information Governance Strategy has been written following the release of Version 14 of the toolkit to allow for changes within the toolkit to be built into the strategy. The organisation will continue to develop its Information Governance Framework and will be supported by North of England Commissioning Support (NECS) with collecting and uploading evidence and with the IGT action plan.

3.1 Information Governance Toolkit

HSCIC released version 14 of the toolkit in June 2016. NECS has carried out a mapping exercise to identify changes which need building into the action plan. This exercise showed there were only minor changes.

The CCG will ensure that any partners they work with meet IG standards and that assurance of this has been given.

It is anticipated that the CCG will be able to build on the work completed for version 13 and improve the overall percentage score for version 14.

3.2 Training

All CCG staff are required to conduct their mandatory training via the HSCIC Information Governance online training tool.

The HSCIC IG Training Tool is an online training tool focused on all aspects of learning. The aim of the tool is to develop and improve staff knowledge and skills in information governance, to support the provision of high-quality health & social care.

The tool contains various information governance training modules, including specialist modules for SIRO and Information Asset Owner (IAO) roles. Training must be undertaken by these roles on an annual basis.

All staff should receive IG training appropriate to their role on an annual basis through the online NHS IG Training Tool. At the end of March 2016 the percentage of staff within the CCG having completed IG training was 100%.
3.3 **Policy Review**

The CCG has, in conjunction with NECS, undertaken a review of IG policies during the report period. The IG policies will be reviewed on a bi-annual basis. The policies will be reviewed and approved via the Quality and Safety Committee. Where there is release of new national guidance or legislation, policies will be created/ amended to reflect this. The IG service within NECS has performed this function for the CCG and will continue to do so in 2016/17. The IG policies are as follows:

<table>
<thead>
<tr>
<th>Policy number</th>
<th>Policy Title</th>
<th>Review Date</th>
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<tbody>
<tr>
<td>IG01</td>
<td>Confidentiality and Data Protection Policy</td>
<td>Jan 2018</td>
</tr>
<tr>
<td>IG02</td>
<td>Data Quality Policy</td>
<td>Jan 2018</td>
</tr>
<tr>
<td>IG03</td>
<td>Information Governance &amp; Information Risk Policy</td>
<td>Jan 2018</td>
</tr>
<tr>
<td>IG04</td>
<td>Information Access Policy</td>
<td>Jan 2018</td>
</tr>
<tr>
<td>IG05</td>
<td>Information Security Policy</td>
<td>Jan 2018</td>
</tr>
<tr>
<td>IG06</td>
<td>Records Management Policy &amp; Strategy</td>
<td>Jan 2018</td>
</tr>
</tbody>
</table>

3.4 **Freedom of Information and Subject Access Requests**

NHS North Tyneside CCG received 239 Freedom of Information requests in the year 2015/2016. All requests were responded to within the statutory 20 day period. Requests continue to be from a mixture of sources; individuals, organisations and media organisations.

There were no Subject Access Requests for NHS North Tyneside CCG received in the corporate Information Governance team at NECS.

3.5 **Key Performance Indicators**

The CCG has two IG KPIs with NECS, these being;
- FOI and DPA requests acknowledged within 2 days and responded to within the statutory timescales 100% of the time
And
- Provision of progress report on Information Governance Toolkit

The NECS IG service processed all FOI and DPA requests within the statutory timescales consistently throughout the year. IG Toolkit progress reports were made available to the CCG and NECS worked with the CCG on a regular basis to enable the CCG to publish at a satisfactory level in March 2016.

3.6 **Risks**

During the year the CCG did not report any information related risks.
3.7 Incidents

The CCG has an Incident Reporting and Management Policy in place. This policy is to be used by for staff for the recording, reporting and reviewing of information governance (IG) and information security incidents.

During 2015 / 2016 the CCG had no IG related incidents.

Incidents of data loss continue to occur across the NHS and in some cases these can be significant and in breach of national guidance. In June 2013, the Department of Health introduced a new online reporting tool. All NHS organisations are required to report a Level 2 IG related Serious Incident Requiring Investigation (IG SIRI) on the reporting tool. The Information Commissioners Office (ICO), Department of Health and NHS England (where appropriate) will be notified via the tool of the reported IG SIRI. All information recorded under a ‘Closed’ IG SIRI on the IG Toolkit Incident Reporting Tool will be published quarterly by the HSCIC.

The CCG has not reported any SIRI’s in 2015/2016.

3.8 Reporting

Ongoing reporting has continued as part of the Quality and Safety Committee agenda and minutes are supplied to the Governing Body.

3.9 Performance Monitoring

The IG Toolkit will continue to be monitored via the Quality and Safety Committee. KPIs will continue to be reported by NECS on a regular basis.

The NECS IG team will be looking to embed the various IG documents throughout the CCG, checking staff understanding and compliance as well as improving areas identified in the IG work plan and Toolkit action plan for 2015/16.

4. Summary

The CCG has developed its Information Governance Framework throughout the year.

Highlights include;

- Level 2/3 Satisfactory performance in the IG Toolkit
- 100% compliance with FOI requests
- 100% compliance with Subject Access Requests
- 100% staff trained in IG

The CCG has made significant strides in its IG agenda during the year and will continue to build on this.
Title of report: Information Governance Report Q1 16/17  
Sponsor: Dr Lesley Young-Murphy  
Author: Hilary Murphy, Information Governance Officer

Purpose of the report and action required: 
Information governance ensures that best practice is implemented and on-going awareness is evident across the CCG. The CCG is committed to ensuring that all records and information are dealt with legally, securely, efficiently and effectively.

This report provides assurance to the committee that the CCG is compliant with legislation, regulation and its own strategy and polices.

Action Required  
Governing Body is asked to receive this Q1 16-17 Information Governance report for assurance.

1. Links to corporate objectives

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
<td>✓</td>
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<tr>
<td>2  Deliver the Financial Recovery Plan, leading to the achievement of the CCG’s statutory financial duties and future sustainability</td>
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<td>3  Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside</td>
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<tr>
<td>4  Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
<td>✓</td>
</tr>
</tbody>
</table>

2. Consultation and engagement
Staff are engaged through the sharing of strategy, polices and training.

3. Resource implications
No impact.

4. Risks
Non-compliance with information governance requirements may breach information confidentiality, security etc.

5. Equality assessment
Not applicable – this report is about governance arrangements.

6. Environment and sustainability assessment
Not applicable – this report is about governance arrangements.
This report focuses on data from 1\textsuperscript{st} April 2016 to 30 June 2016 (quarter one).

**Freedom of Information Act 2000 and Data Protection Act 1998 Update**

1. **Freedom of Information Requests**

The CCG has a generic FOI email account (accessible via the CCG website) which is managed by the IG Team. FOI requests received by the CCG directly either by email or through the post are forwarded to the IG team for action.

Between 1\textsuperscript{st} April - 30 June 2016, 68 FOI requests have been received, 28 in April, 22 in May and 18 in June.

66 requests have been responded to and completed for the quarter. 2 requests are due to be completed in July and expected to be responded to within 20 working days. The average response time to the requester is 12 working days. All completed responses were responded to within the statutory 20 working day timescale with no breaches.

<table>
<thead>
<tr>
<th>No. of requests received</th>
<th>No. of breaches</th>
<th>No. of exemptions</th>
<th>Total no. of requests 2016/2017</th>
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<tbody>
<tr>
<td><strong>Quarter 1</strong></td>
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<tr>
<td>April</td>
<td>28</td>
<td>0</td>
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<td>May</td>
<td>22</td>
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<td>6</td>
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<tr>
<td>June</td>
<td>18</td>
<td>0</td>
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There were 7 part exemptions applied to FOI requests in quarter one.  
**April** - 1 x part exemption, section 21 – information accessible to applicant by other means.  
**May** - 3 x part exemptions, section 21 – information accessible to applicant by other means.  
1 x part exemption, section 22 – information intended for future publication.  
2 x part exemptions, section 40 – personal information.  
**June** – no exemptions applied.

During Quarter 1 2016/17, requests have been received from sources including:

- Individuals
- Together for Short Lives
- RAC
- University of Sheffield
- Members of Parliament
- Insight Consulting Group
- What do they know?
- Heart of England NHS FT
No complaints relating to either the process or responses released have been received. No requests for FOI review have been received.

It is important to remember the need to be ‘requester blind’, in that all requests are dealt with in the same way, irrespective of a request’s origin.

All requests received were acknowledged within 48 hours in line with the Information Commissioner’s Office (ICO) requirements.

Round robin requests, (requests sent to most or all CCGs) continue to be received and coordinated by the IG team to ensure a consistent approach and, where possible, a joint response is given.

Freedom of Information – Year to Date (YTD)

From 1 April 2016 to 30 June 2016, there have been 68 FOI Requests received by the CCG. This compares to 67 requests received 1 April 2015 – 30 June 2015, an increase of 1.5%.

2. Subject Access Requests

There were two Subject Access Requests received by the IG team for the CCG during quarter one 2016/17, one in May and one in June. Both were responded to within the statutory 40 working day timescale.

3. Environmental Information Regulations Requests

There were no EIR requests received during quarter one 2016/17.

4. Information Asset Register

The Governance Team has looked at the IAR and is planning to standardise this across the CCGs in line with the improvements made to the NECS IAR. These improvements will ensure the robustness of the register and will be discussed at the toolkit update meetings with the CCG.

5. Information Governance Toolkit Update

Information Governance Toolkit

- IMS Health
- MSI Recruitment
- OCD UK
- University of Nottingham
- Process Flows UK
- Young Minds
- Mansfield Advisors LLP
- Parkinson’s UK
- Capita Technology Solutions
- Huffingotn Post UK
- Laing Buisson

- Royal Stoke University Hospital
- EMAP Publishing
- GP online
- Trinity Mirror
- Prostate Cancer UK
- Specialist Computer Centres PLC
- Dell Services
- BBC Cymru Wales News
- Target Information Systems Ltd
- SCC.Com
- Add Strategy
The IG Toolkit is an online system which allows NHS Organisations and partners assess themselves against Department of Health (DH) IG policies and standards. All NHS organisations are required to carry out self-assessments of their compliance against the IG requirements, using the Toolkit as an assessment tool.

CCGs have a specific toolkit containing 25 requirements which must be assessed and evidence gathered to demonstrate compliance. This evidence can take many forms, it can be a policy or procedure, a job description for someone who is responsible for information management within the organisation, minutes of a meeting, emails etc. Detailed guidance for each requirement can be found at:

https://nww.igt.hscic.gov.uk/RequirementsList.aspx?tk=422873862812777&lnv=2&cb=8aa51e4f-a7af-452e-aeb2-7dfc23baf62c&sViewOrgType=24&sDesc=Clinical Commissioning Group

The following requirements within the IG Toolkit have been marked not relevant as part of the CCGs IG Toolkit submission:

- 14-236; transfers of personal information have been reviewed and no overseas processing is carried out.
- 14-347; ICT networks are not controlled by the organisation, they are controlled by NECS.
- 14-421; the CCG is not an Accredited Safe Haven (ASH) and does not have access to patient identifiable information.

Toolkit Progress

The NECS IG Team have been working on producing a new evidence log and gap analysis of key documentation that is required. This will be shared with the CCG once complete to enable evidence collation to begin.

It was agreed at an IG meeting that a Level 3 in requirement 349 would be completed for this year to aid continuous improvement in the toolkit. The CCG will provide CCG evidence where this is not held by NECS, which will then be uploaded by NECS. It is anticipated that monthly meetings will be scheduled between NECS and the Head of Governance.

The CCGs v13 IG Toolkit was submitted in March 2016 as satisfactory with a score of 72%. The v11 IG Toolkit was submitted as satisfactory with a score of 66% and the v12 IG toolkit was submitted as satisfactory with a score of 69%. The increase in score shows continuous improvement in the embedding of IG policies, procedures and practices within the CCG. The CCGs v13 IG Toolkit was audited in 2015/16 receiving a satisfactory outcome and it was also reviewed by HSCIC who marked the submission as “satisfactory” on 14/06/2016.

It is anticipated that there will be an improvement in the overall score for the 2016/17 v14 submission.

6. Staff Information Governance Questionnaires
The questionnaires are sent to a varied selection of staff on a quarterly basis. The purpose of the questionnaires is to gain assurance that there is a good understanding and knowledge of information Governance throughout the organisation. This questionnaire will also help to identify any gaps in which IG knowledge of the organisation requires improvement. Fact sheets will be provided by the NECS Information Governance Team.

**Quarter 1 2016/17**

In June 2016, three members of the CCG were asked to complete the IG questionnaire for quarter 1. These members of staff were selected by the CCG to take part in the questionnaire. All three staff members completed and returned the questionnaire to the IG team within NECS.

A blank copy of the questionnaire is attached at Appendix 1.

The overall scores for those who completed the questionnaires were:-

<table>
<thead>
<tr>
<th>Staff member 1</th>
<th>Staff member 2</th>
<th>Staff member 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.5 / 39</td>
<td>37.5 / 39</td>
<td>32 / 39</td>
</tr>
</tbody>
</table>

Results are shown at Appendix 2.

**7. IG Compliance – Confidentiality Audit Compliance Checklist**

In June 2016, the CCG were asked to complete the confidentiality audit compliance checklist for quarter 1. A copy of the completed checklist is shown at the end of the report.

**8. IG Document review**

There was one document reviewed this quarter, CCG IG Strategy which is scheduled for committee approval in September 2016.

**9. Caldicott Guardian requests**

There were no reported Caldicott issues in Quarter 1, 2016/17

**10. IG Incidents**

SIRMS has been rolled out to the CCG and all IG incidents should be reported via the SIRMS system.

There were no incidents reported in Quarter 1 relating to patient identifiable data.

There have been no SIRIs of a Level 2 or above or any cyber security incidents required to be reported via the IG Toolkit in quarter 1 2016/17.

Please note that NECS have received clarity from NHS England that as data controllers CCGs are legally responsible for the processing of personal data carried out by a data processor (NECS). Therefore, if an IG SIRI occurs within NECS whilst carrying out work on behalf of the CCG it should be reported via the CCGs IG Toolkit rather than the
NECS IG Toolkit in accordance with the Checklist for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents requiring investigation. The exception to this is where it is NECS staff non-compliance.

11. Information Risks (Risk Register)

Information Risks on the CCGs Risk Register

There are currently no information risks on the CCGs Risk Register.

12. Information Risk Incidents

There were no incidents with regard to information risk reported to the NECS IG Team in quarter 1 of 2016/17.

13. Information Governance Mandatory Training Update

It is a mandatory requirement for existing staff to complete the online ‘information governance: the refresher module’ course. All new staff are required to complete the Introduction to Information Governance’ online course. The IG team has reminded the CCG to inform staff to complete their IG training.

The information governance mandatory training must be completed every financial year.

Below shows the mandatory IG training modules that must be completed by staff groups:

**Training Modules - Information Governance**

<table>
<thead>
<tr>
<th>Job Profile</th>
<th>Modules to be undertaken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caldicott Guardian</td>
<td>1. Information Governance: The Refresher Module</td>
</tr>
<tr>
<td></td>
<td>2. The Caldicott Guardian in the NHS &amp; Social Care</td>
</tr>
<tr>
<td></td>
<td>3. Patient Confidentiality</td>
</tr>
<tr>
<td></td>
<td>4. Secure Handling of Confidential Information</td>
</tr>
<tr>
<td></td>
<td>5. Access to Health Records</td>
</tr>
<tr>
<td></td>
<td>6. Information Security Guidelines</td>
</tr>
<tr>
<td></td>
<td>7. Information Security Management – Foundation</td>
</tr>
<tr>
<td></td>
<td>8. Business Continuity Management</td>
</tr>
<tr>
<td></td>
<td>9. NHS Information Risk Management – Foundation</td>
</tr>
<tr>
<td></td>
<td>10. Password Management</td>
</tr>
<tr>
<td></td>
<td>11. Secure Transfers of Personal Data</td>
</tr>
<tr>
<td>SIRO</td>
<td>1. Information Governance: The Refresher Module</td>
</tr>
<tr>
<td></td>
<td>2. NHS Information Risk management for SIRO’s &amp; IAO’s</td>
</tr>
<tr>
<td>Information Asset Owner (IAO)</td>
<td>3. NHS Information Risk Management – Introductory</td>
</tr>
<tr>
<td></td>
<td>4. NHS Information Risk Management – Foundation</td>
</tr>
<tr>
<td></td>
<td>5. Records Management &amp; The NHS Code of Practice</td>
</tr>
<tr>
<td>Information Asset Administrator (IAA)</td>
<td>1. Information Governance: The Refresher Module</td>
</tr>
<tr>
<td></td>
<td>2. Information Security Guidelines</td>
</tr>
<tr>
<td></td>
<td>3. NHS Information Risk Management – Introductory</td>
</tr>
<tr>
<td></td>
<td>4. NHS Information Risk Management – Foundation</td>
</tr>
<tr>
<td></td>
<td>5. Records Management &amp; The NHS Code of Practice</td>
</tr>
<tr>
<td>Executive Officers</td>
<td>1. Information Governance: The Refresher Module</td>
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<tr>
<td>--------------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>2. Business Continuity Management</td>
</tr>
<tr>
<td></td>
<td>3. Information Security Guidelines</td>
</tr>
<tr>
<td></td>
<td>4. NHS Information Risk Management – Foundation</td>
</tr>
<tr>
<td></td>
<td>5. Password Management</td>
</tr>
<tr>
<td></td>
<td>6. Records Management &amp; The NHS Code of Practice</td>
</tr>
<tr>
<td></td>
<td>7. Secure Transfers of Personal Data</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Staff</th>
<th>1. Information Governance: the Refresher Module</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Patient Confidentiality</td>
</tr>
<tr>
<td></td>
<td>3. Information Security Guidelines</td>
</tr>
<tr>
<td></td>
<td>4. Password Management</td>
</tr>
<tr>
<td></td>
<td>5. Records Management &amp; The NHS Code of Practice</td>
</tr>
<tr>
<td></td>
<td>6. Secure Transfers of Personal Data</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Governance Staff</th>
<th>1. Information Governance: The Refresher Module</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Information Security Guidelines</td>
</tr>
<tr>
<td></td>
<td>3. Patient Confidentiality</td>
</tr>
<tr>
<td></td>
<td>4. NHS Information Risk Management – Introductory</td>
</tr>
<tr>
<td></td>
<td>5. NHS Information Risk Management – Foundation</td>
</tr>
<tr>
<td></td>
<td>6. Password Management</td>
</tr>
<tr>
<td></td>
<td>7. Records Management &amp; The NHS Code of Practice</td>
</tr>
<tr>
<td></td>
<td>8. Secure Transfers of Personal Data</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Lay Members</th>
<th>1. Information Governance: The Refresher Module</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Information Security Guidelines</td>
</tr>
<tr>
<td></td>
<td>3. Password Management</td>
</tr>
<tr>
<td></td>
<td>4. Records Management &amp; The NHS Code of Practice</td>
</tr>
<tr>
<td></td>
<td>5. Secure Transfers of Personal Data</td>
</tr>
<tr>
<td></td>
<td>6. Patient Confidentiality</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>All other staff</th>
<th>1. Information Governance: The Refresher Module</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Information Security Guidelines</td>
</tr>
<tr>
<td></td>
<td>3. Password Management</td>
</tr>
<tr>
<td></td>
<td>4. Records Management &amp; The NHS Code of Practice</td>
</tr>
<tr>
<td></td>
<td>5. Secure Transfers of Personal Data</td>
</tr>
<tr>
<td></td>
<td>6. Patient Confidentiality</td>
</tr>
</tbody>
</table>

Figure 4: Mandatory IG training modules that must be completed by staff groups:

**N.B:** Modules in bold are mandatory. Modules in light print and italics; these modules are recommended and at the discretion of the line manager.

_Hilary Murphy_

Information Governance Officer

29 June 2016
A requirement of the Information Governance Toolkit v14 is that North Tyneside CCG monitors IG awareness throughout the organisation.
Please complete all of the questions below by ticking the answer that you feel are most appropriate.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>IG Toolkit ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is Information Governance?</td>
<td>a) Data Protection and Confidentiality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>133 / 134</td>
</tr>
<tr>
<td></td>
<td>b) Freedom of Information and Records Management</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Information and IT security</td>
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<tr>
<td></td>
<td>d) All of the above</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>2. Who is responsible for good Information Governance behaviours?</td>
<td>a) The Information Governance team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>133</td>
</tr>
<tr>
<td></td>
<td>b) The Chief Officer</td>
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<td></td>
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<tr>
<td></td>
<td>c) All staff</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>d) Only staff who deal with personal identifiable information</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>3. Where would you find the North Tyneside CCG IG policies?</td>
<td>a) Intranet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>235</td>
</tr>
<tr>
<td></td>
<td>b) North Tyneside CCG internet site</td>
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<tr>
<td></td>
<td>c) Both of the above</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>4. How often do I have to complete the online IG training (via the Health and Social Care Information Centre)?</td>
<td>a) Never</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>134 / 235</td>
</tr>
<tr>
<td></td>
<td>b)Annually</td>
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<td></td>
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<tr>
<td></td>
<td>c) 3 yearly</td>
<td></td>
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</tr>
<tr>
<td>5. What is the most appropriate course of action if an IG incident is noticed?</td>
<td>a) Report it to reception</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>349</td>
</tr>
<tr>
<td></td>
<td>b) Report it on the SIRMS system</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>c) Do nothing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) Email the person involved</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Department:……………………………………………………….                                 Date:………………………………………..
6. Where would be the most appropriate place to direct the public when they need to find out some information about North Tyneside CCG?
   a) The Publication Scheme (websites) or the Freedom of Information email address (ntccg.foi@nhs.net)
   b) The Chief Executive
   c) They are not entitled to this information
   d) The media

7. The North Tyneside CCG Caldicott Guardian is:
   a) Lesley Young-Murphy
   b) Shelagh Cockburn
   c) Dr Martin Wright
   d) Pauline Fox

8. What is the principle NHS staff guidance containing patient confidentiality?
   a) Code of confidentiality
   b) Faxing guidelines
   c) Freedom of Information Act

9. If you discover a breach of confidentiality you should:
   a) Reprimand the offender
   b) Tell the patient
   c) Submit an incident form

10. If you have direct contact with patients should you be explaining why you are collecting information about them and what you will do with it?
    a) Yes
    b) No
    c) Don’t know

11. What do you do if you are unable to answer a complex query about how North Tyneside CCG uses patient information?
    a) Refer to the relevant procedure
    b) Ask my line manager
    c) Refer to a Commissioning Manager
    d) a and c

12. How should you record patient consent to share information?
    a) On the relevant file
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Answers</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 13. How would you request your personnel file or personal data that is held about you? | a) Contact the IG team  
   b) Contact Human Resources  
   c) Look around the building for the file  
   d) Not bother | □ □ □ □ | 234   |
| 14. When can you access your own health or employment records?          | a) Whenever I am at work  
   b) I have no right of access to my records  
   c) By submitting a Data Protection (subject access) request  
   d) With my line manager's permission | □ □ □ □ | 234   |
| 15. You are allowed access to information about a patient or employee:   | a) When you forget when their birthday is  
   b) For patient care or agreed secondary uses e.g. audit / assurance  
   c) When you wonder why your neighbour attend an appointment last week  
   d) When someone demands the information from you | □ □ □ □ | 231   |
| 16. Who would you refer patients to concerning a request for access to records? | a) Their doctor  
   b) Your line manager  
   c) The IG team | □ □ □ □ | 234   |
| 17. The police can be provided with information about patients:          | a) Automatically  
   b) If they are very demanding  
   c) Only if there are significant reasons or with a court order / section 29 form  
   d) Never | □ □ □ □ | 133   |
| 18. Telephone messages containing personal identifiable information should be received via: | a) Secure voicemail  
   b) Insecure answerphone  
   c) Nearest passer by | □ □ □ □ | 235   |
| 19. Is it acceptable for staff to discuss patients where other people can hear? | a) Yes  
   b) No | □ □ □ □ | 235   |
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Options</th>
<th>Correct Answer</th>
<th></th>
</tr>
</thead>
</table>
| 20| Which of the following email routes can be used to send personal identifiable information? | a) joe.bloggs@nhs.net to joe.smith@newcastle.gov.uk  
b) joe.bloggs@nhs.net to joe.smith@nhs.net  
c) joe.bloggs@tees.nhs.uk to joe.smith@tees.nhs.uk  
d) joe.bloggs@nhs.net to joe.smith@GP-A98765.nhs.uk |   | 231 / 350 |
| 21| What is a safe haven?                                                    | a) A special fax machine  
b) A secure repository for patient information  
c) A refuge for homeless people |   | 235 |
| 22| What is a fair processing notice?                                        | a) It explains how personal information is used and shared  
b) It states that information is not collected  
c) It protects the organisation from litigation |   | 349 / 235 |
| 23| The North Tyneside CCG Senior Information Risk Owner is:                | a) Shelagh Cockburn  
b) Pauline Fox  
c) Lesley Young-Murphy  
d) Jim Hayburn |   | Conf audit |
| 24| What are the main roles of an Information Asset Owner?                  | a) Understand the risks to the information asset  
b) Monitor use of and access to information assets  
c) Ensure the information asset is fully used to the benefit of NECS  
d) All of the above |   | 345 |
| 25| When setting up a new process or service involving the use of personal information, what needs to be considered? | a) What type of food to provide at the grand opening  
b) Where computers will be located  
c) Completion of an IG checklist (privacy impact assessment)  
d) No consultation with the IG team is required |   | 237 |
| 26| Any new information assets containing personal identifiable information should be: | a) Declared to the responsible Information Asset Owner (IAO)  
b) Recorded on the Information Asset Register (IAR) |   | 235 |
<table>
<thead>
<tr>
<th>Question</th>
<th>Option</th>
<th>Answer 1</th>
<th>Answer 2</th>
<th>Answer 3</th>
<th>Answer 4</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before sharing information, wherever possible, it should be:</td>
<td>a) Anonymised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>235</td>
</tr>
<tr>
<td></td>
<td>b) Encrypted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Deleted</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>d) All of the above</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Who would it be appropriate to share a log in or password with?</td>
<td>a) A temporary member of staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>232</td>
</tr>
<tr>
<td></td>
<td>b) Your line manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Nobody</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) The IT department</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>It is acceptable to share smartcards because:</td>
<td>a) It saves having to keep logging on to the system</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>235</td>
</tr>
<tr>
<td></td>
<td>b) You can still do your job if you forget or lose your card</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Smartcards should never be shared with anyone</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>What should you do if you find a lost smartcard?</td>
<td>a) Report it to the registration authority (IT) and record it as an incident on SIRMS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>342 / 343</td>
</tr>
<tr>
<td></td>
<td>b) Hand it in to my line manager</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Nothing as it is not mine</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>d) Destroy the card using scissors</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>When you have access to a laptop or other mobile device for work usage, what must you do?</td>
<td>a) Never leave the mobile device in your car overnight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>348</td>
</tr>
<tr>
<td></td>
<td>b) Never give your username / password for the device to another person</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Never leave the device unattended</td>
<td></td>
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<td></td>
<td>d) All of the above</td>
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<tr>
<td>What should happen to information (in emails and personal network drive) when a member of staff leaves North Tyneside CCG?</td>
<td>a) Access is granted to the line manager</td>
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<td></td>
<td></td>
<td>237</td>
</tr>
<tr>
<td></td>
<td>b) Transferred to the appropriate drive or deleted if no longer required</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>c) Deleted</td>
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<td></td>
<td>d) Saved by the IT department</td>
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<td>Question</td>
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</tbody>
</table>
| 33. | Where should emails be saved if they are classed as a corporate record? | a) In the email inbox | □ | □ | □ | □ | 420
|   |                                                                         | b) They don't need to be saved | □ | □ | □ | □ |   |
|   |                                                                         | c) On the C drive (hard drive) of the computer | □ | □ | □ | □ |   |
|   |                                                                         | d) On the network drive in an appropriately named location / folder | □ | □ | □ | □ |   |
| 34. | You should never connect personal equipment to your laptop or PC because:| a) There is a risk of transferring viruses | □ | □ | □ | □ | 235
|   |                                                                         | b) The network will crash | □ | □ | □ | □ |   |
|   |                                                                         | c) Both of the above | □ | □ | □ | □ |   |
| 35. | In addition to facilitating hot desking, a clear desk policy helps to ensure:| a) The cleaner can access the desk tops | □ | □ | □ | □ | 235
|   |                                                                         | b) Personal identifiable information is secured when not in use | □ | □ | □ | □ |   |
|   |                                                                         | c) You get a good reputation for being tidy | □ | □ | □ | □ |   |
| 36. | Do you know which department to contact for Records Management advice i.e. the storage, classification, archiving and disposal of records? | a) Information Governance | □ | □ | □ | □ | 231
|   |                                                                         | b) Finance | □ | □ | □ | □ |   |
|   |                                                                         | c) Communications & Engagement | □ | □ | □ | □ |   |
|   |                                                                         | d) Chief Officer | □ | □ | □ | □ |   |
| 37. | In accordance with the NHS England Document and Records Management Policy documents should be: | a) Named | □ | □ | □ | □ | 235
|   |                                                                         | b) Include version control | □ | □ | □ | □ |   |
|   |                                                                         | c) Be securely stored | □ | □ | □ | □ |   |
|   |                                                                         | d) All of the above | □ | □ | □ | □ |   |
| 38. | What type of information does a department need to keep about records that are stored in offsite (secondary) storage? | a) Contents of the box | □ | □ | □ | □ | 420
|   |                                                                         | b) Job title of the person responsible for records (Information Asset Owner) | □ | □ | □ | □ |   |
|   |                                                                         | c) Destruction date | □ | □ | □ | □ |   |
|   |                                                                         | d) All of the above | □ | □ | □ | □ |   |
39. How would you retrieve records from offsite storage?
   a) Turn up and knock on the door
   b) Email the company post the records to you
   c) Ask a friend or colleague to collect on their way to work
   d) Make a request through the Information Governance team

For Official Use only:

<table>
<thead>
<tr>
<th>Quarter and Year:</th>
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<tr>
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<table>
<thead>
<tr>
<th>Total questions correct</th>
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<tbody>
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</table>
Appendix 2

Results - Staff Information Governance Questionnaires

All staff members achieved a pass and scored 32 or more out of 39. The collation of the questions that were answered incorrectly is shown below:-

**Question 3: Where would you find the North Tyneside CCG IG policies?**
One of the responders indicated that these policies were only available on the CCG internet site when in fact they are available on the CCG Intranet and Internet site.

**Question 11: What do you do if you are unable to answer a complex query about how North Tyneside CCG uses patient information?**
Although all available answers would be acceptable, the correct answer would be to refer to the relevant policy. The staff member would however be able to consult their line manager for advice. Only one of the responders identified the correct answer to this question.

**Question 14: When can you access your own health or employment records?**
One of the responders thought they could access records with their line manager’s permission. The other two responders correctly identified they could access records by completing and submitting a Subject Access Request.

**Question 16: Who would you refer patients to concerning a request for access to records?**
One of the responders answered their Doctor however a Subject Access Request (SAR) could be submitted to various organisations, it would therefore be advisable to consult the IG team prior to redirecting the patient.

**Question 21: What is a safe haven?**
One member of staff gave a special fax machine as the answer to this question. Although a fax machine may be present, the correct answer is a secure repository for patient information.

**Question 23: The North Tyneside CCG Senior Risk Owner is?**
Two responders answered incorrectly identifying the Senior Risk Owner as the IG Lead but the other responder correctly identified Lesley Young-Murphy.

**Question 24: What are the main roles of an Information Asset Owner?**
Two responders ticked one or two given options as the answer to this question which are roles of an Information Asset owner, however, the correct answer is all 3 of the listed options which one member of staff answered correctly.

**Question 34: You should never connect personal equipment to your laptop or PC because:**
All three of the responders answered that there is a risk of transferring viruses. This is partially correct but there is also a risk that the system may crash.

**Question 38: What type of information does a department need to keep about records that are stored in offsite (secondary) storage?**
One responder ticked one option as the answer to this question which is a type of information you need for offsite storage, however the correct answer is all 3 of the listed options, which two members of staff answered correctly.
## Confidentiality Audit Compliance Checklist

<table>
<thead>
<tr>
<th>Compliance Check</th>
<th>Observations and Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCs: Are users logged out / password screen saver activated when PC is left unattended</td>
<td>Yes all users log out and a screen saver used when away from PC.</td>
</tr>
<tr>
<td>Photocopiers / printers: Has all confidential information been removed</td>
<td>Confidential information is removed</td>
</tr>
<tr>
<td>Clear desk: Ensure that confidential information is not left on desks overnight / when staff leave the office</td>
<td>No confidential information is left on desks overnight or when staff leave their desk.</td>
</tr>
<tr>
<td>USB sticks: Ensure USB sticks are encrypted</td>
<td>All USB sticks are encrypted.</td>
</tr>
<tr>
<td>Laptops: Ensure that laptops are locked away when not in use. Check laptops are encrypted</td>
<td>Laptops are 'locked' when not in use. All laptops are encrypted.</td>
</tr>
<tr>
<td>Confidential waste: Ensure confidential waste is appropriately destroyed e.g. placed in secure confidential waste bins</td>
<td>All confidential waste is placed in the confidential waste bins</td>
</tr>
<tr>
<td>Access to PID – paper files: Ensure confidential information is kept in locked drawers / cabinets when not in use</td>
<td>Confidential files are kept in locked filing cabinets</td>
</tr>
<tr>
<td>Access to electronic information – ensure permissions are set correctly and reviewed regularly</td>
<td>Staff have been allocated access according to need. This is reviewed on a regular basis.</td>
</tr>
<tr>
<td>Access to areas: Check physical security mechanisms are working appropriately i.e. electronic door locks are in place</td>
<td>All electronic door locks are in place.</td>
</tr>
</tbody>
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### Office Use Only

<table>
<thead>
<tr>
<th>Department:</th>
<th>Date: 13/5/2016</th>
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<tr>
<td>Auditors Name:</td>
<td>Auditors signature:</td>
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<tr>
<td>CCG IG Lead Signature:</td>
<td>Date: 13/7/2016</td>
</tr>
<tr>
<td>CCG Caldicott Guardian Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>
Report to: Governing Body

Date: 22 November 2016
Agenda item: 12.4

Title of report: Policies for Approval

Sponsor: Dr Lesley Young-Murphy
Author: Irene Walker, Head of Governance, North Tyneside CCG.

Purpose of the report and action required: Members are asked to approve the following policies which have been scrutinised and are recommended by the Quality & Safety Committee:

- Complaints
- Deprivation of Liberty (DoLs)
- Mental Capacity Act
- Standards of Business Conduct & Declarations of Interest
- Social Media

Executive summary:

**Complaints Policy & Procedure**

This policy has been updated to include the addition of information in relation to Safeguarding concerns, information regarding unplanned face to face meetings, amendment of the NECS Clinical Quality team to NECS Complaints team. The removal of the Equality and Diversity Questionnaire as this is no longer in use. The numbering of the appendices has been updated and a reference has been added with regarding complaints about primary care contractors.

**Deprivation of Liberty DoLs**

The Deprivation of Liberty Policy was approved as part of a suite of policies at the inception of the CCG in 2013. The policy has been substantially revised to reflect current legislation, guidance and case law, by NECS.

**Mental Capacity Act**

The policy CCG CO10 Mental Capacity Act Policy was approved as part of a suite of policies at the inception of the CCG in 2013. The policy has been updated to reflect national guidance, by NECS.
Standards of Business Conduct and Declaration of Interest Policy

The Policy has been updated to take into account new guidance “Managing Conflicts of Interest” Revised Statutory Guidance for CCGs” issued by NHS England on 28 June 2016.

Key amendments to the policy are:

• The recommendation for CCGs to have a minimum of three lay members on the Governing Body, in order to support with conflicts of interest management;
• The introduction of a conflicts of interest guardian in CCGs. We expect that the CCG audit chairs will assume this role, which will be an important point of contact for any conflicts of interest queries or issues;
• The requirement for CCGs to include a robust process for managing any breaches within their conflict of interest policy and anonymised details of the breach to be published on the CCG’s website for the purpose of learning and development
• Strengthened provisions around decision-making when a member of the governing body, or committee or sub-committee is conflicted;
• Strengthened provisions around the management of gifts and hospitality, including the need for prompt declarations and a publicly accessible register of gifts and hospitality;
• A requirement for CCGs to include an annual audit of conflicts of interest management within their internal audit plans and to include the findings of this audit within their annual end-of-year governance statement;
• A requirement for all CCGs employees, governing body and committee members and practice staff with involvement in CCG business, to complete mandatory online conflict of interest training, which will be provided by NHS England. The online training will be supplemented by a series of face to face training sessions for CCG leads in key decisions-making roles.

Social Media

This is the first version of this policy. The aims of this policy are to:

• Provide clarity to staff on the use of social media tools when acting independently or as a representative of the CCG and give them the confidence to engage effectively;
• Ensure that the organisation’s reputation is not brought into disrepute and that it is not exposed to legal risk; and
• Ensure that internet users are able to distinguish official corporate CCG information from the personal opinion of staff.
Governance and Compliance

1. **Links to corporate objectives**

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
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<tr>
<td>2. Deliver the Financial Recovery Plan, leading to the achievement of the CCG’s statutory financial duties and future sustainability</td>
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<tr>
<td>3. Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside</td>
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<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
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</table>

2. **Consultation and engagement**
None applicable.

3. **Resource implications**
None applicable.

4. **Risks**
None applicable.

5. **Equality assessment**
An Equality Impact Assessment has been completed in Section 9 of the policy.

6. **Environment and sustainability assessment**
None applicable.
Corporate

CCG CO02: Complaints Policy and Procedure

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Date Issued</th>
<th>Review Date</th>
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<tr>
<td>V3 Draft 4</td>
<td>--/--/--</td>
<td>September 2018</td>
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Prepared By: Senior Clinical Quality Officer

Consultation Process: Quality and Safety Committee
Governing Body

Formally Approved: TBC

Policy Adopted From: CCG CO02 Complaints Policy and Procedure (2)
Approval Given By: Governing Body

Document History

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<tr>
<th>Version</th>
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<tr>
<td>1</td>
<td>28/02/2013</td>
<td>First issue</td>
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<tr>
<td>2</td>
<td>01/07/2014</td>
<td>Reviewed and updated to include reference to the Clywd Hart report</td>
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| 3       | 05/07/2016 | • Addition of actions required in relation to complaints containing Safeguarding concerns  
 • Addition of update with regard to unplanned, face to face meetings with complainants  
 • Removal of reference to the requirement for the CCG to obtain consent prior sharing the complaint with the NECS Complaints Team  
 • Replacement of the term ‘Clinical Quality Team’ and ‘Senior Clinical Quality Officer’ with ‘NECS Complaints Team’  
 • Removal of Equality and Diversity Questionnaire as this is no longer in use  
 • Replacement of appendices to show updated documents  
 • Addition of reference to complaints regarding primary care contractors |

Equality Impact Assessment

<table>
<thead>
<tr>
<th>Date</th>
<th>Issues</th>
</tr>
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<tbody>
<tr>
<td>June 2016</td>
<td>See section 11 of this document</td>
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Policy Validity Statement

This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.
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1. Introduction

For the purposes of this policy North Tyneside Clinical Commissioning Group will be referred to as “the CCG”.

The CCG aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the CCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

This policy is designed to outline the process for handling complaints generated by patients or their representatives and aims to set out clear guidelines for staff, managers and complainants around how complaints will be managed.

It is our aim that all patients, relatives and their carers will not be treated differently as a result of making a complaint. This will be achieved by ensuring that complaints are handled fairly and openly. It is clearly not always possible for the complainant to receive the outcome they hoped for, but if they feel that their complaint has been handled appropriately and that they have had a fair hearing, this is a positive outcome.

The CCG is very keen to ensure that complaints are used as learning opportunities and that trends are analysed and reported on. It is essential that information we gain from complaints is used to improve the quality and safety of the services we commission.

This policy has been written in accordance with the ‘Local Authority Social Services and National Health Service Complaints (England) Regulations 2009’, Reference is also made to the Department of Health guidance in complaints handling ‘Listening, Responding, Improving’, Parliamentary and Health Service Ombudsman’s ‘Principles of Good Complaints Handling’, the NHS Constitution (2008) and ‘A Review of the NHS Hospitals Complaints System Putting Patients Back in the Picture’ (Right Honourable Ann Clwyd MP and Prof Tricia Hart, 2013).

2. Status

This policy is a corporate policy.

3. Purpose and scope

This policy describes the systems in place to effectively manage all complaints received by the organisation in accordance with NHS complaints regulations. It outlines the responsibilities and processes for receiving, handling, investigating and resolving complaints relating to the actions of the organisation, its staff and services.
The policy also includes the process used for complaints received relating to commissioned services such as NHS Trusts, community NHS services, independent contractors (general practices, dental practices, pharmacies and opticians) and independent sector providers.

The purpose of this policy is to ensure that the CCG promotes best practice within its complaints management function, and also that it is compliant with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The CCG also adheres to the NHS Constitution including the five rights covering complaints and redress.

This policy and procedure sets out how the NHS complaints procedure will be implemented locally and must be followed by all staff employed or hosted by the CCG. The CCG commissions the North of England Commissioning Support Unit (NECS) to provide a complaints handling service on behalf of the CCG. NECS undertakes to work within the parameters of the policy and procedure.

4. Definitions

The following terms are used in this document:

4.1 **Complaint**: a written or oral expression of dissatisfaction which requires a response.

4.2 **Issues/concerns**: a written or oral expression of dissatisfaction that can be resolved without the need for formal investigation or correspondence.

4.3 **Independent Complaints Advocacy (ICA)**: is the organisation that provides independent help and support for people pursuing an NHS complaint.

4.4 **Investigating officer**: the person identified as responsible for handling and investigating an individual complaint.

4.5 **The Parliamentary and Health Service Ombudsman (PHSO)**: is the organisation that manages the second stage of the NHS complaints procedure

4.6 **Serious Incident (SI)**: is an incident or near miss occurring on health service premises or in relation to health services provided, resulting in death, serious injury or harm to patients, staff or the public, significant loss or damage to property or the environment, or otherwise likely to be significant public concern.

Any other special terms or abbreviations used in this document are defined as they occur.
5. **NHS complaints procedure and process**

The regulations covering both health and adult social care complaints were revised and introduced in April 2009. The new regulations enable organisations and the person complaining to agree on the best way to handle the complaint to achieve a satisfactory outcome. Within this process both concerns and complaints can be made either verbally, in writing or electronically via email.

There are two stages to the NHS complaints procedure:

- Local resolution of complaint through investigation and response by the CCG or provider
- Independent Review of complaint by the Parliamentary and Health Service Ombudsman

5.1 **Who can complain?**

5.1.1 Anyone who is receiving, or has received, NHS treatment or services or who is affected or is likely to be affected by an action, omission or decision can complain. This includes services provided by independent contractors who have a contract with the organisation to provide NHS services and services that are provided by independent providers as part of an NHS contract.

5.1.2 If a patient is unable to complain themselves then someone else, usually a relative or friend, can complain on their behalf providing written consent is given. (Refer to appendix A for an example of a complaint authorisation form.)

5.1.3 If a complainant is the parent or guardian of a child under the age of 18 (to whom the complaint relates) the organisation must be satisfied that there are reasonable grounds for the complaint being made by the representative instead of the child.

5.1.4 If a patient is unable to act, for instance due to physical incapacity or lack of capacity within the meaning of the Mental Capacity Act (2005) consent is not required. This will be agreed on an individual basis by the manager responsible for complaints.

5.1.5 If a complaint is raised concerning a patient who is deceased, this must be made by a suitable representative, for example next of kin. If the complainant is assessed as not being a suitable representative, the complaint maybe declined and a recommendation made that another person acts on the deceased patient’s behalf.
5.2 Where a complaint is received about a Primary Care Contractor (ie GP practice, dentist, community pharmacy, optician), the CCG or NECS Complaints Team will advise the complainant to send their complaint to NHS England for investigation and response.

5.3 **Support for persons making a complaint**

ICA provides a free, impartial and independent service for people wishing to make a complaint about the NHS. All complainants will be provided with information about ICA. Information regarding other specialist advocacy services will be provided, as required.

5.4 **Process for verbal complaints**

5.4.1 Clear information about the complaints process is made available to patients, the public and staff via the CCG’s website.

5.4.2 Complaints can be made verbally to a member of the North of England Commissioning Support (NECS) Complaints Team. When a verbal complaint is made a written account of the patients concerns will be taken from the complainant. This will include all salient points requiring a response being documented.

5.4.3 The written statement will be sent to the complainant asking them to make any changes to ensure it is an accurate reflection of their complaint. The complainant will then be asked to sign and return the statement to NECS. The complainant will be advised that their complaint will not be processed until the signed statement is returned. A copy of this signed statement must be forwarded to the Head of Quality & Safety for information.

5.4.4 There may be instances when it is not appropriate to take a formal complaint over the telephone, for example, if the concerns raised are complex. In cases such as this a face to face meeting may be offered to clarify the complaint or with the complainant’s permission a referral can be made to ICA. Face to face appointments with the NECS Complaints Team are by appointment only.
5.5 **Time-limit for making a complaint**

5.5.1 The timescale within which an NHS or social care complaint must be made is 12 months from the date on which a matter occurred, or the matter came to the notice of the complainant.

5.5.2 The regulations set out that the organisation has the discretion to investigate beyond this time, especially if there is good reason for a complaint not being received within the 12 months. The time limit can, and should, be waived if it is still practical and possible to investigate the complaint, for example, the records still exist and the individuals concerned are still available to be questioned.

5.5.3 When a complaint is made outside these limits and the time limits are not waived, NECS will advise the complainant of their rights to request that the Parliamentary and Health Service Ombudsman consider their case.

5.6 **Issues that cannot be addressed within the complaints procedure**

This policy and procedure does not address:

5.6.1 A complaint made by a responsible body to another responsible body. For example disputes on contractual matters between independent contractors should not be handled through this procedure.

5.6.2 Complaints regarding privately funded treatment.

5.6.3 Complaints which are made verbally and resolved to the satisfaction of the complainant no later than the next working day after the complaint was made.

5.6.4 Complaints regarding an alleged failure to comply with a request for information under the Freedom of Information Act (2000). These will be dealt with via information governance processes.

5.6.5 A complaint made by an employee about any matter relating to his/her employment. These matters will be handled via human resources procedures.

5.6.6 Complaints that have already been locally investigated under the complaints regulations or which are being or have been investigated by a Local Commissioner under the Local Government Act 1974 or the Health Service Commissioner under the 1993 Act.
5.6.7 Where a complaint is received that is disputing a funding decision (for example an individual funding request/continuing health care case) this will be handled in accordance with the appropriate appeals process.

5.6.8 If the organisation decides that a complaint meets any of the criteria detailed in sections 5.5.1 – 5.5.7 the complainant will be notified in writing of this decision and the reasons why by NECS.

5.7 **Written complaints received**

5.7.1 Most written complaints will come directly to the Accountable Officer. However, if a member of staff receives a written complaint, they have a duty to send it immediately to the Head of Quality and Safety, who will decide on how best to resolve the issue. This may be on an informal basis or through a formal complaints investigation, depending upon the nature of the complaint.

Formal complaints received by CCG staff must be forwarded to the NECS secure email account, necsu.complaints@nhs.net, within one working day of receipt.

5.7.2 The complainant has a choice of complaining directly to the CCG as commissioners rather than to the organisation who provided the care. The final decision on who will investigate the complaint rests with the CCG once all mitigating circumstances are taken into account.

5.7.3 This will include the complainant’s wishes and the seriousness of the complaint, for example where there has been a poor record of complaints handling or the complaint suggests a significant risk to patient safety or there appears to be a trend. Please refer to section 5.9 for guidance on how provider complaints are handled.

5.8 **Process for complaints handled by the CCG**

5.8.1 Acknowledging the complaint

5.8.1.1 Upon receipt of a complaint the Head of Quality and Patient Safety will assess the issues raised for wider governance issues, such as patient safety issues or potential poor performance concerns.
5.8.1.2 The complaint will be risk rated to determine the level of risk to the CCG and the level of investigation required.

5.8.1.3 All complaints received will be acknowledged verbally or in writing within three days of receipt by the NECS Complaints Team or from when the signed verbal statement is received by NECS.

5.8.1.4 At the time of acknowledging the complaint the NECS Complaints Team must offer to discuss and agree the following with the complainant:

- A plan for handling the complaint.
- When the investigation is likely to be completed.
- What reasonable outcome is desired.
- When the response is likely to be sent.
- Offer an early meeting if appropriate.
- Advise the complainant of advocacy services, such as ICA

5.8.1.5 The agreed complaint plan and timescales for response will be confirmed in writing to the complainant. Please see Appendix B.

5.8.1.6 If the complainant does not take up the offer of a discussion the NECS Complaints Team should determine the response period and the complainant will be notified of this in writing.

5.8.1.7 Where it is agreed that NECS, on behalf of the CCG, will handle the complaint rather than the provider or where it has been agreed that the CCG will co-ordinate the response, consent will be required from the complainant to obtain access to relevant medical records and/or to seek a response from the provider organisation(s) (Appendix A).

5.8.1.8 If the complainant fails to provide written consent they will be notified in writing of the elements of the complaint that are unable to be investigated and responded to.
5.8.2 Investigation

5.8.2.1 The investigation will be conducted in a timely manner, proportionate to the complaint.

5.8.2.2 The NECS Complaints Team or the Head of Quality and Patient Safety will:

- Forward the complaint to the appropriate lead for investigation, with details of the issues to be investigated and agreed in the complaint plan.
- Identify at an early stage whether it would be helpful to introduce conciliation.
- NECS will keep the complainant up to date with the progress of the investigation.

5.8.2.3 The investigating officer will:

- Establish what happened, what should have happened and who was involved and make written records of the investigation/staff statements.
- Make sure a sincere and appropriate apology is made as appropriate.
- Identify what actions can be implemented to ensure that there is no recurrence and address any training issues and learning points.
- Draft a report addressing the issues raised by the complainant and comment on what action is being taken to prevent a recurrence in the future.

5.8.2.4 Staff involved in a complaint:

- Will be made aware of the complaint and asked to prepare written statements as part of the investigation.
- Are required to co-operate with the complaints procedure as part of their terms of employment. Where an employee refuses to give an interview or a written account without reasonable grounds, this should be considered a disciplinary offence.

5.8.2.5 Where the complaint relates to a clinical matter, a written report from any appropriate clinician should be obtained. These reports can be potentially disclosed to the complainant and therefore must be written in plain English and without jargon or abbreviations.
5.8.3 The Response

5.8.3.1 The written response will include the investigation report (where appropriate) and will:

- Address all the issues raised by the complainant
- Provide explanations and apologies, where appropriate.
- Indicate lessons learned from the complaint.
- Include what steps have been taken to prevent a recurrence.
- Outline what options are available if the complainant is not satisfied with the response, including details of the Parliamentary and Health Service Ombudsman.

5.8.3.2 NECS will forward the formatted written response, including the investigation report, for the approval to the investigating officer and any other relevant staff involved in the complaint.

5.8.3.3 The response will then be forwarded for final approval to the Accountable Officer.

5.8.3.4 If for any reason a response cannot be made within the agreed timescale (for example a person involved in the complaint is absent from work) the complainant will be contacted by the NECS Complaints Team and an extension to the specified revised timescale will be agreed.

5.8.3.5 If the complainant is satisfied with the response the case will then be closed. The issues giving rise to the complaint and any changes made to practice or procedures as a result of the investigation will be subject to on-going review through the Quality and Safety Committee.

5.8.3.6 If a complainant is dissatisfied with the response, they are requested to contact the NECS Complaints Team within 28 days of receipt and every effort will then every effort will be made to achieve a satisfactory outcome at local level by:

- identifying outstanding issues
- arranging further meetings
- providing a further written response
- involving a conciliator, where appropriate
5.8.3.7 If following all attempts to resolve the complaint locally the complainant remains dissatisfied they will be notified that local resolution is at an end and that they can ask the Parliamentary and Health Services Ombudsman (PHSO) to consider their case. Information on the PHSO will be routinely given to complainants at the completion of local resolution.

5.9 Conciliation Process

5.9.1 A conciliation service with access to trained lay conciliators is available to assist in the resolution of complaints. Arrangements for conciliation will be made via the NECS Complaints Team throughout the complaints process, as required.

5.9.2 The lay conciliator will report back to the NECS Complaints Team on outcomes and agreed action points but will not disclose the substance of any discussions.

5.9.3 The conciliation process is confidential. However, where information is raised within that process regarding a child or adult protection or patient safety issue, the conciliator may have to breach confidentiality and seek further advice from NECS who will refer to the Head of Quality and Patient Safety or the Head of Safeguarding.

5.10 Process for complaints received about NHS providers

5.10.1 In the majority of cases when a complaint is received the provider will normally be given the opportunity to respond to the complaint. The complaint will be acknowledged verbally or in writing within three working days and consent will be sought to forward the complaint to the provider. (Please refer to appendix C for example of a consent form).

5.10.2 When consent is received the complaint will be passed to the provider who will handle it in accordance with the NHS complaints procedure. A letter confirming that the complaint has been passed to the provider will then be sent to the complainant by NECS.
5.10.3 There may be occasions when the CCG considers it appropriate to handle the complaint itself rather than it being managed by the provider. This decision will be taken once all mitigating circumstances have been taken into account, including the complainant’s wishes, seriousness of complaint or significant patient safety issues or where there appears to be a pattern.

5.10.4 In such cases both the complainant and provider will be notified and the complaint will be processed in accordance with section 5.7.

5.10.5 The CCG will ensure via contractual agreement that all NHS providers and any private provider with whom it has a contract or service level agreement have arrangements in place for handling complaints made about services they provide that is comparable with the NHS complaints procedure.

5.10.6 All providers will, via contractual agreement, be asked to report on the number and nature of complaints, concerns, comments and compliments received on an annual basis. This will include evidence of all lessons learned and improvements to services to prevent a recurrence of similar complaints. Process for handling joint NHS and local authority complaints

5.10.7 When a complaint is received about both health and local authority services, with the complainants consent, the organisations involved will co-operate with each other to deal with the aspects of the complaint that relates to them. Both agencies will agree who will lead on the complaint and will aim to provide a single co-ordinated response.

5.10.8 The Accountable Officer (or nominated deputy) will sign the response. Irrespective of lead responsibility each organisation retains its duty of care to the complainant and must handle its part of the complaint in accordance with its own procedures.

5.11 Process for complex complaints that span several NHS organisations

5.11.1 Where a complaint is received that spans a number of NHS provider organisations, the NECS Complaints Team on behalf of the CCG, will seek assurance that there will be a co-ordinated approach to the handling of the complaint across the various parties involved, prior to passing the complaint to the lead organisation.
5.11.2 The organisation who will lead on the handling of the complaint will be agreed following discussion with the parties involved. This decision will be made taking into account the organisation that has the greater part in the complaint as well as the complainant’s wishes.

5.11.3 Where the complaint is particularly complex or where serious patient safety issues have been identified the CCG may choose to co-ordinate the response or lead in the investigation of the complaint with the complainant’s consent, rather than the providers.

5.11.4 In cases where the complaint is in part about care commissioned by NHS England, NHS England is willing to take on the co-ordinator role on behalf of the CCG. Such complaints should be redirected to the relevant complaints manager after the patient permission has been granted.

5.12 Process for handling complaints about non NHS services

5.12.1 Occasionally complaints are received about services not funded by the NHS, e.g. private treatment. In such cases, wherever possible, NECS will advise the complainant of the correct agency to contact and will offer to forward the complaint for investigation. Beyond this the organisation will have no further input.

5.13 Staff support during the complaints process

5.13.1 It can be very stressful for those involved in the complaint process and advice and support is available to staff. Information is available on request from the NECS Complaints Team.

5.14 Equality and diversity

5.14.1 Every complainant will be treated fairly and equally regardless of age, disability, race, culture, nationality, gender, sexual orientation and faith.

5.14.2 The patient/complainant will not receive less help, will not have things made difficult for them and will not have the quality of their care will be compromised as a result of a complaint.

5.14.3 For people who require language or signed interpreting this will be made available throughout the complaints process.
5.15 **Disciplinary procedures**

5.15.1 The complaints procedure is concerned with resolving complaints to the satisfaction of complainants and learning lessons for improvement and not for investigating disciplinary matters.

5.15.2 The complaints procedure and the Serious Incident investigation procedure are entirely separate. However, complaints can occasionally reveal the need for an investigation under the disciplinary procedure. In such an event the line manager of the member of staff concerned will be contacted and informed by NECS. The NECS Complaints Team will not be involved in any disciplinary investigation.

5.16 **Serious incidents (SIs) and complaints**

5.16.1 The procedure for investigating SIs is managed in accordance with the CCGs Serious Incidents Policy and the NHS England Serious Incident Framework (2013). If during the course of investigating a SI, a complaint is also received, the SI procedure will normally take precedence in terms of the investigation.

5.16.2 If a complaint investigation reveals the need to take action under the SI procedure the incident procedure will normally take precedence in terms of investigation.

5.16.3 In these circumstances the complainant will be notified of the SI investigation and will be kept updated on the progress by NECS. It should be remembered that the issues raised in a complaint will not always be exactly the same as those investigated under the SI procedure and a separate and full response to the complaint will be required.

5.17 **Process for dealing with anonymous complaints**

All anonymous complaints received will be investigated if there is enough information to carry out an investigation. Investigating officers will be requested to report to the appropriate director and make appropriate recommendations based on any concerns raised.

5.18 **Withdrawal of a complaint**

If a complainant withdraws a complaint at any stage in the procedure, which involves issues raised against an individual, those complained against will be informed.
5.19 Learning and monitoring of complaints

5.19.1 The CCG’s philosophy for the management of complaints is to recognise their positive value through the effective monitoring of complaints. In applying these principles and sharing the learning we can all effect change.

5.19.2 The CCG will use the intelligence gained from complaints information (individual complaints received and provider annual complaints reports) to develop a greater awareness of services commissioned and where these may not meet quality standards.

5.19.3 The Quality and Safety Committee and the governing body will receive quarterly complaints reports produced by NECS as part of governance and performance reporting. The reports will identify any trends and patterns arising from complaints, and any subsequent action taken as a result of lessons learned.

5.19.4 An annual report produced by NECS will be prepared for the governing body on the handling and consideration of complaints, outlining actions, monitoring compliance and outcomes.

5.20 Recording of complaints

5.20.1 Record keeping will be in accordance with the Records Management Policy and Strategy, and will be of the highest standard. The electronic risk management system will be used to record and collate all complaints information.

5.20.2 The ‘Principles of Good Administration’ established by the PHSO have been adopted. The principles are not a checklist but provide a framework is to be used when dealing with complaints.

5.20.3 Staff dealing with complaints must maintain accurate and up to date complaints files at all times in accordance with the principles of good record keeping and the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The complaints record will not be filed within a clinical record but held within a separate complaints file.
5.21 Confidentiality/consent

5.21.1 Care will be taken at all times throughout the complaints procedure to ensure that any information disclosed about the patient/service user is confined to that which is relevant to the investigation of the complaint. Information will only be disclosed to people who have a demonstrable need to know it for the purpose of investigating the complaint or ensuring that the complaints process is followed.

5.21.2 In transferring complaints between agencies (including the PHSO) confidentiality will be maintained at all times. Every effort will be made to obtain the patient/service user (or their representative's) consent before sharing confidential information with another body or organisation. Consent will be obtained in writing or where this is not possible NECS will seek further advice from the Caldicott Guardian.

5.21.3 It is recognised that there may be circumstances in which the nature of, or aspects of, a complaint suggests possible concerns about a child or adult being at risk or suffering significant or serious harm. In these circumstances a referral will be made to children or adults Social Care services in line with the CCG and Local Safeguarding Children and Adults Boards safeguarding procedures. This maybe with or without the consent of the individuals involved including the complainant, depending on the nature and details of the concerns.

5.21.4 Where a complaint refers to allegations of a safeguarding nature against a member of staff, the CCG’s Safeguarding Children and Adults policies which includes a section on managing allegations against staff must be followed. This will supersede the complaints policy where such concerns form the whole of the basis of the complaint. Where these concerns form only part of the complaint, the two processes will be undertaken simultaneously with decisions about response times and involvement of the member of staff being taken jointly. Where the Safeguarding Policy is invoked, the complainant should normally be notified immediately however there are some circumstances in which they would not be informed. Advice should be sought from the CCG’s Head of Safeguarding or Children’s or Adults Social Care. Further guidance on when the complainant or member of staff should not be informed is available from the CCG’s Safeguarding Children and Adults policies.
5.21.5 If the receiving manager or member or the NECS Complaints Team is unsure about which policy to follow, they must consult with the CCG’s Head of Safeguarding or another member of the safeguarding team within one working day.

5.21.6 Where safeguarding concerns are identified, the complainant will be notified within one working day of the escalation and rationale for disclosure of information if this is appropriate as per 5.21.4. Where safeguarding concerns form only part of a complaint the complainant will be informed of how the differing aspects of the complaint will be handled.

5.22 **Access to personal information/medical records**

5.22.1 Under the Data Protection Act (1998), individuals (both service users and employees) have certain rights regarding the way information about them is used. These include having the rights to see information that is recorded about them (subject access request) and to have any part of it that they do not understand explained.

5.22.2 Where clinical records are used in a complaint investigation, investigating officers must comply with regulations within the procedure for sharing of information across services or external agencies (incorporating the code of practice on openness in the NHS). Where copies or access to records is provided as part of the resolution of a complaint there is discretion to waive the usual access fee and associated charges.

5.22.3 Any requests received for access to complaint documentation will be sent to the information governance department for appropriate action.

5.23 **Complaints and Litigation**

5.23.1 On receipt of a complaint in which legal action is being taken or the police are involved the CCG should continue to resolve the complaint unless there are clear legal reasons not to do so.

5.23.2 Advice will be sought from relevant authorities (such as legal advisors or the NHS Litigation Authority) to determine whether progressing the complaint might prejudice subsequent legal action.

5.23.3 If there is likely to be any prejudice to the legal case the complaint will be put on hold and the complainant will be advised of this in writing and provided with an explanation.

5.23.4 Paperwork relating to the complaints investigation can be used in a court of law.
5.24 **Complaints about Freedom of Information**

Complaints about Freedom of Information are not dealt with through the NHS complaints procedure. Any complaint of this nature will be forwarded to the appropriate information governance officer for investigation through relevant channels.

5.25 **Dealing with media interest**

All enquiries from the media must be immediately referred to the communications department ensuring that confidentiality is maintained at all times.

5.26 **Retention of complaint records**

Complaint files will be retained securely for a minimum of 10 years.

5.27 **Unreasonable and persistent complainants**

5.27.1 Some complainants find it difficult to accept the findings following an investigation even when it has been to the second stage of the complaints procedure. The difficulty in managing such complaints places a strain on resources and causes undue stress for staff.

5.27.2 In such cases, it is important to ensure that the complaints procedure has been correctly implemented as far as possible and that no material element of the complaint has been overlooked or inadequately addressed.

5.27.3 The procedure on how to handle unreasonable and persistent complainants is attached at Appendix D.
### Duties and Responsibilities

<table>
<thead>
<tr>
<th>The Governing Body</th>
<th>The Group establishes the CCG’s governance arrangements. The Governing Body has delegated authority from the Group to set the strategic context in which organisational process documents are developed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Officer</td>
<td>The Chief Officer has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements.</td>
</tr>
</tbody>
</table>
| North of England Commissioning Support | The NECS Complaints Team is responsible for the day-to-day handling of complaints and will be readily available to receive complaints, support staff with the local resolution process and to give information and advice where required.  

Where appropriate, NECS will also arrange a conciliation service to assist in the resolution of complaints. Information will also be relayed to the complainant regarding advocacy services that are available.  

NECS will co-ordinate and collate all the information required in order to produce a draft response to the complainant. All actions arising as a result of a complaint investigation will be monitored by NECS to ensure implementation, in conjunction with line managers and heads of service.  

NECS is responsible for entering information onto the risk management database and producing appropriate reports as required, including the collection of data to enable the annual complaints return to the Department of Health.  

NECS will keep up to date with current legislation and advise the CCG as appropriate.  

In cases that involve the PHSO, NECS will be the point of contact for the Ombudsman and will liaise with them in any investigation. |
### The Investigating Manager

The investigating manager is responsible for undertaking the detailed investigation of complaints, to provide information in order that NECs can draft the written response for signature by the accountable officer or nominated director.

The investigating manager will establish the underlying causes of complaints and ensure that these are properly understood, lessons are learned and where appropriate, improvements to patient care are implemented. The investigating manager is also responsible for ensuring that any actions arising from complaints are implemented and the outcome is fed back to NECS for inclusion in reports.

### Members of the Senior Management Team

The senior management team is responsible for ensuring that complaints are investigated in accordance with this policy; working with NECS to ensure satisfactory resolution of complaints, including the implementation of any lessons learned.

### All staff

All staff, including temporary and agency staff, are responsible for:
- Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken.
- Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities.
- Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly.
- Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager.
- Attending training / awareness sessions when provided.

### 7. Implementation

7.1 This policy will be available to all staff for the effective management of all complaints received by the organisation in accordance with NHS complaints regulations.

7.2 All managers are responsible for ensuring that relevant staff within the CCG have read and understood this document and are competent to carry out their duties in accordance with the procedures described.
8. **Training Implications**

The NECS Complaints Team will provide or arrange coaching or training in complaints handling and good customer care as requested. Managers should ensure that appropriate staff in their areas that require such support contact NECS to arrange training.

Complaints awareness is included in the corporate induction program for all new members of staff.

9. **Related Documents**

9.1 Other related policy documents

- Safeguarding Children Policy
- Safeguarding Adults Policy
- Freedom of Information Policy and Procedure
- Records Management Policy and Strategy
- Serious Incidents Policy
- Whistle Blowing Policy
- Confidentiality and Data Protection Policy

9.2 Legislation and statutory requirements

9.3 Best practice recommendations

- PHSO. (2009) Principles of Good Administration

10. Monitoring, Review and Archiving

10.1 Monitoring

The Governing Body will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

10.2 Review

10.2.1 The governing body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

10.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Governing Body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

10.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the 'version control' table on the second page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsoring director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.
10.3 Archiving

The Governing Body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2009.

11. Equality Analysis

A full Equality Impact Assessment has been completed:

EI A - Complaints Policy - June 2016.do
Appendix A

Complaint Authorisation Form

Section A – Patient Details

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename(s)</th>
<th>Date of birth</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Postcode</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Section B – Authorisation (to be completed as appropriate)

EITHER

a) Patient: I ......................................... of .................................................................

hereby authorise ................................................................. to receive relevant medical details for the purposes of a complaint made on my behalf. I also confirm my consent to the disclosure of information between organisations for the purpose of investigating my complaint.

Signature: ______________ Name: ______________ (please print)

Date: ______________

Please note the form should be signed by the patient themselves.

OR

b) Other: I ......................................... of .................................................................

hereby confirm that I am making a complaint on behalf of the above patient who can not make a complaint themselves because (please delete as appropriate):

• They are under 16 years of age
• other reason (please state)*

I also confirm my consent to the disclosure of information between organisations for the purpose of investigating my complaint.

Signature: ______________ Name: ______________ (please print)

Date: ______________

For advice on completing this form please contact NECS on: 0191 3744218
Appendix B

Complaint Plan

This complaint plan must be read in conjunction with correspondence received from the complainant which provides specific detail relating to the complaint.

<table>
<thead>
<tr>
<th>Reference number: XXX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complainant's name and address (include title):</td>
</tr>
<tr>
<td>Patient's Name:</td>
</tr>
<tr>
<td>Brief Background to complaint:</td>
</tr>
<tr>
<td>The following will be investigated by NHS XXX Clinical Commissioning Group (CCG):</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>Agreed plan for addressing the issues:</td>
</tr>
<tr>
<td>NHS XXX CCG will investigate and respond to the complaint in accordance with the NHS complaints procedure.</td>
</tr>
<tr>
<td>Outcome the complainant is seeking:</td>
</tr>
<tr>
<td>Agreed timescale for response:</td>
</tr>
<tr>
<td>Agreed feedback following investigation:</td>
</tr>
<tr>
<td>Client informed about ICA?:</td>
</tr>
<tr>
<td>Date of complaint plan:</td>
</tr>
<tr>
<td>Completed by (name):</td>
</tr>
</tbody>
</table>

Appendix C

Consent Form

Full Name of Complainant: ____________________________________________
Address: ____________________________________________
______________________________________________________
Telephone number: __________________________(please complete)
I, XXX, give my permission for my complaint to be forwarded to XXX NHS Foundation Trust, who will respond to the concerns outlined in my letter in line with the NHS complaints procedure.

Please note that the Complaints Team at NHS North England Commissioning Support Unit (NECS) handles all complaints on behalf of NHS XXX CCG. To enable your complaint to be processed NHS XXX CCG is required to share details of your complaint with NECS.

Signature of Complainant: …………………………………………………

Date: ……………………………

Please send completed form (freepost envelope provided) to:

FREEPOST RLSH-KHYU-YREH
Complaints Team
NHS North England Commissioning Support Unit
John Snow House
Durham University Science Park
DH1 3YG
Appendix D

Procedure for Handling Unreasonable and/or Persistent Complainants

1. Introduction

1.1 Unreasonable and/or persistent complainants can be a significant problem for the NHS. The difficulty in managing such complainants places a strain on time and resources and can cause undue stress for staff who may need support. NHS staff are trained to respond with patience and empathy to the needs of complainants but there are times where there is nothing further that can be done to bring a real or perceived problem to resolution.

1.2 It is also recognised that a persistent complainant should be protected by ensuring that they receive a response to all genuine grievances and are provided with details of independent advocacy. The Parliamentary and Health Service Ombudsman (PHSO) also clearly sets out the responsibility on NHS trusts to ensure that it deals with people and issues objectively and consistently and that all decisions and actions are appropriate and fair.

1.3 Complaints are processed in accordance with the NHS complaints procedure and every effort will be made to ensure that no genuine element of a complaint has been overlooked or inadequately addressed. During this process staff will inevitably come into contact with a small number of complainants who require a disproportionate amount of time and resources whilst dealing with their complaint.

1.4 This procedure will only be implemented with the full authorisation of the Accountable Officer, or a deputy in their absence. Where a deputy makes the decision, the reason for the non-availability of the Accountable Officer will be recorded on the complaints file.

2. Criteria for identifying an unreasonable and/or persistent complainant

Complainants (and/or anyone acting on their behalf) may be deemed to be unreasonable and/or persistent where previous or current contact with them demonstrates that they have met two or more (or are in serious breach of one) of the following criteria:

2.1 Persists in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted. For example where an investigation is deemed to be ‘out of time’ or where the PHSO has declined to investigate the complaint.

2.2 Changes the substance of a complaint or persistently raises further issues or seeks to prolong contact by unreasonably raising further concerns or questions upon receipt of a response whilst the complaint is still being dealt with. Care must be taken not to disregard new issues which differ significantly from the original complaint that may need to be addressed separately.
2.3 Unwilling to accept documented evidence of treatment given as being factual (e.g. drug records, GP manual or computer records, nursing records) or denies receipt of an adequate response despite correspondence specifically answering their questions or concerns being provided. This can also extend to include those persons who do not accept that facts can sometimes be very difficult to verify after a long period of time has elapsed.

2.4 Do not clearly identify the precise issues that they wish to be investigated, despite reasonable efforts by NHS North Tyneside Clinical Commissioning Group (the CCG) staff and, where appropriate, ICA, to help them specify their concerns and/or where the concerns identified are not within the remit of the CCG to investigate.

2.5 Focus on a trivial matter to an extent that it is out of proportion to its significance and continue to focus on this point. Please note careful judgement must be used before applying this criterion as determining what constitutes a ‘trivial’ matter is subjective.

2.6 In the course of addressing a complaint has an excessive number of contacts with the CCG, which places unreasonable demands on staff. Contacts may be in person, by telephone, letter, e-mail or fax. Discretion must be used in deciding how many contacts are required to qualify as excessive, using judgment based on the specific circumstances of each case.

2.7 Fail to engage with staff in a manner which is deemed appropriate, for example repeatedly using unacceptable language or secretly recording telephone calls or meetings without consent of the other parties involved. Refusing to adhere to previously agreed communication plans or behaving in a threatening or abusive manner on more than one occasion, despite having been warned about this. It may be necessary to explain to a complainant at the outset of any investigation into their complaint(s) that such behaviour is unacceptable and in some circumstances can be illegal.

2.8 Have harassed or been abusive or verbally aggressive, either directly or indirectly, on more than one occasion towards staff, their families or associates. If the nature of the harassment or aggressive behaviour is sufficiently serious this could, in itself, be sufficient reason for classifying the complainant as unreasonably persistent. Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety or distress and reasonable allowances should be made for this. All incidents of harassment or aggression must be documented in accordance with the CCG’s incident reporting procedures.

3. Possible options for dealing with complainants prior to classifying as unreasonable and or persistent

Consideration will be given as to whether any further action can be taken prior to classifying a complainant as unreasonable and/or unreasonably persistent.
This might include:

3.1 Trying to resolve matters before invoking this procedure by drawing up a signed agreement with the complainant which sets out a code of behaviour for both parties. If these terms are not adhered to, then consideration will be given as to whether to implement the other options in this section.

3.2 Where no meetings with staff have been held, the NECS Complaints Team will consider offering this as a means to dispel misunderstandings and move matters forward. This option will only be appropriate when risks have been assessed and a suitably senior member of staff can be present.

3.3 The NECS Complaints Team will consider whether the assistance of a lay conciliator or Independent Advocacy Service (ICA) advocate might be helpful in a formal complaint where this has not previously been taken up.

3.4 Where multiple departments are being contacted by the complainant, the complaints team will consider setting up a meeting to agree a cross-departmental approach.

4. **Invoking the unreasonable and or persistent procedure**

4.1 When complainants have been identified as meeting the criteria outlined in section 2 and all possible options in section 3 have been exhausted the Complaints Team will escalate this to the Accountable Officer.

4.2 The Accountable Officer will consider any evidence of this behaviour and then make the decision as to whether to classify the complainant as unreasonable or persistent.

4.3 If the Accountable Officer considers that a complainant meets the criteria he/she will then be notified in writing of this. Written information will also be copied to other parties involved in the complaint, such as ICA.

4.4 A record will be kept for future reference of the reasons why a complainant has been deemed as unreasonable and/or persistent.

4.5 The Accountable Officer (or deputy) may decide to deal with the complainant in one or more of the following ways:

- Once it is clear that the complainant meets the criteria outlined in section 2 and options in 3 have been exhausted, it may be necessary to write to inform them that if their behaviour persists they may be classified as an unreasonable and/or persistent complainant. The complainant will be provided with a copy of this procedure. This letter will also be copied to other persons involved in the complaint such as ICA.

- Decline contact with the complainant in person, by telephone, fax or letter or any combination of these, providing that one form of contact is maintained. It may be necessary to consider contact via a third party such as ICA. If staff members are required to withdraw from telephone conversations with the complainant, an agreed statement will be made available.
- Notify the complainant in writing that the points raised have been responded to in full and that the CCG has tried to resolve the complaint but there is nothing more to add and continued contact would serve no useful purpose. The complainant will also be notified that correspondence is at an end and any further letters received will only be acknowledged but not responded to.

- Inform the complainant in writing that in extreme cases of harassment or verbal abuse, the CCG reserves the right to pass an unreasonable or persistent complainant to a legal representative for further advice.

- Temporarily suspend all contact with the complainant or investigation of a complaint whilst seeking legal advice or guidance from the Parliamentary and Health Service Ombudsman.

- In cases where the complaint is made against the Accountable Officer the decision about whether a complainant is persistent or unreasonable will be taken by the chair of the organisation.

4.7 Once a restriction is put in place, a letter will be issued to inform the complainant about the decision; what it means for their future contact with the CCG; how long the restrictions will remain in place; and what they can do to have their position reviewed. The complainant will be provided with a copy of this procedure.

4.8 Concluding letters to complainants will be sent by recorded delivery.

5. Withdrawing a persistent and/or unreasonable status

5.1 Once a complainant has been determined as persistent and/or unreasonable there needs to be a mechanism for withdrawing this status at a later date. For example, if the complainant subsequently demonstrates a more reasonable approach, or if they submit a further complaint for which normal complaints procedures would appear appropriate.

5.2 Staff will previously have used discretion in recommending persistent and/or unreasonable status at the outset and discretion should similarly be used in recommending that this status be withdrawn, when appropriate. This decision will only be taken by the Accountable Officer in conjunction with the NECS Complaints Team and other relevant staff.

5.3 Once a complainant who had been deemed persistent or unreasonable is no longer considered to be such, normal contact will be resumed with him/her and the NHS complaints procedure will once again apply.
6. Requesting a review of the decision

6.1 If a complainant, or someone with authority to act on their behalf, disagrees with the decision to classify him/her persistent or unreasonable, they may put their reasons in writing and address this to the chair of the organisation.

6.2 Upon receipt of the request the chairman will reconsider the decision.

6.3 The chairman will notify the complainant in writing of the outcome.
Appendix E

<table>
<thead>
<tr>
<th>Working Days</th>
<th>Who</th>
<th>Role</th>
</tr>
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<tbody>
<tr>
<td>Day 1</td>
<td></td>
<td></td>
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<tr>
<td>Day 3</td>
<td>NECS</td>
<td></td>
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<tr>
<td>Day 25</td>
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<td></td>
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<tr>
<td>Day 27</td>
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</tbody>
</table>

1. Determine whether communication is complaint/concern/MP Letter/FOI and seek from CCG Safeguarding Team if concerns that a child or adult maybe at risk of significant or serious harm
2. FOI – Send to NTCCG.FOI@nhs.net
3. Alert Head of Governance
4. Complaint/Concern/MP Letter - log on spreadsheet in I Drive
5. Create named file on I Drive and apply hyperlink to spreadsheet
6. Send complaint/concern to NECS and request acknowledgement NECS.complaints@nhs.net
7. If MP Letter – send to NECS (comms) and request acknowledgement caroline.latta1@nhs.net
8. Save acknowledgement in named file on I Drive

1. Acknowledge receipt of complaint/concern/MP Letter in email to maureen.grieveson@nhs.net and copy to susan.askew1@nhs.net
2. Send letter/make a call, send email to patient/MP acknowledging receipt of complaint/MP Letter (on CCG letter headed paper) and outline timescales and advise CCG that this has happened by email to:
   maureen.grieveson@nhs.net
   copy to susan.askew1@nhs.net
1. Check response letter against complaint/concern/MP letter and amend if necessary
2. Pass to Chief Officer (or deputy) for signature
1. Send letter of response to complainant/MP
2. Copy complaint response to NECS.complaints@nhs.net or if MP letter to caroline.latta1@nhs.net
3. Update spreadsheet on I Drive
4. File response letter in appropriate file
Corporate | CCG CO03 Deprivation of Liberty Safeguards (DoLS) Policy

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Date Issued</th>
<th>Review Date</th>
</tr>
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<tbody>
<tr>
<td>V3 (draft 3)</td>
<td>November 2016</td>
<td>November 2019</td>
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**Prepared By:** Joint Commissioning Manager

**Consultation Process:** CCG Executive Director of Nursing & Transformation and Safeguarding Professionals for North Tyneside CCG. North Tyneside CCG Quality and Safety committee

**Formally Approved:** DATE TBC

**Policy Adopted From:** V1: CO03: DoLS policy

**Approval Given By:** North Tyneside CCG Governing Body

**Document History**

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<th>Version</th>
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<tr>
<td>Version 1</td>
<td>28/02/2013</td>
<td>First Issue</td>
</tr>
<tr>
<td>Version 2</td>
<td>12/11/2015</td>
<td>Substantially revised to reflect current legislation, guidance, and case law</td>
</tr>
<tr>
<td>Version 3</td>
<td>01/11/2016</td>
<td>Revised to reflect transfer of CHC to Local Authority</td>
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**Equality Impact Assessment**

<table>
<thead>
<tr>
<th>Date</th>
<th>Issues</th>
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</thead>
<tbody>
<tr>
<td>1 October 2015</td>
<td>None identified</td>
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**POLICY VALIDITY STATEMENT**

This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.
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“The deprivation of a person’s liberty is a very serious matter and should not happen unless it is absolutely necessary, and in the best interests of the person concerned.”

Deprivation of Liberty Safeguards: Code of Practice

1. Introduction

For the purposes of this policy, North Tyneside Clinical Commissioning Group will be referred to as “the CCG”.

This policy sets out how the CCG will fulfil its duties and responsibilities effectively, both within its own organisations and across the local health economy via their commissioning arrangements in relation to the Deprivation of Liberty Safeguards (DoLS).

The CCG aspires to the highest standards of corporate behaviour and clinical competence to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients, their carers, the public, staff, and other stakeholders, and in the use of public resources. In order to provide clear and consistent guidance, the CCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

The Deprivation of Liberty Safeguards provide legal protection for vulnerable people over the age of 18, who are or may become, deprived of their liberty in a hospital or care home environment, whether placed there under public or private arrangements. Those affected by DoLS include people with a “mental disorder”, as defined within the Mental Health Act 2007, who lack the capacity to make informed decisions about arrangements for their care or treatment. A risk that the person may be deprived of their liberty must be identified. The safeguards do not apply to people detained under the Mental Health Act (MHA) 1983. The DoLS clarify that a person may be deprived of their liberty:

- in their own best interests to protect them from harm
- if it is a proportionate response to the likelihood and seriousness of the harm, and
- if there is no less restrictive alternative.

The preparation of this document has included an assessment against equality and diversity requirements and Human Rights considerations, to ensure that there is no direct or indirect discrimination against individuals or groups of persons and that no human rights are unlawfully restricted.

This policy should be read in conjunction with the:

- The Mental Capacity Act: Code of Practice
On 1 April 2013, Primary Care Trusts ceased to exist and their Supervisory Body (SB) role was transferred to Local Authorities (LA). Consequently, the CCG is not a Supervisory Body (SBs) but is required to work closely with providers and the LAs to ensure the protections offered by DoLS are implemented appropriately.

The purpose of this policy is to support the CCG in discharging its duties and responsibilities as a commissioner. This requires the CCG to understand and be able to apply the principles of the Deprivation of Liberty Safeguards (DoLS) Code of Practice, so it can be assured that assessments of capacity are carried out appropriately by commissioned services and that decisions made on behalf of people who lack capacity are made in their best interests. Commissioned services are expected to demonstrate compliance with the code of practice and any legal changes as a result of case law.

This policy applies to all staff employed by the CCG, including any agency, self-employed or temporary staff. All managers must ensure their staff are made aware of this policy and how to access it and ensure its implementation within their line of responsibility and accountability.

2. Definitions

The following terms are used in this document:

<table>
<thead>
<tr>
<th>Reference</th>
<th>Abbreviated Term</th>
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<tbody>
<tr>
<td>Advance Decision to refuse treatment</td>
<td>ADRT</td>
</tr>
<tr>
<td>Best Interests Assessor</td>
<td>BIA</td>
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<tr>
<td>Court of Protection</td>
<td>CoP</td>
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<tr>
<td>Deprivation of Liberty</td>
<td>DOL</td>
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<tr>
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<td>EPA</td>
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<td>GP</td>
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<tr>
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<td>IMCA</td>
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<td>Lasting Power of Attorney</td>
<td>LPA</td>
</tr>
<tr>
<td>Managing Authority (Hospital)</td>
<td>MA</td>
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<tr>
<td>Mental Capacity Act</td>
<td>MCA</td>
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<tr>
<td>Mental Health Act</td>
<td>MHA</td>
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<tr>
<td>Office of the Public Guardian</td>
<td>OPG</td>
</tr>
<tr>
<td>Relevant Persons Representative</td>
<td>RPR</td>
</tr>
<tr>
<td>Supervisory Body (LA)</td>
<td>SB</td>
</tr>
</tbody>
</table>

2.1. Equality and Diversity Leads:
2.2. Definition of Mental Capacity

A person lacks capacity at a certain time if they are unable to make a decision for themselves in relation to a matter, because of impairment, or a disturbance in the functioning of the mind or brain. An impairment or disturbance in the brain could be as a result of (not an exhaustive list):

- A stroke or brain injury
- A mental health problem
- Dementia
- A significant learning disability
- Confusion, drowsiness or unconsciousness because of an illness or treatment for it
- A substance misuse

Lacking capacity is about the ability to make a particular decision at a certain time, not a range of decisions. If someone cannot make complex decisions it does not mean they cannot make simple decisions.

It does not matter if the impairment or disturbance is permanent or temporary but if the person is likely to regain capacity in time for the decision to be made, delay of the decision should be considered. Therefore Capacity Testing may be required at various periods.

Capacity cannot be established merely by reference to a person’s age, appearance or condition or aspect of their behaviour, which might lead others to make an assumption about their capacity. An assumption that the person is making an unwise decision must be objective and related to the person’s cultural values.

3. Mental Capacity Act Principles

The MCA provides legal protection from liability for carrying out certain actions in connection with care and treatment of people provided that:

- the principles of the MCA have been observed
- an assessment of capacity has been carried out and it is reasonable to believe that the person lacks capacity in relation to the matter in questions
- it is reasonable to believe the action to be taken is in the best interests of the person

There are five key principles underpinning the MCA as follows:

- A person must be assumed to have capacity unless it is established that they lack capacity.
- A person is not unable to make a decision unless all steps have been taken unsuccessfully.
• A person is not unable to make a decision merely because he makes an unwise decision.
• An act/decision made on behalf of a person who lacks capacity must be in his best interests.
• Before the act or decision, ensure it is achieved in the least restrictive way.

The Mental Capacity Act applies to all people over the age of 16, except when making a lasting power of attorney (LPA); making an advance decision to refuse treatment and making a will; in these situations, a person must be aged 18 or over.

4. Deprivation of Liberty Safeguards (DoLS)

Whilst a Deprivation of Liberty may occur in any care setting, the Deprivation of Liberty Safeguards (DoLS) provide legal protection for vulnerable people over the age of 18, who are or may become, deprived of their liberty in a hospital or care home environment, whether placed under public or private arrangements. Those affected by the DoLS will include people with a “mental disorder”, as defined within the Mental Health Act (1983) (2007), who lack the capacity to make informed decisions about arrangements for their care or treatment. DoLS clarifies that a person may be deprived of their liberty:

• If they lack the mental capacity to consent to their accommodation and care plans, and;
• it is in their own best interests to protect them from harm, and;
• if it is a proportionate response to the likelihood and seriousness of the harm, and;
• it is the least restrictive way of meeting their needs safely.

In determining whether a deprivation of liberty has occurred or is likely to occur, staff must consider all of the facts. No universal definition can be applied to every case, and no single factor will determine the overall steps being taken which will amount to a deprivation of liberty. The case of HL v United Kingdom (The Bournewood case) assists practitioners by stating that “the distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance” (para.89), staff should therefore consider:

• All the circumstances in each and every case and the measures taken.
• When they are required & what period do they endure?
• The effects of any restraints/restrictions on the individual - Are they necessary?
• What aim do the restrictions seek to meet?
• What are the views of the relevant person, family or carers? Do any of them object?
• How are any restraints or restrictions implemented?
• Do the constraints go beyond ‘restraint’/restriction to the extent they constitute a deprivation of liberty?
• Are there less restrictive options that would avoid deprivation of liberty altogether?
• Does the effect of all of the restrictions amount to deprivation of liberty, even if individually they don’t?
• That practical steps can be taken to reduce the risk of deprivation of liberty occurring?

The CCG will aim to reduce the risk of deprivation of liberty to include minimising the restrictions imposed and ensuring decisions are taken with the involvement of all relevant people. The processes for staff to follow are:
• Ensure that decisions are taken, reviewed & recorded in a structured way.
• Assess whether the person lacks capacity to see whether or not to accept the care
• Consider the least restrictive form of care.
• Help the person retain contact with family/friends/carers/advocacy service support.
• Review the care plan including an independent view e.g. advocacy service.

Section 6(4) of the MCA states that someone is using restraint if they use force, or threaten, to make someone do something that they are resisting, or restrict a person’s freedom of movement, whether they are resisting or not. However, where the restriction or restraint is frequent, cumulative and on-going, or if there are other factors present, then care providers should consider whether this has gone beyond permissible restraint.

On 19th March 2014, the Supreme Court published its judgement in the P v Cheshire West and Chester Council and P & Q v Surrey County Council cases. This judgement significantly clarified the definition of what constitutes a deprivation of liberty by establishing an ‘Acid Test’. For a person to be deprived of their liberty, they must:
• lack capacity to consent to the relevant care and support arrangements
• be subject both to continuous supervision and control and
• not be free to leave.

In all cases the following are not relevant to the application of the test:
• The person’s compliance or lack of objection to the care arrangements.
• The reason or purpose behind a particular placement; and
• The relative normality of the placement (whatever the comparison made). This means that the person should not be compared with anyone else in determining whether there is a Deprivation of Liberty. However, young persons aged 16 or 17 should be compared to persons of a similar age and maturity without disabilities).

The introduction of the ‘Acid Test’ has reduced the threshold and widened the scope of who may be affected to include Independent Living Schemes, Adult Placements,
Children’s Foster Placements and people at home receiving funded packages of care.

This test is far broader than those set by previous judgements - disabled people should not face a tougher standard for being deprived of their liberty than non-disabled people.

The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This can include a placement in a supported living arrangement in the community or in the person’s own home. These must be authorised by the Court of Protection.

5. Consideration of a Potential Deprivation of Liberty within supported living services, shared lives schemes (formerly known as adult placements) and extra care housing.

Application of guidelines
These guidelines are relevant to people who receive commissioned support within a setting other than a hospital or care home, and whose care arrangements may amount to a deprivation of their liberty. The guidelines specifically apply to those individuals who have a mental disorder (as defined by the Mental Health Act 1983) and lack capacity to consent to the arrangements made for their care and treatment and where the circumstances of that care and treatment may amount to a deprivation of liberty.

Overview of Process
When the case manager assisting in identification of the health outcomes develops the support plan in conjunction with the individual (and their family if appropriate), they must also consider whether the plan results in the individual being deprived of their liberty. If following discussion it is felt that this maybe the case, then there is a responsibility to take all reasonable steps to consider whether the support plan can be amended to reduce the level of restrictions so that a deprivation is not occurring.

If this is not possible then the responsible CCG will need to be notified so that they can make a decision, in line with their responsibility as the decision maker, on the appropriateness of a referral to the Court of Protection. Dependent on the contractual agreement between the Local Authority and the CCG, in some cases it maybe that the submission of the application is the responsibility of the Local Authority. However, this will need to be discussed on an individual case-by-case basis and clarity should be sought locally.

Due to the high probability that there will be commissioned cases where individuals are already having their liberty deprived in the their own home/supported tenancy, then CHC teams need to ensure that there is a clear process in place to identify potential cases so that the relevant CCG is aware of the potential level of non-compliance.

To assist in the identification of potential cases, it is suggested that there should be a locality based action plan developed. Appendix 1 outlines the potential areas the action plan needs to address, including clear plans developed in relation to how
historical cases are going to assessed. Dependent on the CCG’s preference, a potential solution would be to use the tool developed by ADASS to prioritise work load (Appendix 2). However, the CCG needs to be aware that if there is a legal challenge in relation to unauthorised deprivation of liberty then an individual may successfully claim damages for breach of their human rights. This would also involve legal costs.

5.1. **What is a supported living service?**

The generic term, ‘supported living’, describes a form of domiciliary care whereby a CCG or local authority arranges a package of care and accommodation to be provided to a disabled, elderly or ill person. The individual lives in their own (often rented) home and typically receives social care and/or support to enable them to be as autonomous and independent as possible. The provision of accommodation is thereby separated from the delivery of care at an organisational level. There is usually some form of tenancy or licence arrangement with a landlord attracting housing benefit, with means-tested tailored support being provided by a distinct care provider with activities of daily living, education, training, employment and social interaction. The care setting is therefore not likely to constitute a “care home” for registration purposes.

Supported living services need only be registered with the Care Quality Commission (“CQC”) if they carry on a regulated activity that is nursing or personal care. If, for example, the individual is supported with cleaning, cooking and shopping, or is supervised to take prescribed medicine, the service does not require registration. If personal care is being provided but not in the place where they are living, for example at day services, then registration of the service is not required. However, where nursing or personal care is provided to those, for example, with more complex needs, then such care will need to be a regulated activity requiring CQC registration. The Care Act 2014 adopts the definition of nursing and personal care presently provided for in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010:

> “nursing care” means any services provided by a nurse and involving:
> (a) the provision of care; or
> (b) the planning, supervision or delegation of the provision of care, other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a nurse;

> “personal care” means:
> (a) physical assistance given to a person in connection with:
> (i) eating or drinking (including the administration of parenteral nutrition),
> (ii) toileting (including in relation to the process of menstruation),
> (iii) washing or bathing,
> (iv) dressing,
> (v) oral care, or
> (vi) the care of skin, hair and nails (with the exception of nail care provided by a chiropodist or podiatrist); or
> (b) the prompting, together with supervision, of a person, in relation to the performance of any of the activities listed in paragraph (a), where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision.”
Such regulated activities do not apply to the provision of accommodation to someone by a carer under a shared lives scheme (see below), school, or a further education institution.

5.2. **Supported living: liberty-restricting measures**

The following are measures which may be found in the specific features of this care setting:

- Decision on where to live being taken by others;
- Decision on contact with others not being taken by the individual;
- Doors of the property locked, and/or chained, and/or bolted for security reasons or to prevent residents leaving;
- Access to the community being limited by staff availability;
- A member or members of staff accompanying a resident to access the community to support and meet their care needs;
- Mechanical restraint, such as wheelchairs with a lapstrap or harness (e.g. Crelling), reinforced glass in mobility vehicles, protective helmets;
- Varying levels of staffing and frequency of observation by staff;
- Restricted access to finances, with money being controlled by staff or welfare benefits appointee;
- Restricted access to personal items to prevent harm;
- Restricted access to parts of the property, such as the kitchen or certain cupboards therein, to minimise health and safety risks;
- Chemical restraint, such as medication with a sedative or tranquillising effect;
- Physical restraint/intervention, such as with personal care tasks, breakaway or block techniques, distraction methods, staff withdrawing, physical touches or holds;
- Restricted access to modes of social communication, such as internet, landline or mobile telephone, correspondence;
- Positive behavioural reward systems, to reward “good” behaviour;
- Restricted access to family, depending on level of risk and availability of staff and resources;
- Lack of flexibility, in terms of having activities timetabled, set meal times, expected sleep times
5.3. **What are Shared Lives schemes?**

These schemes, formerly known as adult placements, differ from supported living arrangements as they involve the individual being placed in a family setting. They are likened to adult fostering arrangements and are available to those aged 16 and over. Usually a local authority arranges for the person to receive day support, short breaks or respite, or long term care in the family home of a Shared Lives carer so as to enable them to share the family life, social life and community activities. The schemes are designed for those wanting to live independently but not on their own. The majority of those receiving such care have learning disabilities, although the scheme extends to those with physical disabilities, mental health issues or drug or alcohol problems. Shared Lives carers are self-employed, with rates of payment set by the local authority or the scheme itself according to the location and the person’s level of need. Carers receive payments to cover some of their time, rent and a contribution towards the household running costs.

Although accommodation is often provided together with personal care, it is not required to be registered as a “care home”. But Shared Lives schemes are regulated under the Health and Social Care Act 2008. The schemes approve and train the carer, receive referrals (typically from the local authority), match the needs of the person with the carer, and monitor the arrangements. A maximum of three people (two in Wales) can be supported by the carer at any one time and carers do not employ staff.

5.4. **Shared Lives schemes: liberty-restricting measures**

The following are measures which may be found in the specific features of this care setting:

- Varying levels of supervision and guidance with activities of daily living;
- Encouraging participation in family and community activities;
- Preventing the person from leaving unaccompanied for their immediate safety;
- Ensuring behavioural boundaries;
- Conveying the person to health and other appointments;
- Addressing challenging behaviour;
- Assist with medication, including sedative effect.

5.5. **Extra care housing**

Extra care housing represents a hybrid between living at home and living in residential care. Usually purpose built, self-contained properties on a single site, schemes provide access to 24-hour domiciliary care and support and community resources. Their models differ from assistive technology in someone’s own home to retirement and care villages to, for example, specialist dedicated schemes for those with dementia. Unlike residential care, those in extra care housing usually rent, purchase, or share ownership of typically a one or two-bedroomed apartment or bungalow in the housing scheme or care village and do not receive one-to-one care. Unlike living in one’s own home, those in extra care housing will have 24-hour access to personal care with progressive degrees of privacy, dependent upon their level of need.
Some individuals will have a domiciliary carer. A warden is also usually on site to check on the welfare of residents. For the larger schemes, there are also on-site facilities and social care services usually available for those requiring daily support. These can include on-site care teams, rehabilitation services, day centre activities, restaurants, laundrettes, hairdressing and beauty suites, and possibly shops, cinemas, gyms, even the garden shed. Moving into extra care housing may be a lifestyle choice. Or it may be necessary due to an individual’s level of social and/or health care need. The decision to move in may or may not be made at a time when the individual had mental capacity, or their mental functioning may deteriorate subsequently, with it no longer being safe for them to go out unaccompanied. It is therefore a common occurrence for those in extra care housing to not be free to access the community but the intensity of care measures varies enormously.

5.6. Extra care housing: liberty-restricting measures
- The following are measures which may be found in the specific features of this care setting:
  - Location devices;
  - Door sensors to raise to alert staff to the person’s exit from their property;
  - Movement sensors to raise alert staff to the person’s movements within their property;
  - Verbal or physical distraction techniques used, for example, to dissuade the person from going out unaccompanied;

5.7. Within their own home
This could be a home that they own or rent themselves, or a home owned or rented by a family member or members with whom they live.

5.8. The home environment: liberty restricting measures
Almost by definition, arrangements made at home will be more varied and more flexible than arrangements made in any institutional or quasi-institutional setting. It is also more likely that, because the arrangements are likely to be more tailored to the individual, they will less obviously be directed to the control of that individual in the interests of others within a placement (whether other service users or the staff).

It is important to remember that, in the case MIG and MEG (2010) EWHC 785 (Fam), MIG (Mental health law online, case: MIG and MEG (2010) EWHC 785 (Fam)) was found to be deprived of her liberty in an adult foster placement – i.e. a home-like environment – in circumstances where the supervision and control to which she was subject was “intensive support in most aspects of daily living,” even though she attended a further education college daily during term time and was taken on trips and holidays by her foster mother.

The following features may constitute liberty-restricting measures in the home environment:
- The prescription and administration of medication to control the individual's behaviour, including on a PRN basis;
The provision of physical support with the majority of aspects of daily living, especially where that support is provided according to a timetable set not by the individual but by others;

The use of real-time monitoring within the home environment (for instance by use of CCTV or other assistive technology);

The regular use of restraint by family members or professional carers which should always be recorded in the individual’s care plan;

The door being locked, and where the individual does not have the key (or the number to a key pad) and is unable to come and go as they please, strongly suggests that they are not free to leave;

The individual regularly being locked in their room (or in an area of the house) or otherwise prevented from moving freely about the house.

Use of medication to sedate or manage behaviour, including PRN

Where a Deprivation of Liberty is identified, either the care plan must be significantly altered to remove restrictions and end the deprivation or authorisation must be obtained via a prescribed legal process. Such authorisation should be obtained via the Mental Health Act 1983 (MHA), the Deprivation of Liberty Safeguards 2009 (DoLS) or via an application to the Court of Protection (CoP). The CCGs should be able to seek assurance from commissioned services that they are compliant with the DoLS framework and CoP requirements. This includes providers of Continuing Health Care Services (CHC) and NHS Funded Care.

As Supervisory Bodies, local authorities have established MCA DoLs policies and procedures which clearly outline expectations of NHS hospital providers and care homes, as Managing Authorities (MA) to apply for a DoLS.

Any unauthorised deprivations carry with it a potential risk of litigation. If a CCG identifies via its commissioned services that such a risk exists, this should be included on the risk register and an action plan to address the risk developed and reviewed in accordance with the CCG Risk management arrangements.

6. Governance and Accountability

The CCG is responsible for having assurance that providers have arrangements in place to meet their statutory requirements as well as service contract standards, and that these are being complied with. CCGs are to assure themselves that commissioned services are compliant with MCA DoLS, and should receive regular reports and updates to this effect. The CCG will also need assurance about effective leadership, commissioning and governance through:

- Ensuring all commissioned services are fully aware of their local and statutory responsibilities regarding compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs)
- Ensuring that commissioning, contracting, contract monitoring and quality assurance processes fully reflect this
- Ensuring service specifications, invitations to tender and service contracts fully reflect MCA and MCA DoLS requirements as outlined in this policy with specific reference to the clear standards for service delivery.
- Ensuring a system is in place for escalating risks.

7. Duties and Responsibilities

<table>
<thead>
<tr>
<th>Council of Practices</th>
<th>The council of practices has delegated responsibility to the governing body (GB) for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Chief Officer</td>
<td>The Chief Officer as the Accountable Officer has overall responsibility for the strategic direction and operational management, including ensuring that process documents comply with all legal, statutory and good practice guidance requirements. The Chief Officer is accountable for ensuring that the health contribution to MCA and MCA DoLS is discharged effectively across the whole local health economy through CCG commissioning arrangements. This role is supported by the Executive Nurse who holds delegated responsibility and is the executive lead for Safeguarding Adults. The Head of Quality and Safety provides expert advice to the Governing Body on MCA and MCA DoLS matters.</td>
</tr>
</tbody>
</table>
| The Executive Lead for Safeguarding Adults | The Executive Nurse, as executive lead for safeguarding adults, MCA and MCA DoLS, will ensure that the CCG has effective professional appointments, systems, processes and structures in place, ensuring that there is a programme of training. The Executive Director is the Sponsoring Director for this policy and is responsible for ensuring that:
  - This policy is drafted, approved and disseminated in accordance with the Policy for the Development and Approval of Policies
  - The necessary training required to implement this document is identified and resourced.
  - Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this document.
  - The Chief Officer and governing body members are made aware of any concerns relating to a commissioned service.
  - The CCG has in place assurance processes to ensure compliance with MCA, MCA DoLS legislation, guidance, policy, procedures, code of practice, quality standards, and contract monitoring of providers |
| Lead Professional MCA and Dols | Accountable to Executive Director of Nursing and Transformation. Reports to Executive Director of Nursing and Transformation.  

CCGs are required to have a designated MCA Lead and MCA Dols to take a strategic and professional lead on all aspects of the NHS contribution to MCA and MCA Dols across the CCG’s area; which include all commissioned providers.  

They will  
- Provide advice and expertise to the CCG governing bodys and Safeguarding Adults Board and associated groups and to professionals across both the NHS and partner agencies.  
- Provide professional leadership, advice and support to lead adult safeguarding professionals across provider trusts/services and independent contractors.  
- Represent the CCG on relevant committees, networks and multiagency groups charged with responsibility for leadership, oversight and implementation of the MCA, MCA DoLS.  
- Lead and support the development of MCA, MCA DoLS policy, and procedures in the CCG in accordance with national, regional, local requirements.  
- Provide advice and guidance in relation to MCA, MCA DoLS training including standards.  
- Ensure quality standards for MCA, MCA DoLS are developed and included in all provider contracts and compliance is evidenced.  
- The Head of Quality and Safety will work closely with the Designated Professionals for Safeguarding Children to ensure that where appropriate there is effective information flow across both adults and children’s safeguarding teams. |
| CCG Staff | All staff, including temporary and agency staff are responsible for actively co-operating with managers in the application of this policy to enable the CCG to discharge its legal obligations and in particular:  
- Comply with the MCA and DoLS Policy.  
- Ensure they familiarise themselves with their role and responsibility in relation to the MCA and DoLS Policy.  
- Identify training needs in respect of the MCA and DoLS Policy and informing their line manager  
- Complete mandatory MCA and MCA DoLS training in accordance with the CCG Safeguarding Adult and MCA, MCA DoLS Training Plan. |
| Commissioning Support Unit (CSU) | The CCG obtains services from the Commissioning Support Unit. This arrangement provides the CCG with a resource to enable it to fulfil its statutory duties and responsibilities. The CSU will be expected to comply with the Service contract standards relating to MCA and DoLS. |
GP practices will be informed of the Service contract standards and encouraged to take account of these. The CCG in partnership with NHS England and supported by the CSU will develop a programme to support and monitor their adoption, and implementation in GP practices.

8. Implementation

This policy will be available to all Staff within the CCGs via the shared intranet and the internet sites.

8.1. Training Implications
The training required for staff to comply with this policy are:
- Mandatory Safeguarding Adults, MCA, including MCA DoLS training programme

8.2. Documentation
Other related policy documents:
- Guidance on Advance Decision to Refuse Treatment (ADRT)
- Safeguarding Adults Policy

8.3. Legislation and statutory requirements
• P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents) P and Q (by their litigation friend, the Official Solicitor) (appellants) v Surrey County Council (Respondents) [2014] UKSC 19 on appeal from: [2011] EWCA Civ 1257; [2011] EWCA Civ 190

8.4. Best practice recommendations


• Independent Safeguarding Authority (http://www.isa-gov.org.uk/)

9. Document Consultation, Approval & Ratification Process

9.1 Document Consultation

This document has been produced by the Designated Adult Safeguarding Manager on behalf of North Tyneside CCG. In preparing the document for official ratification by the Governing Body, the following stakeholders were consulted upon and their comments added to the document as appropriate:

• CCG Director and Executive Lead for Safeguarding Adults
• Designated Adult Safeguarding Manager.

9.2 Document Approval and Ratification

North Tyneside CCG Governing Body is the committee with authority for the approval and ratification of this document. The Committee has ensured that there has been appropriate consultation and has considered the content of the document in terms of current best practice, guidelines, legislation and mandatory and statutory requirements before approval. In considering the document for approval the committee also took into account the results and recommendations of the Equality Analysis.

9.3 Document Development

The Quality and Safety Committee and nominated author are responsible for the development, review, implementation, performance management and distribution of this Policy.

9.4 Version Control and Review Section

Version control of this document is the responsibility of the Executive Director of Nursing & Transformation who must ensure that timely reviews are completed.

This Policy document will be reviewed at least every three years by the CCG Safeguarding Adults or as and when significant changes make earlier review necessary.
10. Monitoring Compliance with this policy

North Tyneside CCG will monitor compliance with this policy - see table below.

<table>
<thead>
<tr>
<th>No.</th>
<th>Monitoring/audit arrangements of compliance with policy and methodology</th>
<th>Source</th>
<th>Reporting Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Safeguarding Adults training (CCG staff).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of training data.</td>
<td>CCG data.</td>
<td>CCG Quality and safety Committee.</td>
<td>Quarterly</td>
</tr>
<tr>
<td>2.</td>
<td>CCG Risk register:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Standards from Provider Performance Dashboard (developed by CCG for Providers from whom they commission services).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of data provided.</td>
<td>Provider performance dashboard</td>
<td>Quality and safety Committee.</td>
<td>Quarterly</td>
</tr>
<tr>
<td>4.</td>
<td>Providers compliance MCA and Dols:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review provider compliance with training.</td>
<td>Local Authority and other partner agencies. General public and patients.</td>
<td>Quality and safety Committee.</td>
<td></td>
</tr>
</tbody>
</table>
11. Equality Impact Assessment

A full Equality Impact Assessment has been completed.
## Appendix 1

### Deprivation of Liberty Action Plan

<table>
<thead>
<tr>
<th>Issue</th>
<th>Objective</th>
<th>Action</th>
<th>Lead</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raising Staff awareness of the Supreme Court Ruling 'Cheshire West' implications.</td>
<td>Ensure CHC assessors are aware of the implications in relation to CCG funded packages.</td>
<td>Take legal advice from legal services Training could be provided by CCG Safeguarding Adults Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review which cases need to be referred to relevant Supervisory Body for DoLS</td>
<td>Identify cases which can be authorised via Deprivation of Liberty Safeguards process</td>
<td>CHC funded cases in Care homes can be authorised via the DoLS safeguards – this function was transferred to Local Authorities in April 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify Which CHC funded care packages in their own homes, etc have capacity to consent</td>
<td>Ensure consent is recorded for CHC funded care packages where recipients have mental capacity</td>
<td>CHC assessors to identify which service users have the capacity to consent to their care packages and record their consent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review care packages of CHC funded care at home, ISL or foster/adult placements</td>
<td>Care packages need to be reviewed to see is restrictions could be removed</td>
<td>CHC assessors should explore less restrictive ways of delivering care to negate the risk of a deprivation of liberty occurring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify potential deprivations of liberty that need authorisation form the Court of Protection</td>
<td>Create a substantive list of cases likely to meet the ‘acid test’ that stand in need of an application to the Court of Protection</td>
<td>Notify CCG reference overview of cases and consider next steps. Take Legal advice on how to proceed. Draw up a priority risk which targets those most likely deprived first Identify costs of court proceedings and potential funding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan for the increase in Section 117 budget demand</td>
<td>Ensure there is sufficient resource to cover an increase in S117 funded care</td>
<td>Discuss with Local Authority arrangements for Joint Funded packages The Supreme Court Ruling has led to an increase in MHA detentions which has a knock on effect of more people entitled to Section 117 aftercare and this will create budget growth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2

ADASS TASK FORCE

A Screening tool to prioritise the allocation of requests to authorise a deprivation of liberty

Due to the vast increase in demand for assessments under the Deprivation of liberty safeguards the ADASS task force members have shared practice in relation to prioritisation and produced this screening tool. The aim of the tool is to assist Councils to respond in a timely manner to those requests which have the highest priority. The tool sets out the criteria most commonly applied which indicates that an urgent response may be needed so as to safeguard the individuals concerned. The use of this tool must be balanced against the legal criteria for the Deprivation of Liberty Safeguards which remains unchanged. The criteria should be used as an indicative guide only as it will generally be based on information provided by the Managing Authority in the application and each case must be judged on its own facts.

<table>
<thead>
<tr>
<th>HIGHER</th>
<th>MEDIUM</th>
<th>LOWER</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Psychiatric or Acute Hospital and not free to leave</td>
<td>• Asking to leave but not consistently</td>
<td>• Minimal evidence of control and supervision</td>
</tr>
<tr>
<td>• Continuous 1:1 care during the day and / or night</td>
<td>• Not making any active attempts to leave</td>
<td>• No specific restraints or restrictions being used. E.g. in a care home not objecting, no additional restrictions in place.</td>
</tr>
<tr>
<td>• Sedation/medication used frequently to control behaviour</td>
<td>• Appears to be unsettled some of the time</td>
<td>• Have been living in the care home for some time (at least a year)</td>
</tr>
<tr>
<td>• Physical restraint used regularly – equipment or persons</td>
<td>• Restraint or medication used infrequently.</td>
<td>• Settled placement in care home/hospital placement, no evidence of objection etc. but may meet the requirements of the acid test.</td>
</tr>
<tr>
<td>• Restrictions on family/friend contact (or other Article 8 issue)</td>
<td>• Appears to meet some but not all aspects of the acid test</td>
<td>• End of life situations, intensive care situations which may meet the acid test but there will be no benefit to the person from the Safeguards</td>
</tr>
<tr>
<td>• Objections from relevant person (verbal or physical)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Objections from family /friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Attempts to leave</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Confinement to a particular part of the establishment for considerable period of time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• New or unstable placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Possible challenge to Court of Protection, or Complaint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Already subject to DoL about to expire</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CASE NO:</td>
<td>DATE:</td>
<td>PRIORITISED BY:</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
<td>-----------------</td>
</tr>
<tr>
<td>SUMMARY OF CRITERIA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALLOCATED PRIORITY:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Corporate**

---

**CCG CO10 Mental Capacity Act Policy**

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Date Issued</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 (draft 3)</td>
<td>November 2016</td>
<td>November 2019</td>
</tr>
</tbody>
</table>

**Prepared By:** Joint Commissioning Manager.

**Consultation Process:**

CCG Executive Director of Nursing & Transformation and Safeguarding Professionals for North Tyneside CCG. North Tyneside CCG Quality and Safety committee

**Formally Approved:** DATE TBC

**Policy Adopted From:**

North Tyneside CCG Mental Capacity Act Policy (v1, 2013) and Newcastle Gateshead CCG MCA Policy (2015)

**Approval Given By:** North Tyneside CCG Governing Body

### Document History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Significant Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version 1</td>
<td>12.11.15</td>
<td>First Issue</td>
</tr>
<tr>
<td>Version 2</td>
<td>01.11.16</td>
<td>Scheduled review</td>
</tr>
</tbody>
</table>

### Equality Impact Assessment

<table>
<thead>
<tr>
<th>Date</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 October 2015</td>
<td>None identified</td>
</tr>
</tbody>
</table>

**POLICY VALIDITY STATEMENT**

This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.
Table of Contents

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1. Introduction

The North Tyneside Clinical Commissioning Group (CCG) aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients, their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the CCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

The impact of the Mental Capacity Act 2005 (MCA) for CCGs is in relation to Commissioner’s duties to ensure provider services are delivered in accordance with the MCA and that the rights of those who use services are promoted and protected. The CCG has responsibility for commissioning high quality care and treatment. The CCG must ensure providers understand the MCA, apply it to practice and monitor compliance.

Fundamentally the CCG will need to ensure that;

- The MCA is given a high profile and priority within the CCG
- Compliance and how this will be achieved is a key part of the tendering process
- On-going compliance is monitored in detail through performance review and quality monitoring processes.

The main policy covers the areas outlined in the Department of Health Code of Practice.

The Governing Body and Accountable Officer of the CCG are committed to the development of a just and fair “no blame” culture, and this document supports that ethos.

The preparation of this document has included an assessment of risk covering clinical, financial, business and operational risks arising specifically from the implementation of the procedures described herein.

The preparation of this document has included an assessment against equality and diversity requirements and Human Rights considerations, to ensure that there is no direct or indirect discrimination against individuals or groups of persons and that no human rights are unlawfully restricted.

1.1 Status
This policy is a corporate policy

1.2 Purpose and scope
To outline the responsibilities of the CCG in applying the Mental Capacity Act Code of Practice, with regard to ensuring that as Commissioners of services, these responsibilities are also adopted by those that we commission services from.
2. Definitions

2.1 The following terms and abbreviations are used within this document:

<table>
<thead>
<tr>
<th>Reference</th>
<th>Abbreviated Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act</td>
<td>MCA</td>
</tr>
<tr>
<td>Mental Health Act</td>
<td>MHA</td>
</tr>
<tr>
<td>Independent Mental Capacity Advocate</td>
<td>IMCA</td>
</tr>
<tr>
<td>Office of the Public Guardian</td>
<td>OPG</td>
</tr>
<tr>
<td>Court of Protection</td>
<td>CoP</td>
</tr>
<tr>
<td>Lasting Power of Attorney</td>
<td>LPA</td>
</tr>
<tr>
<td>Enduring Power of Attorney</td>
<td>EPA</td>
</tr>
<tr>
<td>Advance Decision to refuse treatment</td>
<td>ADRT</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>GP</td>
</tr>
</tbody>
</table>

2.2 Definition of Mental Capacity

A person lacks capacity at a certain time if they are unable to make a decision for themselves in relation to a matter, because of impairment, or a disturbance in the functioning of the mind or brain.

An impairment or disturbance in the brain could be as a result of (not an exhaustive list):

- A stroke or brain injury
- A mental health problem
- Dementia
- A significant learning disability
- Confusion, drowsiness or unconsciousness because of an illness or treatment for it
- The effects of drugs and/or alcohol
- Delirium

Lacking capacity is about a particular decision at a certain time, not a range of decisions. If someone cannot make complex decisions it does not mean they cannot make simple decisions.

It does not matter if the impairment or disturbance is permanent or temporary but if the person is likely to regain capacity in time for the decision to be made, delay of the decision should be considered. Therefore Capacity Testing may be required at various periods.
Capacity cannot be established merely by reference to a person’s age, appearance or condition or aspect of their behaviour, which might lead others to make an assumption about their capacity. An assumption that the person is making an unwise decision must be objective and related to the person’s cultural values.

Lack of Capacity must be established following the processes outlined in Appendix A.

3. **Mental Capacity Act Principles**

3.1 The MCA provides legal protection from liability for carrying out certain actions in connection with care and treatment of people provided that:

- You have observed the principles of the MCA
- You have carried out, or been party to, an assessment of capacity and reasonably believe that the person lacks capacity in relation to the matter in question and;
- You reasonably believe the action you have taken is in the best interests of the person

3.2 Provided you have complied with the MCA in assessing capacity and acting in the person’s best interests you will be able to diagnose and treat patients who do not have the capacity to give their consent. For example (not an exhaustive list):

- Diagnostic examinations and tests
- Assessments
- Medical and dental treatment
- Surgical procedures
- Admission to hospital for assessment or treatment (except for people detained under the Mental Health Act 2007 (MHA))
- Nursing care
- Emergency procedures – in emergencies it will often be in a person’s best interests for you to provide urgent treatment without delay under the common law doctrine of necessity/emergency.
- Placements in residential care
3.3 There are five key principles underpinning the MCA as follows:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not unable to make a decision unless all steps have been taken unsuccessfully.
3. A person is not unable to make a decision merely because he makes an unwise decision.
4. An act/decision made behalf of a person who lacks capacity must be in his best interests.
5. Before the act or decision, ensure it is achieved in the least restrictive way.

3.4 The Mental Capacity Act applies to all people over the age of 16, with the exception of making a lasting power of attorney (LPA); making an advance decision to refuse treatment and making a will; in these situations, a person must be aged 18 or over.

The Act also introduces new bodies and regulations that staff must be aware of including:

- The Independent Mental Capacity Advocate (section a)
- The Office of the Public Guardian (section b)
- The Court of Protection (section c)
- Advance Decisions to refuse treatment (section d)
- Lasting Powers of Attorneys (section e)

3.5 The Independent Mental Capacity Advocate (IMCA)

3.5.1 Advocacy is taking action to help people:

- Express their views
- Secure their rights
- have their interests represented
- access information and services
- explore choices and options

3.5.2 Advocacy promotes equality, social justice and social inclusion. Therefore an IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker.
3.5.3 Referrals to an IMCA **MUST** be considered when:

- There needs to be a decision relating to serious medical treatment.
- Changes in long-term care (more than 28 days in a hospital or 8 weeks in a care home)
- A long-term move to different accommodation is being considered for a period of over 8 weeks

Referrals to an IMCA **MAY** be considered when

- Care Reviews take place – if the IMCA would provide a particular benefit e.g. continuous care reviews about accommodation or changes to accommodation.
- Adult protection cases take place even if befriended.

3.5.4 If a decision is to be made in relation to any of the above statutory areas (apart from emergency situations) an IMCA **MUST** be instructed **PRIOR** to the decision being made. If it is urgent then the decision can be taken without an IMCA but they must be instructed afterwards.

3.5.5 If, after consultation with your line manager, you consider appointment of an IMCA would be of particular benefit to an individual then a referral must be made as outlined within Appendix A.

3.5.6 It is important to remember that an IMCA is not a decision maker for a person who lacks capacity but to support the person who lacks capacity and represent their views and interests to the decision maker, nor are they mediators between parties in dispute.

3.5.7 The IMCA will prepare a report for the person who instructed them and if they disagree with the decision made they can also challenge the decision maker.

3.6 **The Office of the Public Guardian (OPG)**

3.6.1 This exists to help protect people who lack capacity by setting up a register of Lasting Powers of Attorney; Court appointed Deputies; receiving reports from Attorneys acting under LPAs and from Deputies; and providing reports to the Court of Protection, as requested.

3.6.2 The OPG can be contacted to carry out a search on three registers which they maintain, these being registered LPAs, registered EPAs and the register of Court orders appointing Deputies. Application to search the registers costs **£25.00**

3.6.3 Further information regarding the Office of the Public Guardian can be found by the following link:

http://www.publicguardian.gov.uk/
3.7 The Court of Protection (CoP)

3.7.1 This is a specialist court for all issues relating to people who lack capacity to make specific decisions. The Court makes decisions and appoints Deputies to make decisions in the best interests of those who lack capacity to do so.

3.7.2 The Act provides for a new CoP to make decisions in relation to the property and affairs and healthcare and personal welfare of adults (and children in a few cases) who lack capacity. The Court also has the power to make declarations about whether someone has the capacity to make a particular decision. The Court has the same powers, rights, privileges and authority in relation to mental capacity matters as the High Court. It is a superior court of record and is able to set precedents (set examples to follow in future cases).

3.7.3 The Court of Protection has the powers to:

- decide whether a person has capacity to make a particular decision for themselves; make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions;
- appoint deputies to make decisions for people lacking capacity to make those decisions;
- decide whether an LPA or EPA is valid; and remove deputies or attorneys who fail to carry out their duties;
- and hear cases concerning objections to register an LPA or EPA and make decisions about whether or not an LPA or EPA is valid.

3.7.4 Details of the fees charged by the court, and the circumstances in which the fees may be waived or remitted, are available from the Office of the Public Guardian.

3.7.5 Further information regarding the Court of Protection can be accessed via the Office of the Public Guardian website and the following link:

http://www.hmcourts-service.gov.uk/HMSCourtFinder/

3.7.6 It must be stressed that any reference to the Court of Protection must be discussed with the Equality & Human Rights service in the first instance. The CCG must ensure that all informal and formal internal mechanisms be exhausted before making any application to the Court of Protection. This is outlined in Appendix A.
3.8 **Advance Decisions to Refuse Treatment (ADRT)**

3.8.1 A person may have given advance decisions regarding health treatments, which will relate mainly to medical decisions. These should be recorded in the person’s file where there is knowledge of them. These may well be lodged with the person’s GP and are legally binding if made in accordance with the Act.

3.8.2 If over the age of 18 years, a person making an advance decision to refuse treatment allows their decision about particular types of treatment, to be honoured in the event of losing capacity. This is legally binding and doctors and other healthcare professionals must follow directions.

3.8.3 You must take all reasonable efforts to be aware of the advance decision and that it exists, is valid and applicable to the particular treatment in question.

3.8.4 The Act introduces a number of rules to follow. Therefore a person should check that their current advance decision meets the rules if it is to take effect.

3.8.5 An advance decision need not be in writing although it is more helpful. For life sustaining treatment (treatment needed to keep a person alive and without which they may die) this must be in writing.

3.8.6 Life sustaining advance decisions must:

- Be in writing
- Contain a specific statement, which says your decision applies even though your life may be at risk
- Signed by the person or nominated appointee and in front of a witness
- Signed by the witness in front of the person

This does not change the law on euthanasia or assisted suicide. You cannot ask for an advance decision to end your life or request treatment in future.

3.8.7 The validity of an advance decision may be challenge on the following grounds;

- If the Advance Decision is not applicable to this treatment decision
- If it is treatment for a mental disorder, treatment could be given under the Mental Health Act is the criteria for admission are met.
- If the relevant person changes their mind
- If they do a subsequent act that contradicts the Advance Decision
- They have appointed an LPA for Health and Welfare after the date of the Advance Decision
3.9 Lasting Powers of Attorney (LPA)

3.9.1 This is where a person with capacity appoints another person to act for them in the eventuality that they lose capacity at some point in the future. This has far reaching effects for healthcare workers because the MCA extends the way people using services can plan ahead for a time when they lack capacity. These are Lasting Powers of Attorney (LPAs), advance decisions to refuse treatment and written statement of wishes and feelings. LPAs can be friends, relatives or a professional for:

- Property and affairs LPA re financial and property matters
- Personal Welfare LPA re decisions about health and welfare, where you live day to day care or medical treatment.

This must be recorded in the person’s file where there is knowledge of it. It only comes into effect after the person loses capacity and must be registered with the Office of the Public Guardian. An LPA can only act within the remit of their authority.

3.9.2 Important facts about LPAs

- Enduring Powers of Attorney (EPAs) will continue whether registered or not.
- When a person makes an LPA they must have the capacity to understand the importance of the document.
- Before an LPA can be used it must be registered with the Office of the Public Guardian.
- An LPA for property and affairs can be used when the person still has capacity unless the donor specifies otherwise.
- A personal welfare attorney will have no power to consent to, or refuse treatment whilst a person has the capacity to decide for themselves.
- If a person is in your care and has an LPA, the attorney will be the decision maker on all matters relating to a person’s care and treatment.
- If the decision is about life sustaining treatment the attorney will only have the authority to make the decision if the LPA specifies this.
- If you are directly involved in care or treatment of a person you should not agree to act as an attorney.
- It is important to read the LPA to understand the extent of the attorney’s power.
3.10 Clinical Intervention

3.10.1 Decisions that are not covered by the MCA:

- Making a will
- Making a gift (unless they have a finance LPA)
- Entering into a contract
- Entering into litigation
- Entering into marriage
- Consenting to Sexual Relationships
- Divorce
- Adoption
- Voting or standing for office

3.10.2 There must always be an assumption of capacity. Procedural guidance at Appendix A tells a practitioner what to do if it is suspected that a vulnerable person has a disturbance in the function of the mind or brain and may lack capacity to make a decision at this particular time. The second test, often referred to as the Functional Test, supports assessors to determine whether or not the patient can make the decision or lacks the mental capacity to do so.

3.10.3 It is recognised that a number of different professionals are involved with persons who may lack capacity and in certain circumstances may be required to make decisions on their behalf, as long as they decisions they make are within their job remit.

3.10.4 The extent to which expert input is required, and the degree to which detailed recording is necessary, depends on the nature of the decisions being made. Some decisions will be day to day, such as what to wear, and other decisions many have more lasting or serious consequences such as a change of accommodation.

3.10.5 Practitioners have to show that they

- have followed the five key principles which must inform everything you do when providing care or treatment for a person who lacks capacity,
- have enabled a person, so far as is possible, to make their own decisions
- have taken reasonable steps to establish lack of capacity,
- have reasonable belief that the person lacks capacity,
- have demonstrated their action will be in the person’s best interest.

3.10.6 Section 5 of the Act offers statutory protection from liability where a person is performing an act in connection with the care or treatment of someone who lacks capacity, provided they have followed due process. Appendix A covers the procedure required.
## 4. Duties and Responsibilities

<table>
<thead>
<tr>
<th>Council of Practices</th>
<th>The council of practices has delegated responsibility to the governing body (GB) for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.</th>
</tr>
</thead>
</table>
| The Chief Officer    | The Chief Officer as the Accountable Officer has overall responsibility for the strategic direction and operational management, including ensuring that process documents comply with all legal, statutory and good practice guidance requirements.  

The Chief Officer is accountable for ensuring that the health contribution to MCA and MCA DoLS is discharged effectively across the whole local health economy through CCG commissioning arrangements.

This role is supported by the Executive Nurse who holds delegated responsibility and is the executive lead for Safeguarding Adults. The Head of Quality and Safety provides expert advice to the Governing Body on MCA and MCA DoLS matters. |
| The Executive Lead for Safeguarding Adults | The Executive Lead for safeguarding adults

The Executive Nurse, as executive lead for safeguarding adults, MCA and MCA DoLS, will ensure that the CCG has effective professional appointments, systems, processes and structures in place, ensuring that there is a programme of training. The Executive Director is the Sponsoring Director for this policy and is responsible for ensuring that:

- This policy is drafted, approved and disseminated in accordance with the Policy for the Development and Approval of Policies
- The necessary training required to implement this document is identified and resourced.
- Mechanisms are in place for the regular evaluation of the implementation and effectiveness of this document.
- The Chief Officer and governing body members are made aware of any concerns relating to a commissioned service.
- The CCG has in place assurance processes to ensure compliance with MCA, MCA DoLS legislation, guidance, policy, procedures, code of practice, quality standards, and contract monitoring of providers |
### Lead Professional MCA and Dols

Accountable to Executive Director of Nursing and Transformation.
Reports to Executive Director of Nursing and Transformation.

CCGs are required to have a designated MCA Lead and MCA DoLs lead to take a strategic and professional lead on all aspects of the NHS contribution to MCA and MCA DoLs across the CCG area; which include all commissioned providers.

The lead will

- Provide advice and expertise to the CCG governing body and Safeguarding Adults Board and associated groups and to professionals across both the NHS and partner agencies.
- Provide professional leadership, advice and support to lead adult safeguarding professionals across provider trusts/services and independent contractors.
- Represent the CCG on relevant committees, networks and multiagency groups charged with responsibility for leadership, oversight and implementation of the MCA, MCA DoLS.
- Lead and support the development of MCA, MCA DoLS policy, and procedures in the CCG in accordance with national, regional, local requirements.
- Provide advice and guidance in relation to MCA, MCA DoLS training including standards.
- Ensure quality standards for MCA, MCA DoLS are developed and included in all provider contracts and compliance is evidenced.
- The Head of Quality and Safety will work closely with the Designated Professionals for Safeguarding Children to ensure that where appropriate there is effective information flow across both adults and children’s safeguarding teams.

### CCG Staff

All staff, including temporary and agency staff are responsible for actively co-operating with managers in the application of this policy to enable the CCG to discharge its legal obligations and in particular:

- Comply with the MCA and DoLS Policy.
- Ensure they familiarise themselves with their role and responsibility in relation to the MCA and DoLS Policy.
- Identify training needs in respect of the MCA and DoLS Policy and informing their line manager
- Complete mandatory MCA and MCA DoLS training in accordance with the CCG Safeguarding Adult and MCA, MCA DoLS Training Plan.

### Commissioning Support Unit (CSU)

The CCG contracts with a Commissioning Support Unit. This arrangement provides the CCG with a resource to enable it to fulfil its statutory duties and responsibilities. The CSU will be expected to comply with the Service contract standards relating to MCA and DoLS.
Primary Medical Services (GP practices)  
GP practices will be informed of the Service contract standards and encouraged to take account of these. The CCG in partnership with NHS England and supported by the CSU will develop a programme to support and monitor their adoption, and implementation in GP practices.

5. Implementation

5.1 This policy will be available to all Staff for use in the circumstances described on the title page.

5.2 All managers are responsible for ensuring that relevant staff within the CCG have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

6. Training Implications

The training required to comply with this policy are:
- Policy awareness sessions
- Mandatory training programme
- E-learning
- Multi-Agency training is available from the Local Authority

7. Documentation

7.1 Other related policy documents.
- Guidance on Advance Decision to Refuse Treatment (ADRT)
- Safeguarding Vulnerable Adults Policy.
7.2 Legislation and statutory requirements


7.3 Best practice recommendations

Document and Records Management Policy v3.0 NHSE Feb 2014

NHSLA Risk Management Standards 2013-2014


Independent Safeguarding Authority (http://www.isa-gov.org.uk/)

Ruck Keene, Alex and Dobson, Catherine (April 2014) Mental Capacity Law: Guidance Note. Deprivation of Liberty in the Hospital Setting. London: 39 Essex Street

Social Care, Local Government and Care partnership (2014). Positive and Proactive Care: Reducing the need for restrictive interventions. London: Department of Health

8. Monitoring, Review and Archiving

North Tyneside CCG will monitor compliance with this policy - see table below.

<table>
<thead>
<tr>
<th>No.</th>
<th>Monitoring/audit arrangements of compliance with policy and methodology</th>
<th>Reporting Source</th>
<th>Committee</th>
<th>Frequency</th>
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<tr>
<td>1.</td>
<td>Safeguarding Adults training (CCG staff). Review of training data.</td>
<td>CCG data.</td>
<td>CCG Quality and safety Committee.</td>
<td>Quarterly</td>
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<td>Performance</td>
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<td>Dashboard.</td>
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<td>Serious Incidents.</td>
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<tr>
<td>3.</td>
<td>Standards from Provider Performance Dashboard (developed by CCG for Providers from whom they commission services). Review of data provided.</td>
<td>Provider performance dashboard</td>
<td>Quality and safety Committee.</td>
<td>Quarterly</td>
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<td>4.</td>
<td>Providers compliance MCA and Dols: Review provider compliance with training.</td>
<td>Local Authority and other partner agencies.</td>
<td>Quality and safety Committee.</td>
<td></td>
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</tbody>
</table>
Equality Analysis

A full Equality Impact Assessment has been completed

EIA - MCA Policy (2).doc
Appendix A

Decision maker suspect’s person may have a condition that affects capacity to make a decision regarding specific care or treatment at that specific time.

Assess for possible lack of capacity using the functional test.

Is it possible that the person may regain capacity in the future?

Yes

Can the decision be delayed?

Yes

Delay decision until person regains capacity

No

No has

Consult with person in appropriate format so that he/she can reach decision him/herself

No

Does the person have a current Advanced Decision directly applicable to the care/treatment in question?

Yes

Consult with LPA or Court Appointed Deputy for them to make decision on behalf of person

No

Conduct Functional Capacity Test and a Best Interest Assessment – convene a Best Interest Meeting with applicable family or an IMCA.

Act in accordance to the Advanced Decision

Make decisions regarding treatment/care

Decisions made at Best Interest Meeting challenged?

Yes

Discuss reasons for challenge informally, aim for swift resolution - advise upon mechanisms for formal challenge if informal resolution not possible

Informal resolution achieved?

Yes

No

Informal resolution achieved?

Commence formal Corporate Complaints procedure

Refer decision to the Court of Protection

No

Does the person have a LPA or Court Appointed Deputy?

Yes

No

Can the decision be delayed?

Yes

No

Can the decision be delayed?

Yes

No

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Informal resolution achieved?

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Refer decision to the Court of Protection

No

Does the person have a LPA or Court Appointed Deputy?

Yes

No

Can the decision be delayed?

Yes

No

Does the person have a current Advanced Decision directly applicable to the care/treatment in question?

Yes

Consult with LPA or Court Appointed Deputy for them to make decision on behalf of person

No

Conduct Functional Capacity Test and a Best Interest Assessment – convene a Best Interest Meeting with applicable family or an IMCA.

Act in accordance to the Advanced Decision

Make decisions regarding treatment/care

Decisions made at Best Interest Meeting challenged?

Yes

Discuss reasons for challenge informally, aim for swift resolution - advise upon mechanisms for formal challenge if informal resolution not possible

Informal resolution achieved?

Yes

No

Informal resolution achieved?

Commence formal Corporate Complaints procedure

Refer decision to the Court of Protection

No
Corporate

CO19: Standards of Business Conduct and Declarations of Interest Policy

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Date Issued</th>
<th>Review Date</th>
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<td>V4 Draft 4</td>
<td>November 2016</td>
<td>November 2018</td>
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Prepared By: Senior Governance Manager, North of England Commissioning Support

Consultation Process: NHS North Tyneside CCG Quality and Safety Committee

Formally Approved: Governing Body

Policy Adopted From: Existing Policy

Approval Given By: Governing Body

Document History

<table>
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<th>Significant Changes</th>
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<td>1</td>
<td>25/01/13</td>
<td>First Issue</td>
</tr>
<tr>
<td>2</td>
<td>01/05/14</td>
<td>Removal of redundant web-links and revision to Appendix C</td>
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<tr>
<td>3</td>
<td>05/01/15</td>
<td>Updated to take into account new guidance issued by NHS England on 18 December 2014</td>
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<tr>
<td>4</td>
<td>14/07/16</td>
<td>Updated to take into account new guidance “Managing Conflicts of Interest: Revised Statutory Guidance for CCGs” issued by NHS England on 28 June 2016</td>
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Equality Impact Assessment

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<th>Date</th>
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<tr>
<td>July 2016</td>
<td>Please see Section 17 of this document</td>
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POLICY VALIDITY STATEMENT
This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.
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1. **Introduction, Aims and Objectives**

1.1 For the purposes of this policy, NHS North Tyneside Clinical Commissioning Group will be referred to as “the CCG”.

1.2 The purpose of this policy is to ensure exemplary standards of business conduct are adhered to, as public servants, by Governing Body members, committee and sub-committee members and employees of the CCG (as well as individuals contracted to work on behalf of the CCG or otherwise providing services or facilities to the CCG such as those within commissioning support services). Through this Policy individuals will be aware of their own responsibilities as well as the CCG’s responsibilities as corporate bodies (including the constituent Member Practices). The Policy also sets out the responsibilities of the CCG as an employer, especially in light of the individual and corporate obligations set out in the Bribery Act 2010.

1.3 Importantly, the policy draws attention to the consequences of non-compliance with its requirements which may include disciplinary action and/or legal action.

1.4 The production of this policy draws on the wide range of guidance issued over the years for NHS bodies in relation to this important matter and to guidance published specifically for Clinical Commissioning Groups.

2. **Guidance and Legal Framework**

2.1 The NHS Management Executive published guidance, “Standards of business conduct for NHS staff”, (HSG (93) 5), which remains extant and which provides specific guidance on:

- The standards of conduct expected of all NHS staff where their private interests may conflict with their public duties; and
- The steps which NHS employers should take to safeguard themselves and the NHS against conflicts of interest.

Specifically, it makes it clear that it is the responsibility of staff to ensure that they are not placed in a position which risks, or appears to risk, conflict between their private interests and their NHS duties.

2.2 The Department of Health’s document, “Code of Conduct for NHS Managers”, (October 2002), provides guidance on core standards of conduct expected of NHS Managers to act in the best interests of the public and patients/clients to ensure that decisions are not improperly influenced by gifts or inducements. Professional Codes of Conduct governing health care professionals are also pertinent. Similarly, the General Medical Council’s guidance, “Leadership and management for all doctors” (March 2012), details the standards and expectations required of clinicians in leadership and management positions.
2.3 CCGs should observe the principles of good governance as set out in:

- The Nolan Principles
- The Good Governance Standards for Public Services (2004), Office for Public Management (OPM) and Chartered Institute of Public Finance and Accountancy (CIPFA) sets out the principles of good governance.
- The seven key principles of the NHS Constitution
- The Equality Act 2010
- The UK Corporate Governance Code

2.4 The underpinning legal framework is provided by the Bribery Act 2010, which repeals the Prevention of Corruption Acts, and which:

- creates two general offences covering the offering, promising or giving of an advantage, and requesting, agreeing to receive or accepting an advantage,
- creates a new offence of failure by a commercial organisation to prevent a bribe being paid for or on its behalf (it will be a defence though if the organisation has adequate procedures in place to prevent bribery),
- Bribery is defined as giving someone a financial or other advantage to encourage that person to perform their functions or activities improperly or to reward that person for having already done so.

Any employee breaching the provisions of this Act will be liable to prosecution which may also lead to the loss of their employment and superannuation rights in the NHS.

2.5 Section 25 of Health and Social Care Act 2012 imposes duties on CCGs in relation to maintaining registers of interest and managing conflicts of interest. Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) (“the Act”) sets out the minimum requirements of what both NHS England and CCGs must do in terms of managing conflicts of interest. The guidance in the Act is supplemented by the procurement specific requirements set out in the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Further guidance has been set out in Managing conflicts of interest: statutory guidance for CCGs (June 2016)¹ published by NHS England and issued under sections 14O and 14Z8 of the Act. This supersedes the previously issued NHS England guidance for CCGs. This new document includes guidance for CCGs when commissioning primary care services, either under joint commissioning or delegated commissioning arrangements.

2.6 The aims of the guidance are to:

- enable CCGs and clinicians in commissioning roles to demonstrate that they are acting fairly and transparently and in the best interest of their patients and local populations;
- ensure that CCGs operate within the legal framework, but without being bound by over-prescriptive rules that risk stifling innovation;
- safeguard clinically led commissioning, whilst ensuring objective investment decisions;
- provide the public, providers, Parliament and regulators with confidence in the probity, integrity and fairness of commissioners' decisions; and
- uphold the confidence and trust between patients and GP, in the recognition that individual commissioners want to behave ethically but may need support and training to understand when conflicts (whether actual or potential) may arise and how to manage them if they do.

2.7 This policy has been produced taking into account all of the current guidance and legal framework.

3. Application of Public Service Values and Principles to the NHS

3.1 Public service values must be at the heart of the NHS. High standards of corporate and personal conduct, based on recognition that patients come first, have been a requirement throughout the NHS since its inception. Moreover, since the NHS is publicly funded it is accountable to Parliament for the services it provides and for the effective and economic use of taxpayers' money.

3.2 The Code of Conduct: Code of Accountability in the NHS (Appointments Commission/DOH - 2nd Rev: 2004) defines three crucial public service values which must underpin the work of the health service:

- **Accountability** – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- **Probity** – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of NHS duties.
- **Openness** – there should be sufficient transparency about NHS activities to promote confidence between the NHS body and its staff, patients and the public.

3.3 Following the findings of the Nolan Committee in 1994, a set of recommendations was published by the government setting out 'Seven Principles of Public Life' which apply to all in the public service and which are embodied within the CCG’s Constitution. These are attached in Appendix A.
3.4 Standards for members of NHS Boards and Clinical Commissioning Groups governing bodies in England
http://www.professionalstandards.org.uk/publications/detail/standards-for-members-of-nhs-boards-and-clinical-commissioning-group-governing-bodies-in-england have also been set out by the Professional Standards Authority for Health and Social Care which members of the governing body and members of committees should observe in conduct of the CCG’s business.

4. Appointments and Roles and Responsibilities

4.1 NHS employers

The CCG is responsible for ensuring that the requirements of this policy and supporting documents are brought to the attention of all employees and contractors and that machinery is put in place for ensuring that the guidelines are effectively implemented. These responsibilities are particularly important given the corporate responsibility set out in the Bribery Act for organisations to ensure that their anti-corruption procedures are robust.

Such awareness will be promoted in:

- A clause in written statements of terms and conditions of employment.
- Publication on the CCG’s intranet site for staff.

4.2 NHS staff

NHS staff are expected to:

- Ensure that the interests of patients remain paramount at all times.
- Be impartial and honest in the conduct of their official business.
- Use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.
- Register with the CCG any interest outside the workplace which could be construed as affecting any part of their work within the CCG.

It is also the responsibility of staff to ensure that they do not:

- Abuse their official position for personal gain or to benefit their family or friends;
- Seek to advantage or further private business or other interests, in the course of their official duties

It is the responsibility of all staff to raise any concerns regarding staff business conduct.

All NHS staff should ensure that they are not placed in a position that risks, or appears to risk, conflict between their private interests and their NHS duties.
4.3 **Member Practices, Governing Body and Committee/Sub-Committee Members and individuals acting on behalf of the CCG.**

Governing Body, Committee/Sub-Committee Members and individuals acting on behalf of the CCG (and its constituent Member Practices), must act in accordance with this policy in circumstances whether they are either employed fully by the CCG, hold appointments with the CCG, are employed on a sessional basis or on an honorary contract, or provide services under a service level agreement with the CCG.

Member Practices and individuals of those individual Member Practices acting on their behalf in exercise of the CCG’s commissioning functions must act in accordance with this policy.

4.4 **CSU Staff**

Whilst working on behalf of the CCG, CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the CCG, however they will continue to be governed by all policies and procedures.

4.5 **Candidates for appointment**

Candidates for any appointment with the CCG must disclose in writing if they are related to or in a significant relationship with (e.g. spouse or partner) any Governing Body member or employee of the CCG. The NHS Jobs application form requests this information and therefore must be disclosed before submission.

A member of an appointment panel which is to consider the employment of a person to whom he/she is related must declare the relationship before an interview is held.

Candidates for any appointment with the CCG shall, when applying, also disclose cases where they or their close relatives or associates have a controlling and/or significant financial interest in a business (including a private company, public sector organisation, other NHS employer and/or voluntary organisation), or in any other activity or pursuit, which may compete for an NHS contract to supply either goods or services to the CCG.
4.6 Canvassing for appointments

It is acknowledged that informal discussions concerning an advertised post can be part of the recruitment process, canvassing or lobbying of CCG employees, Governing Body members or any members of an appointments committee, either directly or indirectly, shall disqualify a candidate. This shall not preclude a member from giving a written reference or testimonial of a candidate’s ability, experience or character for submission to an appointments panel. Jobs will be awarded on the merit of the individual candidate and not through any such canvassing or lobbying.

4.7 Appointing governing body or committee members and senior employees

On appointing governing body, committee or sub-committee members and senior staff, the CCG will, on a case by case basis, consider whether conflicts of interest should exclude individuals from being appointed to the relevant role. General principles are reflected in the CCG’s Constitution.

4.8 Lay Members

By statute the CCG must have at least two lay members on the Governing Body. The Managing Conflicts of Interest: Revised Statutory Guidance for CCGs 2016 recommends a minimum of 3 lay members.

Where there are difficulties in recruiting additional lay members the CCG may share lay members with other CCGs in the same Sustainability and Transformation area.

4.9 Conflicts of Interest Guardian

The CCG has appointed a Conflicts of Interest Guardian (akin to a Caldicott Guardian). This role is undertaken by the CCG audit chair and is supported by the CCG’s Governance lead who has responsibility for the day-to-day management of conflicts of interest matters and queries. The CCG Governance lead keeps the Conflicts of Interest Guardian well briefed on conflicts of interest matters and issues arising.

The Conflicts of Interest Guardian, in collaboration with the CCG’s governance lead:

- Acts as a conduit for GP practice staff, members of the public and healthcare professionals who have any concerns with regards to conflicts of interest;
- Is a safe point of contact for employees or workers of the CCG to raise any concerns in relation to this policy;
- Supports the rigorous application of conflict of interest principles and policies;
• Provides independent advice and judgment where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
• Provides advice on minimising the risks of conflicts of interest.

Whilst the Conflicts of Interest Guardian has an important role within the management of conflicts of interest, executive members of the CCG’s governing body have an on-going responsibility for ensuring the robust management of conflicts of interest, and all CCG employees, governing body and committee members and member practices will continue to have individual responsibility in playing their part on an ongoing and daily basis.

4.10 Primary Care Commissioning Committee Chair

To ensure appropriate oversight and assurance and to ensure the CCG audit chair’s position as Conflicts of Interest Guardian is not compromised, the audit chair should not hold the position of chair of the primary care commissioning committee. This is because CCG audit chairs would conceivably be conflicted in this role due to the requirement that they attest annually to the NHS England Board that the CCG has:

• Had due regard to the statutory guidance on managing conflicts of interest; and
• Implemented and maintained sufficient safeguards for the commissioning of primary care.

CCG audit chairs can however serve on the primary care commissioning committee provided appropriate safeguards are put in place to avoid compromising their role as Conflicts of Interest Guardian. Ideally the CCG audit chair would also not serve as vice chair of the primary care commissioning committee. However, if this is required due to specific local circumstances (for example where there is a lack of other suitable lay candidates for the role), this will need to be clearly recorded and appropriate further safeguards may need to be put in place to maintain the integrity of their role as Conflicts of Interest Guardian in circumstances where they chair all or part of any meetings in the absence of the primary care commissioning committee chair.
5. The Guidance in Practice

5.1 Overriding Principle

Employees of the CCG, individuals of Member Practices, Governing Body and Committee members and individuals acting on behalf of the CCG must not accept any fee or reward for work done whilst on CCG duty other than that agreed under their terms and conditions of employment. As a general rule employees should not accept gifts or hospitality arising from their employment or appointment with the CCG, except where these are of a token nature only, in which case employees should inform their manager. This includes gifts or hospitality offered by suppliers and potential suppliers of goods and services to the CCG, and any participation in quasi-official and social events either within or outside normal working hours.

Any offers of gifts, hospitality or sponsorship shall be recorded in accordance with section 6.

5.2 Gifts

A ‘gift’ is defined as any item of cash or goods, or any service, which is provided for personal benefit, free of charge or at less than its commercial value.

All gifts of any nature offered to CCG staff, governing body and committee members and individuals within GP member practices by suppliers or contractors linked (currently or prospectively) to the CCG’s business should be declined, whatever their value. The person to whom the gifts were offered should also declare the offer to the team or individual who has designated responsibility for maintaining the register of gifts and hospitality so the offer which has been declined can be recorded on the register.

Gifts offered from other sources should also be declined if accepting them might give rise to perceptions of bias or favouritism, and a common sense approach should be adopted as to whether or not this is the case. The only exceptions to the presumption to decline gifts relates to items of little financial value (i.e., less than £10) such as diaries, calendars, stationery and other gifts acquired from meetings, events or conferences, and items such as flowers and small tokens of appreciation from members of the public to staff for work well done. Gifts of this nature do not need to be declared to the team or individual who has designated responsibility for maintaining the register of gifts and hospitality nor recorded on the register.

Any personal gift of cash or cash equivalents (e.g. vouchers, tokens, offers of remuneration to attend meetings whilst in a capacity working for or representing the CCG) must always be declined, whatever their value and whatever their source, and the offer which has been declined must be declared to the team or individual who has designated responsibility for maintaining the register of gifts and hospitality and recorded on the register.
In cases of doubt, advice should be sought from the line manager/Chief Officer or the gift should be politely declined.

5.3 Hospitality

Modest hospitality, provided it is usual, responsible and proportionate in the circumstances, (e.g., lunch in the course of working visits), may be acceptable, though it should be similar to the scale of hospitality which the NHS as an employer would be likely to offer. Hospitality of this nature does not need to be declared to the team or individual who has designated responsibility for maintaining the register of gifts and hospitality, nor recorded on the register, unless it is offered by suppliers or contractors linked (currently or prospectively) to the CCG’s business in which case all such offers (whether or not accepted) should be declared and recorded.

5.4 The Provision of Hospitality

The Code of Conduct: Code of Accountability in the NHS advises that the use of NHS monies for hospitality and entertainment, including hospitality at conferences or seminars, should be carefully considered. It advises that all expenditure on these items should be capable of justification as reasonable in the light of general practice in the public sector. It reminds NHS organisations that hospitality or entertainment is open to challenge by auditors and that ill-considered actions can damage respect for the NHS in the eyes of the community.

5.5 Payment for speaking at a meeting/conference

Should a member of staff, Member Practices, Governing Body and Committee members and individuals acting on behalf of the CCG, be asked to speak at an event relating to CCG business for which a payment is offered and it is delivered in working hours then there are two choices open to the member of staff which must be agreed with their line manager:

- The payment should be credited to the CCG.
- The member of staff takes annual leave or unpaid leave and the payment is made to the member of staff as a private matter between the organisation making the payment and the individual member of staff. The member of staff remains responsible for any tax liability which arises.

5.6 Commercial Sponsorship

5.6.1 CCG staff, governing body and committee members, and GP member practices may be offered commercial sponsorship for courses, conferences, post/project funding, meetings and publications in connection with the activities which they carry out for or on behalf of the CCG or their GP practices.
5.6.2 All such offers (whether accepted or declined) must be declared and recorded, and the team or individual designated by the CCG to provide advice, support, and guidance on how conflicts of interest should be managed should provide advice on whether or not it would be appropriate to accept any such offers. If such offers are reasonably justifiable and otherwise in accordance with statutory guidance then they may be accepted.

5.6.3 For the purpose of this policy, commercial sponsorship is defined as including “[NHS funding] from an external source, including funding of all, or part of, the costs of a member of staff, NHS research, staff training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free services (speakers), buildings or premises”.

5.6.4 In all these cases, CCG employees, Member Practices, Governing Body and Committee members and individuals acting on behalf of the CCG must declare sponsorship or any commercial relationship linked to the supply of goods or services and be prepared to be held to account for it. This should be recorded in the Hospitality, Gifts or Sponsorship Register (see section 6).

5.6.5 As a general rule, sponsorship arrangements involving the CCG will be at a corporate, rather than individual level.

5.6.6 Acceptance of commercial sponsorship must not in any way compromise commissioning decisions of the CCG or be dependent on the supply of goods or services. Sponsors should have no influence over the content of an event, meeting, seminar publication or training. The company logo can be displayed materials, but no advertising or promotional information should be displayed. Materials should contain a disclaimer which states that sponsorship of the material does not imply that the CCG endorses any of the company’s products or services. No information should be supplied to a company for their commercial gain unless there is a clear benefit to the NHS.

5.6.7 All CCG employees, Member Practices, Governing Body and Committee members and individuals acting on behalf of the CCG should discuss the implications, with their manager/Chief Operating Officer, before accepting an invitation to speak at a meeting organised by a pharmaceutical company. The company should have no influence over the content of any presentation made by the CCG’s employee/representative. It should be made clear that CCG’s presence does not imply that the CCG endorses any of the company’s products or services.

5.6.8 Under no circumstances will the CCG agree to ‘linked deals’ whereby sponsorship is linked to future purchase of particular products or to supply from particular sources.

5.6.9 During dealings with sponsors there must be no breach of confidentiality or data protection legislation and, as a rule, information which is not in the public domain should not normally be supplied.
5.7 Placing of orders and contracts

5.7.1 Fair and open competition between prospective contractors or suppliers for CCG contracts (including where the CCG is commissioning a service through Any Qualified Provider) is a requirement of NHS Standing Orders and of EC Directives on Public Purchasing for Works and Supplies. This means that:

- No private, public or voluntary organisation or company which may bid for CCG business should be given any advantage over its competitors, such as advance notice of CCG requirements. This applies to all potential contractors, whether or not there is a relationship between them and the CCG, such as a long-running series of previous contracts.

- Each new contract should be awarded solely on merit, taking into account the requirements of the CCG and the ability of the contractors to fulfil them.

- No special favour is to be shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in any capacity. Contracts may be awarded to such businesses when they are won in fair competition against other tenders, but scrupulous care must be taken to ensure that the selection process is conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

5.7.2 All staff, Member Practices, Governing Body, Committee members and individuals acting on behalf of the CCG, in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign orders or place contracts for goods, materials or services, are expected to adhere to professional standards of a kind set out in the ethical code of the Institute of Purchasing and Supply (attached at Appendix B). They are also required to declare any interest if they are participating in a specific procurement and tendering processes.

5.8 Partnership Governance

The CCG should ensure effective arrangements are put in place for the governance of partnerships. The increasing development of partnership based approaches to the commissioning and delivery of care place further emphasis on the necessity for strong governance and performance management in partnership working arrangements. In this respect, there needs to be a clear approach to ensure and demonstrate that investment in partnerships delivers effective and appropriate outcomes for the local population.

As part of an effective governance and assurance process the CCG should satisfy itself that managing conflicts of interests and the principles of this policy are applied to partnership working.
5.9 Private Transactions

Individual staff, Member Practices, Governing Body and Committee members and individuals acting on behalf of the CCG, must not seek or accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had, or may have, official dealings on behalf of the CCG. (This does not apply to concessionary agreements negotiated with companies by NHS management, or by recognised staff interests, on behalf of all staff – for example, NHS staff benefits schemes).

5.10 Employees’ outside employment

5.10.1 The standard contract used across the CCG sets out terms concerning outside employment: ‘You shall not be employed by any other person, firm or company, without the express permission of the CCG. If you have employment other than your employment with the CCG, you must write to your Manager giving details of the hours and days worked and duties carried out, seeking agreement that this work will not be detrimental to your employment within the CCG’.

5.10.2 Any employee who may be considering outside employment should discuss this in the first instance with their Manager before undertaking the employment.

5.10.3 Employees should be advised not to engage in outside employment during any periods of sickness absence from the CCG. To do so may lead to a referral being made to the Local Counter Fraud Specialist for investigation which may lead to criminal and/or disciplinary action in accordance with the CCG’s Anti-Fraud Policy.

5.10.4 The CCG will take all reasonable steps to ensure that employees, committee members, contractors and others engaged under contract are aware of the requirement to inform the CCG if they are employed or engaged in, or wish to be employed or engage in, any employment or consultancy work in addition to their work with the CCG. The purpose of this is to ensure that the CCG is aware of any potential conflict of interest. Examples of work which might conflict with the business of the CCG, including part-time, temporary and fixed term contract work, include:

- Employment with another NHS body;
- Employment with another organisation which might be in a position to supply goods/services to the CCG;
- Directorship of a GP federation; and
- Self-employment, including private practice, in a capacity which might conflict with the work of the CCG or which might be in a position to supply goods/services to the CCG.

5.11 Donations in relation to the organisation

5.11.1 Employees must check with their line manager or director before making any
requests for donations to clarify appropriateness and/or financial or contractual consequences of acquisition. Requests for equipment or services should not be made without the express permission of a senior manager.

5.11.2 Donations/Gifts from individuals, charities, companies (as long as they are not associated with known health-damaging products) – often related to individual pieces of equipment or items – provide additional benefits to patients but may have resource implications for the CCG. Further guidance regarding charitable funds and gifts and donations can be requested from the Chief Finance Officer.

5.11.3 Any gifts to the organisation should be receipted and a letter of thanks should be sent.

5.12 Donations to an individual

5.12.1 Personal monetary gifts to an employee or appointed member should be politely but firmly declined. Where a member of staff is a beneficiary to a Will of a patient who has been under their care, the member of staff must inform their line manager of the gift or gifts so that consideration can be given to whether or not it is appropriate in all the circumstances for that member of staff to retain the gift or gifts in order to avoid subsequent claims by the beneficiaries to the Estate of inducement, reward or corruption.

5.12.2 In order to determine whether the bequest should be accepted it may be necessary to have the gift valued and where the gift has a value over a certain amount for the gift to either be returned to the Estate or the gift to be donated to a Charity of the member of staff’s choice. Where the gift is to be returned to the Estate and the Trustees of the Estate are of the view having regards to all the circumstances that the member of staff should retain the gift regardless of its value, it may be appropriate for the Trustees to provide a disclaimer for future claims against the gift to avoid subsequent claims on the gift or allegations of inducement or reward being made against the member of staff or the CCG at some point in the future.

5.13 Rewards for Initiative

5.13.1 The CCG will identify potential intellectual property rights (IPR), as and when they arise, so that they can protect and exploit them properly, and thereby ensure that they receive any rewards or benefits (such as royalties), in respect of work commissioned from third parties, or work carried out by individuals in the course of their NHS duties. Most IPR are protected by statute; e.g. patents are protected under the Patents Act 1977 and copyright (which includes software programmes) under the Copyright Designs and Patents Act 1988. To achieve this, NHS organisations and employers should build appropriate specifications and provisions into the contractual arrangements which they enter into before the work is commissioned, or begins. They should always seek legal advice if in any doubt, in specific cases.

5.13.2 With regard to patents and inventions, in certain defined circumstances the
Patents Act gives employees or individuals in the course of their duties a right to obtain some reward for their efforts, and the CCG will see that this is effected. Other rewards may be given voluntarily to employees or other individuals who, within the course of their employment or duties, have produced innovative work of outstanding benefit to the NHS.

5.13.3 In the case of collaborative research and evaluative exercises with manufacturers, the CCG will obtain a fair reward for the input it provides. If such an exercise involves additional work for a CCG employee or individual outside that paid for by the CCG under his or her contract of employment, or sessional arrangements, arrangements will be made for some share of any rewards or benefits to be passed on to the employee(s) or individuals concerned from the collaborating parties. Care will, however, be taken that involvement in this type of arrangement with a manufacturer does not influence the purchase of other supplies from that manufacturer.

5.13.4 The CCG’s Intellectual Property Policy should be adhered to.

6. **Recording of gifts, hospitality and sponsorship**

6.1 All offers of gifts (excess of £10) and hospitality (excess of £25) must be declared and recorded. Gifts should be declared if several small gifts worth a total of over £200 are received from the same or closely related source in a 12 month period.

6.2 Gifts, hospitality and sponsorship will be recorded in a central register in accordance with the guidelines. The form at Appendix C should be completed and returned to the relevant governance lead promptly so that the details can be recorded on the central Register. Failure to notify the CCG may lead to disciplinary action against a member of staff.

6.3 Where gifts, hospitality or sponsorship are offered, but declined, the offer should still be recorded using the form at Appendix -E.

6.4 All hospitality or gifts declared must be transferred to a register of gifts and hospitality using the template at appendix F.

6.5 It is acknowledged that there may be circumstances where hospitality may be offered by an organisation, as an integral element of a strategic partnership relationship. A fund should be established so that the CCG may meet the costs of that hospitality, thus enabling the benefits to the strategic relationship, but not compromising compliance with the Standards of Business Conduct. Acceptance of such hospitality and associated funding agreement will be authorised by the Chief Officer and recorded in the Register of Hospitality, Gifts and Sponsorship.
7. **Declaration of Interests**

7.1 **Identification and definition of conflicts of interest**

7.1.1 A conflict of interest occurs where an individual’s ability to exercise judgement, or act in a role is, could be or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship. In some circumstances, it could be reasonably considered that a conflict exists even when there is no actual conflict. In these cases it is important to still manage these perceived conflicts in order to maintain public trust.

7.1.2 Conflicts of interest can arise in many situations, environments and forms of commissioning, with an increased risk in primary care commissioning, out-of-hours commissioning and involvement with integrated care organisations, as clinical commissioners may here find themselves in a position of being both commissioner and provider of services. Conflicts of interest can arise throughout the whole commissioning cycle from needs assessment to procurement exercises, to contract monitoring.

7.1.3 Where an individual, i.e. an employee, member of the Clinical Commissioning Group, a member of the Governing Body, or a member of its committees or sub-committees has an interest, or becomes aware of an interest which could lead to a conflict of interest in the event of the CCG 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 the CCG’s Constitution and this Policy.

7.1.4 Interests can be captured in four different categories:

i. **Financial interests:** This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:

   - A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
   - A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations.
   - A management consultant for a provider.
This could also include an individual being:

- In secondary employment (see paragraph 56-57);
- In receipt of secondary income from a provider;
- In receipt of a grant from a provider;
- In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider;
- In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and
- Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).

ii. **Non-financial professional interests**: This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:

- An advocate for a particular group of patients;
- A GP with special interests e.g., in dermatology, acupuncture etc.
- A member of a particular specialist professional body (although routine GP membership of the RCGP, British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);
- An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE);
- A medical researcher.

GPs and practice managers, who are members of the governing body or committees of the CCG, should declare details of their roles and responsibilities held within their GP practices.

iii. **Non-financial personal interests**: This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:

- A voluntary sector champion for a provider;
- A volunteer for a provider;
- A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;
- Suffering from a particular condition requiring individually funded treatment;
- A member of a lobby or pressure group with an interest in health.
iv. **Indirect interests:** This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above) for example, a:

- Spouse / partner
- Close relative e.g., parent, grandparent, child, grandchild or sibling
- Close friend
- Business partner.

A declaration of interest for a “business partner” in a GP partnership should include all relevant collective interests of the partnership, and all interests of their fellow GP partners (which could be done by cross referring to the separate declarations made by those GP partners, rather than by repeating the same information verbatim).

Whether an interest held by another person gives rise to a conflict of interests will depend upon the nature of the relationship between that person and the individual, and the role of the individual within the CCG. Paragraphs 13 to 17 of the Statutory Guidance provide further information.

Note that the Declaration of Interest Form in use sets out the range of interests as a reminder of the types of interests which should be declared.

**7.2 Questions to ask when declaring Interests**

In determining what needs to be declared, individuals should ask themselves the following questions:

- Am I, or might I be, in a position where I or my family or associates gain from the connection between my private interests and my employment with the CCG?
- Do I have access to information which could influence purchasing decisions?
- Could my outside interest be in any way detrimental to the CCG or to patient’s interests?
- Do I have any other reason to think I may be risking a conflict of Interest?

If in doubt, the individual concerned should assume that a potential conflict of interest exists.
7.3 Declaring and Registering Interests

7.3.1 It is a requirement of the relevant legislation (Section 14O(3) of the 2006 Act, as amended by the Health and Social Care Act 2012) for the CCG to maintain registers of the interests of:

- **All CCG employees**, including:
  - All full and part time staff;
  - Any staff on sessional or short term contracts;
  - Any students and trainees (including apprentices);
  - Agency staff; and
  - Seconded staff

In addition, any self-employed consultants or other individuals working for the CCG under a contract for services should make a declaration of interest in accordance with this policy, as if they were CCG employees.

**Members of the governing body:** All members of the CCG’s committees, sub-committees/sub-groups, including:

- Co-opted members;
- Appointed deputies; and
- Any members of committees/groups from other organisations.

Where the CCG is participating in a joint committee alongside other CCGs, any interests which are declared by the committee members should be recorded on the register(s) of interest of each participating CCG.

**All members of the CCG (i.e., each practice)**
This includes each provider of primary medical services which is a member of the CCG under Section 14O (1) of the 2006 Act.

Declarations should be made by the following groups:

- GP partners (or where the practice is a company, each director);
- Any individual directly involved with the business or decision-making of the CCG.

7.3.2 The CCG will need to ensure that, as a matter of course, declarations of interest are made and regularly confirmed or updated. All persons referred to above must declare any interests as soon as reasonable practicable and by law within 28 days after the interest arises. Further opportunities include;

- **On appointment:**
  Applicants for any appointment to the CCG or its governing body or any committees should be asked to declare any relevant interests. When an appointment is made, a formal declaration of interests should again be made and recorded.
- **Six Monthly:**
  Declarations of interest should be obtained from all relevant individuals every six months and where there are no interests or changes to declare, a “nil return” should be recorded.

- **At meetings:**
  All attendees should be asked to declare any interest they have in any agenda item before it is discussed or as soon as it becomes apparent. Even if an interest is declared in the register of interests, it should be declared in meetings where matters relating to that interest are discussed. Declarations of interest and action taken to manage that conflict of interest at the meeting should be recorded in minutes of meetings.

- **On changing role, responsibility or circumstances:**
  Whenever an individual’s role, responsibility or circumstances change in a way that affects the individual’s interests (e.g., where an individual takes on a new role outside the CCG or enters into a new business or relationship), a further declaration should be made to reflect the change in circumstances as soon as possible, and in any event within 28 days. This could involve a conflict of interest ceasing to exist or a new one materialising.

7.3.3 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 CCG, in writing to the Chief Officer, as soon as they are aware of it and in any event no later than 28 days after becoming aware. The CCG must record the interest in the appropriate registers as soon as the CCG becomes aware of it.

7.3.4 The CCG must ensure that, when members declare interests, this includes the interests of all relevant individuals within their own organisations (e.g. partners in a GP practice), who have a relationship with the CCG and who would potentially be in a position to benefit from the CCG’s decisions.

7.3.5 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, and provide a written declaration as soon as possible thereafter.

7.3.6 The Chief Officer will ensure that the registers of interest are reviewed six-monthly and updated as necessary.

7.3.7 In addition, all CCG Governing Body and Executive members’ appointments are offered on the understanding that they subscribe to the “Codes of Conduct and Accountability in the NHS”.

7.3.8 The Declaration of Interest proforma for completion by members of the group, Governing Body members, members of a committee or sub-committee of the group or Governing Body, and employees within the CCG is available at Appendix D.
7.3.9 Failure to notify the CCG of an appropriate conflict of interest, additional employment or business may lead to disciplinary action against the member of staff and/or criminal action (including prosecution) under the relevant legislation.

7.3.10 An interest should remain on the public register for a minimum of six months after the interest has expired and the CCG will retain a private record of historic interests for a minimum of 6 years after the date on which it expired. The published register will state that historic interests are retained by the CCG for the specified timeframe and details of whom to contact to request this information.

7.4 Managing Conflicts of Interest: general

7.4.1 Members of the groups, committees or sub-committees of the group, the Governing Body and its committees or sub-committees and employees will comply with the arrangements determined by the CCG for managing conflicts or potential conflicts of interest as set out in this Policy.

7.4.2 The Chief 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.

7.4.3 They will write to the relevant individual with the arrangements for managing the specific conflict of interest or potential conflicts of interest, within a week of declaration. The arrangements will confirm the following:

- when an individual should withdraw from a specified activity, on a temporary or permanent basis;
- monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

7.4.4 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 CCG’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 Officer.

7.4.5 Declaration of Interests is, in addition, an agenda item on all Governing Body and Committee agendas. Declarations should be made with regard to any specific agenda items. If a conflict of interest is established with regard to a specific agenda item, the conflict of interest should be recorded in the minutes and published in the registers. Similarly, any new offers of gifts or hospitality (whether accepted or not) which are declared at a meeting must be included on the CCG’s register of gifts and hospitality to ensure it is up-to-date.
7.4.6 Where an individual member, employee or person providing services to the CCG is aware of an interest which:

i. Has not been declared, either in the register or orally, they will declare this at the start of the meeting;

ii. Has previously 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.

7.4.7 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. They will not be able to vote on the issue under any circumstances. Where a prejudicial interest is identified, that person must leave the room during the discussion of the relevant item, and cannot seek to improperly influence the decision in which they have a prejudicial interest. The Chair’s decision will be final in the matter and the individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

7.4.8 Where the chair of any meeting of the groups, including committees or sub-committees, or the Governing Body, including committees and sub-committees of the Governing Body, 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.

7.4.9 Any declarations of interests, and arrangements agreed in any meeting of the groups, including committees or sub-committees, or the Governing Body, including committees and sub-committees of the Governing Body, will be recorded in the minutes. The interest must be subsequently reported to the designated governance lead for recording in the Register.

7.4.10 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 in accordance with the provisions of the Constitution.
7.4.11 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 CCG 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 with the Chief Officer on the action to be taken.

7.4.12 In any transaction undertaken in support of the CCG’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 Officer of the transaction.

7.4.13 The Chief 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.

7.5 Managing Conflicts of Interest throughout the commissioning cycle

7.5.1 Conflicts of interest need to be managed appropriately throughout the whole commissioning cycle. At the outset of a commissioning process, the relevant interests of all individuals involved should be identified and clear arrangements put in place to manage any conflicts of interest. This includes consideration as to which stages of the process a conflicted individual should not participate in, and, in some circumstances, whether that individual should be involved in the process at all.

7.5.2 In designing service requirements attention should be given to public and patient involvement at every stage of the commissioning cycle.

7.5.3 It is good practice to engage relevant providers, especially clinicians, in confirming that the design of service specifications will meet patient needs. Provider engagement should follow the three main principles of procurement law, namely equal treatment, non-discrimination and transparency. This includes ensuring that the same information is given to all at the same time and procedures are transparent. This mitigates the risk of potential legal challenge.

7.5.4 Specifications should be clear and transparent, reflecting the depth of engagement, and set out the basis on which any contract will be awarded.
7.5.1 Anyone seeking information in relation to procurement, or participating in a procurement, or otherwise engaging with the CCG in relation to the potential provision of services or facilities to the CCG, will be required to make a declaration of any relevant conflict / potential conflict of interest.

7.5.2 Anyone contracted to provide services or facilities directly to the CCG will be subject to the same provisions of the CCG’s Constitution and this policy in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

7.5.3 The CCG must comply with two different regimes of procurement law and regulation when commissioning healthcare services: the NHS procurement regime, and the European procurement regime:

- The NHS procurement regime – the NHS (Procurement, Patient Choice and Competition (No.2)) Regulations 2013: made under S75 of the 2012 Act; apply only to NHS England and CCGs; enforced by NHS Improvement; and
- The European procurement regime – Public Contracts Regulations 2015 (PCR 2105): incorporate the European Public Contracts Directive into national law; apply to all public contracts over the threshold value (€750,000, currently £589,148); enforced through the Courts.

7.5.4 The procurement template (appendix I) should be used to complete the register of procurement decisions and to provide evidence of the CCG’s deliberations on conflicts of interest.

7.5.5 The CCG must maintain a register of procurement decisions taken, including:

- The details of the decision
- Who was involved in making the decision
- A summary of any conflicts of interest in relation to the decision and how this was managed
- The award decision taken

7.5.6 The register should be updated whenever a procurement decision is taken and must be made publically available by:

- Ensuring that the register is available in a prominent place on the web site and
- Making the register available upon request for inspection at the CCG’s headquarters

7.5.7 The management of conflicts of interest applies to all aspects of the commissioning cycle, including contract management.
7.5.6 Any contract monitoring meeting needs to consider conflicts of interest as part of the process i.e., the chair of a contract management meeting should invite declarations of interests; record any declared interests in the minutes of the meeting; and manage any conflicts appropriately and in line with this guidance. This equally applies where a contract is held jointly with another organisation such as the Local Authority or with other CCGs under lead commissioner arrangements. A template for recording minutes of contract meetings is at Appendix H.

7.5.7 The individuals involved in the monitoring of a contract should not have any direct or indirect financial, professional or personal interest in the incumbent provider or in any other provider that could prevent them, or be perceived to prevent them, from carrying out their role in an impartial, fair and transparent manner.

7.6 Primary Care Commissioning Committees and Sub-Committees

7.6.1 Each CCG with joint or delegated primary care co-commissioning arrangements must establish a primary care commissioning committee for the discharge of their primary medical services functions. This committee should be separate from the CCG governing body. The interests of all primary care commissioning committee members must be recorded on the CCG’s register(s) of interests.

The primary care commissioning committee should:

- For joint commissioning, take the form of a joint committee established between the CCG (or CCGs) and NHS England; and
- In the case of delegated commissioning, be a committee established by the CCG.

7.6.2 As a general rule, meetings of the primary care commissioning committee, including the decision-making and deliberations leading up to the decision, should be held in public unless the CCG has concluded it is appropriate to exclude the public where it would be prejudicial to the public interest to hold that part of the meeting in public.
7.6.3 CCGs (and NHS England with regards to joint arrangements) can agree the full membership of their primary care commissioning committees, within the following parameters:

- The primary care commissioning committee must be constituted to have a lay and executive majority, where lay refers to non-clinical. This ensures that the meeting will be quorate if all GPs had to withdraw from the decision-making process due to conflicts of interest.
- The primary care commissioning committee should have a lay chair and lay vice chair (see section 4.10 for further information).
- GPs can, and should, be members of the primary care commissioning committee to ensure sufficient clinical input, but must not be in the majority. CCGs may wish to consider appointing retired GPs or out-of-area GPs to the committee to ensure clinical input whilst minimising the risk of conflicts of interest.
- A standing invitation must be made to the CCG’s local HealthWatch representative and a local authority representative from the local Health and Wellbeing Board to join the primary care commissioning committee as non-voting attendees, including, where appropriate, for items where the public is excluded for reasons of confidentiality.
- Other individuals could be invited to attend the primary care commissioning committee on an ad-hoc basis to provide expertise to support with the decision-making process.

7.6.4 In the interest of minimising the risks of conflicts of interest, it is recommended that GPs do not have voting rights on the primary care commissioning committee. The arrangements do not preclude GP participation in strategic discussions on primary care issues, subject to appropriate management of conflicts of interest. They apply to decision-making on procurement issues and the deliberations leading up to the decision.

7.6.5 Whilst sub-committees or sub-groups of the primary care commissioning committee can be established e.g., to develop business cases and options appraisals, ultimate decision-making responsibility for the primary medical services functions must rest with the primary care commissioning committee. As an additional safeguard, it is recommended that sub-groups submit their minutes to the primary care commissioning committee, detailing any conflicts and how they have been managed. The primary care commissioning committee should be satisfied that conflicts of interest have been managed appropriately in its sub-committees and take action where there are concerns.
7.7 Managing Conflicts of Interests: Local CCG Incentive Schemes

GP Practice members will be required to declare an interest in any discussions at Governing Body or Committee meetings relating to Local Incentive Schemes which relate to their GP Practice. Whilst GP practice members may participate in discussions at those meetings of the CCG regarding the recommendations for development of the Local Incentive Scheme they shall withdraw from any decisions at the Governing Body or Committee regarding approval of the Scheme. Any approval of payments to GP Practices under the Incentive Scheme will be made (as a minimum) by the Chief Officer together with the Chief Finance Officer, or their nominated representatives in line with the CCG's financial scheme of delegation.

7.8 Raising Concerns

Individuals who have concerns regarding conflict of interest or ethical misconduct either in respect of themselves or colleagues, should raise it in the first instance with their manager. Alternatively, they can raise it as an issue using the Raising Concerns at Work Policy. If the concern relates to any suspected fraudulent practice, staff should follow the advice given in section 10 of this document.

7.9 Publication of Registers

The CCG will publish the register(s) of interest and register(s) of gifts and hospitality and the Register of Procurement Decisions in a prominent place on the CCG’s website and also as part of the CCG’s Annual Report and Annual Governance Statement; a web link is acceptable.

In exceptional circumstances, where the public disclosure of information could give rise to a real risk of harm or is prohibited by law, an individual’s name and/or other information may be redacted from the publicly available register(s). Where an individual believes that substantial damage or distress may be caused, to him/herself or somebody else by the publication of information about them, they are entitled to submit a written request that the information is not published. Decisions must be made by the Conflicts of Interest Guardian for the CCG, who should seek appropriate legal advice where required, and the CCG should retain a confidential un-redacted version of the register(s).

8. Confidentiality

8.1 Employees, CCG members, members of the Governing Body, or a member of a committee or a sub-committee of the CCG or its Governing Body should be particularly careful using or making public, internal information of a confidential nature, particularly regarding details covered under the Data Protection Act 1998 or other legislation whether or not disclosure is prompted by the expectation of personal gain.
8.2 Disclosure of information which counts as “commercial in confidence” and which might prejudice the principle of a purchasing system based on fair competition may be subject to scrutiny and disciplinary or criminal action or both.

8.3 This does not affect the CCG’s grievance or complaints procedures in terms of freedom of expression and is not intended to restrict any of the freedoms protected under Article 10 of the Human Rights Act 1998. It is designed to complement professional and ethical rules, guidelines and codes of conduct on an individual's freedom of expression.

8.4 An employee or individual who has exhausted all the locally established procedures, including reference to the Raising Concerns at Work Policy, and who has taken account of advice which may have been given, may wish to consult their MP or the Secretary of State for Health in confidence. Extreme caution should be exercised by anyone considering contacting the media.

8.5 Section 43B (1) of the Public Interest Disclosure Act 1998 provides protection for disclosure of information where the reasonable belief of the worker making the disclosure, tends to show that:-

   a. A criminal offence has been committed, is being committed or is likely to be committed,
   b. That a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject,
   c. That a miscarriage of justice has occurred, is occurring or is likely to occur,
   d. That the health or safety of any individual has been, is being or is likely to be endangered,
   e. That the environment has been, is being or is likely to be damaged, or
   f. That information tending to show any matter falling within points a. to e. has been, is being or is likely to be deliberately concealed.

8.6 Protection from disclosure to the media is highly unlikely to be given, if the person making the disclosure has not exhausted all internal and external avenues.

8.7 Any employee, member of the Governing Body, or a member of a committee or a sub-committee of the Governing Body making a disclosure to the media should be mindful that any information that they provide may be misinterpreted thus undermining their genuine concern and potentially wrongly threatening the reputation of colleagues and the CCG. In addition, if they choose to contact the media and the disclosure is not protected by the Public Interest Disclosure Act 1998 their actions might constitute misconduct and will be considered in accordance with the CCG Disciplinary Policy and Procedure.
9. **Use of Resources**

All managers are required (under the Code of Conduct for NHS Managers) to use the resources available to them in an effective, efficient and timely manner having proper regard to the best interests of the public and patients.

10. **Fraud/Theft**

If you suspect theft, fraud, or other untoward events taking place at work you should:

- Make a note of your concerns and;
- In the case of theft contact your Local Security Management Specialist;
- In the case of fraud contact the Local Counter Fraud Specialist on or the Chief Finance Officer;
- You can also report to the national NHS Fraud and Corruption Reporting Line on 0800 028 40 60 or [www.reportnhsfraud.nhs.uk](http://www.reportnhsfraud.nhs.uk).

Staff should not be afraid of raising concerns and will not experience any blame or recrimination as a result of making any reasonably held suspicion known.

If staff have any concerns about any of the issues raised in this document, they should contact their manager or Human Resources Manager.

11. **Non-compliance with Policy**

Failure to notify the CCG of an appropriate conflict of interest, additional employment or business may lead to disciplinary action against the individual including potential dismissal or removal from office in accordance with the CCG’s Disciplinary Policy and procedure and/or criminal action (including prosecution) under the relevant legislation.

A review of lessons learned will be conducted by the Accountable Officer following any incident of non-compliance with this policy and the report to be reviewed by the CCG’s Audit Committee.

If conflicts of interest are not effectively managed, CCGs could face civil challenges to decisions they make. In extreme cases, staff and other individuals could face personal civil liability, for example a claim for misfeasance in public office.

Failure to manage conflicts of interest could lead to criminal proceedings including for offences such as fraud, bribery and corruption. This could have implications for CCGs and linked organisations, and the individuals who are engaged by them.
The CCG has agreed a process for managing breaches of this policy, which includes:

- How the breach is recorded
- How it is investigated
- The governance arrangements and reporting mechanisms
- Links to the Raising Concerns at Work Policy and HR policies
- Communications and management of any media interest
- When to notify NHS England and how
- Process for publishing the breach on the CCG web site

The CCG will publish anonymised details of breaches on its web site.

12. Internal Audit

   The CCG will undertake an audit of conflicts of interest management as part of the internal audit, on an annual basis.

   The results of the audit will be reflected in the CCG’s annual governance statement and should be discussed in the end of year governance meeting with NHS regional teams.

13. Conflicts of Interest Training

   The CCG will ensure that training is offered to all employees, governing body members and members of CCG committees and sub-committees. This training is mandatory and must be completed annually by 31 January each year.

   Completion rates will be recorded as part of the annual conflicts of interest audit.
14. Linked Policies/Guidance

- NHS England: Managing Conflicts of Interest: Statutory Guidance for CCGs
- CCG Constitution
- NHS England: Standards of Business Conduct Policy
- ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry
- Fraud Policy and Response Plan
- Raising Concerns at Work policy
- Guidance to staff on completion of travel and subsistence claims
- Intellectual Property Policy
- Research Governance Policy
- Commercial Sponsorship and Joint Working with the Pharmaceutical Industry Policy
- Secondary Employment guidance as referred to in the standard contract of employment for staff with their respective CCG
- Code of Conduct and Code of Accountability for NHS Boards
- Institute of Purchasing and Supply
  A copy of the ethical code of the Institute of Purchasing and Supply is shown in Appendix B.

15. Further Information

If there are any queries on declaration of interests, acceptance or registering of gifts etc. the Chief Finance Officer or Chief Officer can be contacted for further information.

16. Monitoring, Review and Archiving

16.1 Monitoring

The Governing Body will ensure there is in place for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.
16.2 Review

16.2.1 The Governing Body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

16.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The Governing Body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

16.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the ‘version control’ table on the second page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

16.3 Archiving

The Governing Body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2009.
17. Equality Analysis
Introduction - Equality Impact Assessment

An Equality Impact Assessment (EIA) is a process of analysing a new or existing service, policy or process. The aim is to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff).

We need to:

Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
Advance equality of opportunity between people who share a protected characteristic and those who do not
Foster good relations between people who share a protected characteristic and those who do not

This is the law. In simple terms it means thinking about how some people might be excluded from what we are offering.

The way in which we organise things, or the assumptions we make, may mean that they cannot join in or if they do, it will not really work for them.

It’s good practice to think of all reasons why people may be excluded, not just the ones covered by the law. Think about people who may be suffering from socio-economic deprivation or the challenges facing carers for example.

This will not only ensure legal compliance, but also help to ensure that services best support the healthcare needs of the local population.

Think of it as simply providing great customer service to everyone.

As a manager or someone who is involved in a service, policy, or process development, you are required to complete an Equality Impact Assessment using this toolkit.

<table>
<thead>
<tr>
<th>Policy</th>
<th>A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>A system or organisation that provides for a public need.</td>
</tr>
<tr>
<td>Process</td>
<td>Any of a group of related actions contributing to a larger action.</td>
</tr>
</tbody>
</table>
**STEP 1 - EVIDENCE GATHERING**

<table>
<thead>
<tr>
<th>Name of person completing EIA:</th>
<th>Liane Cotterill</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title of service/policy/process:</strong></td>
<td>Standards of Business Conduct &amp; Declarations of Interest Policy</td>
</tr>
<tr>
<td>Existing: x</td>
<td>New/proposed: ☐</td>
</tr>
</tbody>
</table>

**What are the intended outcomes of this policy/service/process? Include outline of objectives and aims**

The purpose of this policy is to ensure exemplary standards of business conduct are adhered to, as public servants, by Governing Body members, committee and sub-committee members and employees of the CCG (as well as individuals contracted to work on behalf of the CCG or otherwise providing services or facilities to the CCG such as those within commissioning support services). The policy covers managing conflicts of interest in accordance with statutory guidance.

**Who will be affected by this policy/service/process? (please tick)**

- X Staff members
- ☐ Other

If other please state:

**What is your source of feedback/existing evidence? (please tick)**

- ☐ National Reports
- ☐ Staff Profiles
- ☐ Staff Surveys
- ☐ Complaints/Incidents
- ☐ Focus Groups
- ☐ Previous EIAs
- ☐ Other

If other please state:

<table>
<thead>
<tr>
<th>Evidence</th>
<th>What does it tell me? (about the existing policy/process? Is there anything suggest there may be challenges when designing something new?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Reports</td>
<td>No challenges identified</td>
</tr>
<tr>
<td>Staff Profiles</td>
<td>No Challenges identified</td>
</tr>
<tr>
<td>Complaints and Incidents</td>
<td>No Challenges identified.</td>
</tr>
<tr>
<td>Staff focus groups</td>
<td>No Challenges identified.</td>
</tr>
<tr>
<td>Previous EIAs</td>
<td>No Challenges identified.</td>
</tr>
<tr>
<td>Other evidence</td>
<td>No Challenges identified.</td>
</tr>
</tbody>
</table>
## STEP 2 – IMPACT ASSESSMENT

<table>
<thead>
<tr>
<th>Staff Characteristic</th>
<th>Description</th>
<th>Impact Identified</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>A person belonging to a particular age</td>
<td>No impact identified</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td>A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities</td>
<td>No impact identified</td>
</tr>
<tr>
<td><strong>Gender reassignment (including transgender)</strong></td>
<td>Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.</td>
<td>No impact identified</td>
</tr>
<tr>
<td><strong>Marriage and civil partnership</strong></td>
<td>Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters.</td>
<td>No impact identified</td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td>Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.</td>
<td>No impact identified</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td>It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.</td>
<td>No impact identified</td>
</tr>
<tr>
<td><strong>Religion or belief</strong></td>
<td>Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.</td>
<td>No impact identified</td>
</tr>
<tr>
<td><strong>Sex/Gender</strong></td>
<td>A man or a woman.</td>
<td>No impact identified</td>
</tr>
<tr>
<td><strong>Sexual orientation</strong></td>
<td>Whether a person’s sexual attraction is towards their own sex, the opposite sex or to both sexes</td>
<td>No impact identified</td>
</tr>
<tr>
<td><strong>Carers</strong></td>
<td>A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person</td>
<td>No impact identified</td>
</tr>
</tbody>
</table>
STEP 3 - ENGAGEMENT AND INVOLVEMENT

How have you engaged with staff in testing the policy or process proposals including the impact on protected characteristics?

It is an existing policy which has been changed to align with the new NHS England statutory guidance however nothing has been identified which would impact on protected characteristics.

Please state how staff engagement will take place:

Policy will be approved via the normal channels and will made available to staff via the normal channels once approved.

STEP 4 - METHODS OF COMMUNICATION

What methods of communication do you plan to use to inform staff of the policy?

- Verbal – through focus groups and/or meetings
- Verbal – Telephone
- Written – Letter
- Written – Leaflets/guidance booklets
- Email
- Internet
- Other

If other please state:

STEP 5 - SUMMARY OF POTENTIAL CHALLENGES

Having considered the potential impact on the people accessing the service, policy or process please summarise the areas have been identified as needing action to avoid discrimination.

Potential Challenge | What problems/issues may this cause?
--- | ---
1 | None identified

STEP 6 - ACTION PLAN

<table>
<thead>
<tr>
<th>Ref no.</th>
<th>Potential Challenge/ Negative Impact</th>
<th>Protected Group Impacted (Age, Race etc)</th>
<th>Action(s) required</th>
<th>Expected Outcome</th>
<th>Owner</th>
<th>Timescale/ Completion date</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ref no.</td>
<td>Who have you consulted with for a solution? (users, other services, etc)</td>
<td>Person/People to inform</td>
<td>How will you monitor and review whether the action is effective?</td>
<td></td>
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</tbody>
</table>

**SIGN OFF**

<table>
<thead>
<tr>
<th>Completed by:</th>
<th>Liane Cotterill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>July 2016</td>
</tr>
<tr>
<td>Signed:</td>
<td></td>
</tr>
<tr>
<td>Presented to: (appropriate committee)</td>
<td></td>
</tr>
<tr>
<td>Publication date:</td>
<td>July 2016</td>
</tr>
</tbody>
</table>
18. Appendix A

The Nolan Principles on Standards in Public Life

The Nolan Committee was set up in 1994 to examine concerns about standards of conduct of all holders of public office, including arrangements relating to financial and commercial activities, and make recommendations as to any changes in arrangements which might be required to ensure the highest standards of propriety in public life. The committee published “seven principles of Public Life”, which it believes should apply to all those operating in the public sector. These principles should be adopted by CCG staff and are as follows:

**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.

**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.

**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.

**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.

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

**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.

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

All staff will be expected to adopt these principles when conducting official business for and on behalf of the CCG so that appropriate ethical standards can be demonstrated at all times.
19. Appendix B

Institute of Purchasing and Supply (IPS) – Ethical Code
(Reproduced by kind permission of IPS)

1. Introduction

The code set out below was approved by the Institute's Council on 26 February 1977 and is binding on IPS members.

2. Precepts

Members shall never use their authority or office for personal gain and shall seek to uphold and enhance the standing of the Purchasing and Supply profession and the Institute by:

a. maintaining an unimpeachable standard of integrity in all their business relationships both inside and outside the organisations in which they are employed;

b. fostering (the highest possible standards of professional competence amongst those for whom they are responsible;

c. optimising the use of resources [or which they are responsible to provide the maximum benefit to their employing organisation;

d. complying both with the letter and the spirit of;
   i. the law of the country in which they practise;
   ii. such guidance on professional practice as may be issued by the Institute from time to time;
   iii. contractual obligations;

e. rejecting any business practice which might reasonably be deemed improper.

3. Guidance

In applying these precepts, members should follow the guidance set out below:

a. Declaration of interest.
   Any personal interest which may impinge or might reasonably be deemed by others to impinge on a member’s impartiality in any matter relevant to his or her duties should be declared.

b. Confidentiality and accuracy of information
   The confidentiality of information received in the course of duty should be respected and should never be used for personal gain; information given in the course of duty should be true and fair and never designed to mislead.
c. Competition.
While bearing in mind the advantages to the member's employing organisation of maintaining a continuing relationship with a supplier, any relationship which might, in the long term, prevent the effective operation of fair competition should be avoided.

d. Business Gifts.
Business gifts other than items of very small intrinsic value such as business diaries or calendars should not be accepted.

e. Hospitality.
Modest hospitality is an accepted courtesy of a business relationship. However, the recipient should not allow him or herself to reach a position whereby he or she might be deemed by others to have been influenced in making a business decision as a consequence of accepting such hospitality; the frequency and scale of hospitality accepted should not be significantly greater than the recipient's employer would be likely to provide in return.

f. When it is not easy to decide between what is and is not acceptable in terms of gifts or hospitality, the offer should be declined or advice sought from the member's superior.
## 20. Appendix C

### Template Declaration of interests for CCG members and employees

<table>
<thead>
<tr>
<th>Name:</th>
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<table>
<thead>
<tr>
<th>Position within, or relationship with, the CCG (or NHS England in the event of joint committees):</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Detail of interests held (complete all that are applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Interest* *See reverse of form for details</th>
<th>Description of Interest (including for indirect Interests, details of the relationship with the person who has the interest)</th>
<th>Date interest relates From &amp; To</th>
<th>Actions to be taken to mitigate risk (to be agreed with line manager or a senior CCG manager)</th>
</tr>
</thead>
<tbody>
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</table>

The information submitted will be held by the CCG for personnel or other reasons specified on this form and to comply with the organisation’s policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the CCG holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the CCG as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

I **do / do not** [delete as applicable] give my consent for this information to published on registers that the CCG holds. If consent is NOT given please give reasons:

<table>
<thead>
<tr>
<th>Signed:</th>
<th>Date:</th>
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<table>
<thead>
<tr>
<th>Signed:</th>
<th>Position:</th>
<th>Date:</th>
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</table>

(Line Manager or Senior CCG Manager)

Please return to <insert name/contact details for team or individual in CCG nominated to provide advice, support, and guidance on how conflicts of interest should be managed, and administer associated administrative processes>
### Types of interest

<table>
<thead>
<tr>
<th>Type of Interest</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial Interests</strong></td>
<td>This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being:</td>
</tr>
<tr>
<td></td>
<td>• A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations;</td>
</tr>
<tr>
<td></td>
<td>• A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations;</td>
</tr>
<tr>
<td></td>
<td>• A management consultant for a provider;</td>
</tr>
<tr>
<td></td>
<td>• In secondary employment (see paragraph 56 to 57);</td>
</tr>
<tr>
<td></td>
<td>• In receipt of secondary income from a provider;</td>
</tr>
<tr>
<td></td>
<td>• In receipt of a grant from a provider;</td>
</tr>
<tr>
<td></td>
<td>• In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider;</td>
</tr>
<tr>
<td></td>
<td>• In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and</td>
</tr>
<tr>
<td></td>
<td>• Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).</td>
</tr>
<tr>
<td><strong>Non-Financial Professional Interests</strong></td>
<td>This is where an individual may obtain a non-financial professional benefit from the consequences of a commissioning decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is:</td>
</tr>
<tr>
<td></td>
<td>• An advocate for a particular group of patients;</td>
</tr>
<tr>
<td></td>
<td>• A GP with special interests e.g., in dermatology, acupuncture etc.</td>
</tr>
<tr>
<td></td>
<td>• A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defence organisation would not usually by itself amount to an interest which needed to be declared);</td>
</tr>
<tr>
<td></td>
<td>• An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE);</td>
</tr>
<tr>
<td></td>
<td>• A medical researcher.</td>
</tr>
<tr>
<td><strong>Non-Financial Personal Interests</strong></td>
<td>This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is:</td>
</tr>
<tr>
<td></td>
<td>• A voluntary sector champion for a provider;</td>
</tr>
<tr>
<td></td>
<td>• A volunteer for a provider;</td>
</tr>
<tr>
<td></td>
<td>• A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation;</td>
</tr>
<tr>
<td></td>
<td>• Suffering from a particular condition requiring individually funded treatment;</td>
</tr>
<tr>
<td></td>
<td>• A member of a lobby or pressure groups with an interest in health.</td>
</tr>
<tr>
<td><strong>Indirect Interests</strong></td>
<td>This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above). For example, this should include:</td>
</tr>
<tr>
<td></td>
<td>• Spouse / partner;</td>
</tr>
<tr>
<td>Type of Interest</td>
<td>Description</td>
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<tr>
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</tr>
<tr>
<td></td>
<td>• Close relative e.g., parent, grandparent, child, grandchild or sibling;</td>
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<td></td>
<td>• Close friend;</td>
</tr>
<tr>
<td></td>
<td>• Business partner.</td>
</tr>
</tbody>
</table>
## 21. Appendix D

### Template Register of interests for CCGs

<table>
<thead>
<tr>
<th>Name</th>
<th>Current position(s) held- i.e. Governing Body, Member practice, Employee or other</th>
<th>Declared Interest- (Name of the organisation and nature of business)</th>
<th>Type of Interest</th>
<th>Is the interest direct or indirect?</th>
<th>Nature of Interest</th>
<th>Date of Interest From</th>
<th>Date of Interest To</th>
<th>Action taken to mitigate risk</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
22. Appendix E

Template Declarations of gifts and hospitality

<table>
<thead>
<tr>
<th>Recipient Name</th>
<th>Position</th>
<th>Date of Offer</th>
<th>Date of Receipt (if applicable)</th>
<th>Details of Gift / Hospitality</th>
<th>Estimated Value</th>
<th>Supplier / Offeror Name and Nature of Business</th>
<th>Details of Previous Offers or Acceptance by this Offeror/Supplier</th>
<th>Details of the officer reviewing and approving the declaration made and date</th>
<th>Declined or Accepted?</th>
<th>Reason for Accepting or Declining</th>
<th>Other Comments</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

The information submitted will be held by the CCG for personnel or other reasons specified on this form and to comply with the organisation’s policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and published in registers that the CCG holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the CCG as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, professional regulatory or internal disciplinary action may result.

I do / do not (delete as applicable) give my consent for this information to published on registers that the CCG holds. If consent is NOT given please give reasons:

Signed:          Date:
Signed:    Position:     Date:
(Line Manager or a Senior CCG Manager)

Please return to <insert name/contact details for team or individual in CCG nominated to provide advice, support, and guidance on how conflicts of interest should be managed, and administer associated administrative processes>
## 23. Appendix F

**Template: Register of gifts and hospitality**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Date of offer</th>
<th>Declined or Accepted?</th>
<th>Date of Receipt (if applicable)</th>
<th>Details of Gift /Hospitality</th>
<th>Estimated Value</th>
<th>Supplier / Offeror Name and Nature of business</th>
<th>Reason for Accepting or Declining</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
## 24. Appendix G

**Template declarations of interest checklist**

Under the Health and Social Care Act 2012, there is a legal obligation to manage conflicts of interest appropriately. It is essential that declarations of interest and actions arising from the declarations are recorded formally and consistently across all CCG governing body, committee and sub-committee meetings. This checklist has been developed with the intention of providing support in conflicts of interest management to the Chair of the meeting prior to, during and following the meeting. It does not cover the requirements for declaring interests outside of the committee process.

<table>
<thead>
<tr>
<th>Timing</th>
<th>Checklist for Chairs</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>In advance of the meeting</td>
<td>1. <strong>The agenda</strong> to include a standing item on declaration of interests to enable individuals to raise any issues and/or make a declaration at the meeting.</td>
<td>Meeting Chair and secretariat</td>
</tr>
<tr>
<td></td>
<td>2. A <strong>definition of conflicts of interest</strong> should also be accompanied with each agenda to provide clarity for all recipients.</td>
<td>Meeting Chair and secretariat</td>
</tr>
<tr>
<td></td>
<td>3. <strong>Agenda</strong> to be circulated to enable attendees (including visitors) to identify any interests relating specifically to the agenda items being considered.</td>
<td>Meeting Chair and secretariat</td>
</tr>
<tr>
<td></td>
<td>4. <strong>Members should contact the Chair</strong> as soon as an actual or potential conflict is identified.</td>
<td>Meeting members</td>
</tr>
<tr>
<td></td>
<td>5. Chair to review a <strong>summary report from preceding meetings</strong> i.e., sub-committee, working group, etc., detailing any conflicts of interest declared and how this was managed.</td>
<td>Meeting Chair</td>
</tr>
<tr>
<td></td>
<td><strong>A template for a summary report</strong> to present discussions at preceding meetings is detailed below.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. A <strong>copy of the members’ declared interests</strong> is checked to establish any actual or potential conflicts of interest that may occur during the meeting.</td>
<td>Meeting Chair</td>
</tr>
</tbody>
</table>
7. **Check and declare the meeting is quorate** and ensure that this is noted in the minutes of the meeting.

8. Chair requests **members to declare any interests in agenda items**- which have not already been declared, including the nature of the conflict.

9. **Chair makes a decision** as to how to manage each interest which has been declared, including whether / to what extent the individual member should continue to participate in the meeting, on a case by case basis, and this decision is recorded.

10. **As minimum requirement**, the following should be **recorded in the minutes of the meeting**:

    - Individual declaring the interest;
    - At what point the interest was declared;
    - The nature of the interest;
    - The Chair’s decision and resulting action taken;
    - The point during the meeting at which any individuals retired from and returned to the meeting - even if an interest has not been declared;

    - **Visitors in attendance** who participate in the meeting must also follow the meeting protocol and declare any interests in a timely manner.

A template for recording any interests during meetings is detailed below.

### Following the meeting

11. **All new interests declared** at the meeting should be promptly updated onto the declaration of interest form;

12. All new completed declarations of interest should be **transferred onto the register of interests**.
<table>
<thead>
<tr>
<th><strong>Template for recording any interests during meetings</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Report from &lt;insert details of sub-committee/ work group&gt;</strong></td>
</tr>
<tr>
<td><strong>Title of paper</strong></td>
</tr>
<tr>
<td><strong>Meeting details</strong></td>
</tr>
<tr>
<td><strong>Report author and job title</strong></td>
</tr>
<tr>
<td><strong>Executive summary</strong></td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Outcome of Impact Assessments completed (e.g. Quality IA or Equality IA)</strong></td>
</tr>
<tr>
<td><strong>Outline engagement – clinical, stakeholder and public/patient:</strong></td>
</tr>
<tr>
<td><strong>Management of Conflicts of Interest</strong></td>
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<tr>
<td><strong>Assurance departments/ organisations who will be affected have been consulted:</strong></td>
</tr>
<tr>
<td><strong>Report previously presented at:</strong></td>
</tr>
</tbody>
</table>
<insert details of how this paper mitigates risks- including conflicts of interest>
Template to record interests during the meeting

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Date of Meeting</th>
<th>Chairperson (name)</th>
<th>Secretariat (name)</th>
<th>Name of person declaring interest</th>
<th>Agenda Item</th>
<th>Details of interest declared</th>
<th>Action taken</th>
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</tbody>
</table>
25. Appendix H

Template for recording minutes

XXXX Clinical Commissioning Group
Primary Care Commissioning Committee Meeting

Date: 15 February 2016
Time: 2pm to 4pm
Location: Room B, XXXX CCG

Attendees:

<table>
<thead>
<tr>
<th>Name</th>
<th>Initials</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Kent</td>
<td>SK</td>
<td>XXX CCG Governing Body Lay Member (Chair)</td>
</tr>
<tr>
<td>Andy Booth</td>
<td>AB</td>
<td>XXX CCG Audit Chair Lay Member</td>
</tr>
<tr>
<td>Julie Hollings</td>
<td>JH</td>
<td>XXX CCG PPI Lay Member</td>
</tr>
<tr>
<td>Carl Hodd</td>
<td>CH</td>
<td>Assistant Head of Finance</td>
</tr>
<tr>
<td>Mina Patel</td>
<td>MP</td>
<td>Interim Head of Localities</td>
</tr>
<tr>
<td>Dr Myra Nara</td>
<td>MN</td>
<td>Secondary Care Doctor</td>
</tr>
<tr>
<td>Dr Maria Stewart</td>
<td>MS</td>
<td>Chief Clinical Officer</td>
</tr>
<tr>
<td>Jon Rhodes</td>
<td>JR</td>
<td>Chief Executive – Local Healthwatch</td>
</tr>
</tbody>
</table>

In attendance from 2.35pm

Neil Ford NF Primary Care Development Director

<table>
<thead>
<tr>
<th>Item No</th>
<th>Agenda Item</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Chairs welcome</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Apologies for absence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&lt;apologies to be noted&gt;</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Declarations of interest</td>
<td></td>
</tr>
</tbody>
</table>

SK reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of XXX clinical commissioning group.

Declarations declared by members of the Primary Care Commissioning Committee are listed in the CCG’s Register of Interests. The Register is available either via the secretary to the governing body or the CCG website at the following link: http://xxxccg.nhs.uk/about-xxx-ccg/who-we-are/our-governing-body/
Declarations of interest from sub committees.
None declared

Declarations of interest from today’s meeting

The following update was received at the meeting:
- With reference to business to be discussed at this meeting, MS declared that he is a shareholder in XXX Care Ltd.

SK declared that the meeting is quorate and that MS would not be included in any discussions on agenda item X due to a direct conflict of interest which could potentially lead to financial gain for MS.

SK and MS discussed the conflict of interest, which is recorded on the register of interest, before the meeting and MS agreed to remove himself from the table and not be involved in the discussion around agenda item X.

<table>
<thead>
<tr>
<th></th>
<th>Minutes of the last meeting &lt;date to be inserted&gt; and matters arising</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td><strong>Agenda Item</strong> &lt;Note the agenda item&gt;</td>
</tr>
<tr>
<td></td>
<td>MS left the meeting, excluding himself from the discussion regarding xx.</td>
</tr>
<tr>
<td></td>
<td>&lt;conclude decision has been made&gt;</td>
</tr>
<tr>
<td></td>
<td>&lt;Note the agenda item xx&gt;</td>
</tr>
<tr>
<td></td>
<td>MS was brought back into the meeting.</td>
</tr>
<tr>
<td>6</td>
<td>Any other business</td>
</tr>
<tr>
<td>7</td>
<td>Date and time of the next meeting</td>
</tr>
</tbody>
</table>
# Appendix I

## Procurement checklist

<table>
<thead>
<tr>
<th>Question</th>
<th>Comment/ Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG’s proposed commissioning priorities? How does it comply with the CCG’s commissioning obligations?</td>
<td></td>
</tr>
<tr>
<td>2. How have you involved the public in the decision to commission this service?</td>
<td></td>
</tr>
<tr>
<td>3. What range of health professionals have been involved in designing the proposed service?</td>
<td></td>
</tr>
<tr>
<td>4. What range of potential providers have been involved in considering the proposals?</td>
<td></td>
</tr>
<tr>
<td>5. How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?</td>
<td></td>
</tr>
<tr>
<td>6. What are the proposals for monitoring the quality of the service?</td>
<td></td>
</tr>
<tr>
<td>7. What systems will there be to monitor and publish data on referral patterns?</td>
<td></td>
</tr>
<tr>
<td>8. Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers?</td>
<td></td>
</tr>
<tr>
<td>9. In respect of every conflict or potential conflict, you must record how you have managed that conflict or potential conflict. Has the management of all conflicts been recorded with a brief explanation of how they have been managed?</td>
<td></td>
</tr>
<tr>
<td>10. Why have you chosen this procurement route e.g., single action tender?&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. What additional external involvement will there be in scrutinising the proposed decisions?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>12. How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process and award of any contract?</th>
</tr>
</thead>
</table>

**Additional question when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) or direct award (for services where national tariffs do not apply)**

<table>
<thead>
<tr>
<th>13. How have you determined a fair price for the service?</th>
</tr>
</thead>
</table>

**Additional questions when qualifying a provider on a list or framework or pre selection for tender (including but not limited to any qualified provider) where GP practices are likely to be qualified providers**

<table>
<thead>
<tr>
<th>14. How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?</th>
</tr>
</thead>
</table>

**Additional questions for proposed direct awards to GP providers**

<table>
<thead>
<tr>
<th>15. What steps have been taken to demonstrate that the services to which the contract relates are capable of being provided by only one provider?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>16. In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>17. What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?</th>
</tr>
</thead>
</table>

---

<sup>2</sup>Taking into account all relevant regulations (e.g. the NHS (Procurement, patient choice and competition) (No 2) Regulations 2013 and guidance (e.g. that of Monitor).
## Template: Procurement decisions and contracts awarded

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Contract/Service title</th>
<th>Procurement description</th>
<th>Existing contract or new procurement (if existing include details)</th>
<th>Procurement type – CCG procurement, collaborative procurement with partners</th>
<th>CCG clinical lead (Name)</th>
<th>CCG contract manager (Name)</th>
<th>Decision making process and name of decision making committee</th>
<th>Summary of conflicts of interest noted</th>
<th>Actions to mitigate conflicts of interest</th>
<th>Justification for actions to mitigate conflicts of interest</th>
<th>Contract awarded (supplier name &amp; registered address)</th>
<th>Contract value (£) (Total) and value to CCG</th>
<th>Comments to note</th>
</tr>
</thead>
</table>

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed:

On behalf of:

Date:

Please return to <insert name/contact details for team or individual in CCG nominated for procurement management and administrative processes>
# 27. Appendix J

Template Register of procurement decisions and contracts awarded

<table>
<thead>
<tr>
<th>Ref No</th>
<th>Contract/Service title</th>
<th>Procurement description</th>
<th>Existing contract or new procurement (if existing include details)</th>
<th>Procurement type – CCG procurement, collaborative procurement with partners</th>
<th>CCG clinical lead</th>
<th>CCG contract manager</th>
<th>Decision making process and name of decision making committee</th>
<th>Summar y of conflicts of interest declared and how these were managed</th>
<th>Contract Award (supplier name &amp; registered address)</th>
<th>Contract value (£) (Total)</th>
<th>Contract value to CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
28. Appendix K

Template Declaration of conflict of interests for bidders/contractors

<table>
<thead>
<tr>
<th>Name of Organisation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details of interests held:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Interest</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of services or other work for the CCG or NHS England</td>
<td></td>
</tr>
<tr>
<td>Provision of services or other work for any other potential bidder in respect of this project or procurement process</td>
<td></td>
</tr>
<tr>
<td>Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG’s or any of its members’ or employees’ judgements, decisions or actions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Relevant Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>[complete for all Relevant Persons]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Details of interests held:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Type of Interest</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of services or other work for the CCG or NHS England</td>
<td></td>
</tr>
<tr>
<td>Provision of services or other work for any other potential bidder in respect of this project or procurement process</td>
<td></td>
</tr>
</tbody>
</table>

| Personal interest or that of a family member, close friend or other acquaintance? |
Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG’s or any of its members’ or employees’ judgements, decisions or actions

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed:

On behalf of:

Date:
Corporate | CCG: CO24: Social Media Policy

<table>
<thead>
<tr>
<th>Version Number</th>
<th>Date Issued</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1: Draft 2</td>
<td>November 2016</td>
<td>September 2018</td>
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</table>

Prepared By: Senior Governance Manager, North of England Commissioning Support

Consultation Process: CCG Head of Governance Quality & Safety Committee 1.11.16

Policy Adopted From: Non-applicable

Approval Given By: Governing Body

Document History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Significant Changes</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>May 2016</td>
<td>First Issue</td>
</tr>
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</table>

Equality Impact Assessment

<table>
<thead>
<tr>
<th>Date</th>
<th>Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2016</td>
<td>Please see Section 9 of this document</td>
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</table>

POLICY VALIDITY STATEMENT

This policy is due for review on the latest date shown above. After this date, policy and process documents may become invalid.

Policy users should ensure that they are consulting the currently valid version of the documentation.
# Contents

1. Introduction 3
2. Definitions 4
3. Policy for social media use 5
4. Duties and responsibilities 8
5. Implementation 9
6. Training implications 9
7. Documentation 9
8. Monitoring, review and archiving 10
9. Equality Analysis 11
1. Introduction

1.1 The world of communication is changing. Social media is changing the way we, and every organisation in the world conducts its business. Millions of people use social media responsibly every day and it is becoming an increasingly important communications tool.

For the purposes of this policy, NHS North Tyneside Clinical Commissioning Group will be referred to as ‘the CCG’.

The CCG aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, the CCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

The CCG may wish to use social media to provide opportunities for genuine, open, honest and transparent engagement with stakeholders, giving them a chance to participate and influence decision making. These tools are used to build online communities and networks which facilitate peer to peer interactivity.

Staff should use their own discretion and common sense when engaging in online communication. They should know and follow the CCG Standards of Business Conduct & Declarations of Interest Policy. The same principles and guidelines that apply to staff activities in general also apply to online activities. This includes forms of online publishing and discussion, including blogs, wikis, file-sharing, user-generated video and audio, virtual worlds and social networks.

The following sections provide some general rules and best practices which you should abide by at all times.

1.2 Status

This policy is a corporate policy.
1.3 Purpose and aims

The purpose of this document is to provide guidance to CCG staff on social media/networking on the internet and the external use of other online tools such as blogs, discussion forums and interactive news sites. It seeks to give direction to staff in the use of these tools and help them to understand the ways they can use social media to help achieve business goals. This is a rapidly changing area and this policy is expected to be updated and amended as communication strategies evolve.

The purpose of this policy is to help protect the organisation, but also to protect staff interests and to advise staff of the potential consequences of their behaviour and any content that they might post online, whether acting independently or in their capacity as a representative of the CCG.

The aims of this document are to:

- Provide clarity to staff on the use of social media tools when acting independently or as a representative of the CCG and give them the confidence to engage effectively;
- Ensure that the organisation’s reputation is not brought into disrepute and that it is not exposed to legal risk; and
- Ensure that internet users are able to distinguish official corporate CCG information from the personal opinion of staff.

1.4 Scope

This policy applies to those members of staff that are directly employed by the CCG and for whom the CCG has legal responsibility. For those staff covered by a letter of authority/honorary contract or work experience the organisation’s policies are also applicable whilst undertaking duties on behalf of the CCG.

2. Definitions

‘Social’, ‘social media’ or ‘social networking’ are the terms commonly used to describe web sites and online tools which allow users to interact with each other in some way by sharing information, opinions, knowledge and interests.

The following terms are used in this document (note the below list is not exhaustive):

- Micro blogging – for example, Twitter
- Blogging – for example, WordPress, Tumblr, and Blogger
- Video sharing – for example, Flickr, Instagram, and YouTube
- Social bookmarking – for example, Reddit and StumbleUpon
- Social sharing – for example, Facebook
- Professional sharing – for example, LinkedIn
3. Policy for social media use

3.1 Responsibilities

It is the responsibility of everyone within the organisation to use social media responsibly.

Whenever employees engage with social media and post information about their work or employer it is highly likely that the information will be circulated to a wide audience.

Although members of staff are not acting on behalf of the organisation in a formal capacity when engaging with social media in their personal lives they must be mindful that, depending on the content, their online posts could potentially be damaging to the CCG, for example if they are inaccurate or flippant. Staff must also be aware of the potential legal implications of material which could be considered abusive or defamatory.

3.2 Social media in your personal life

The CCG recognises that many employees make use of social media in a personal capacity. While they are not acting on behalf of the organisation, employees must be aware they can damage the organisation if they are recognised as being a CCG employee.

Although it is acceptable for staff to say they work for the NHS or CCG in posts and during online conversations, they should ensure they are clear that they are not acting on behalf of the organisation and post a disclaimer such as “the views posted are my own personal views and do not represent the views of the CCG” or “Tweets are my own views”.

All employees should be aware that the CCG reserves the right to use legitimate means to scan the web, including social network sites for content that it finds inappropriate.
Any communication that employees make in a personal capacity through social media must not:

- Bring the CCG into disrepute by criticising or arguing with customers, colleagues or rivals; making defamatory comments about individuals including judgments of their performance and character, or posting links to inappropriate content
- Breach confidentiality, for example by revealing information owned by the organisation; giving away confidential information about an individual (such as a colleague or customer contact)
- Include contact details or photographs of colleagues without their permission
- Discuss the CCG’s internal workings or its future business plans that have not been communicated to the public
- Breach copyright, for example by using someone else’s images or written content without permission or failing to give acknowledgment where permission has been given to reproduce something. If photos/videos are of the general public in public places then you can use them without obtaining permission
- Do anything that could be considered discriminatory, bullying or harassment of any individual, for example by making offensive or derogatory comments relating to protected characteristics under the Equality Act 2010
- Use social media to bully another individual or posting images that are discriminatory or offensive (or links to such content)
- Post information that breaches any of the conditions in CCG policies.

Incidents of discrimination, bullying or harassment which take place via social media will be managed in line with CCG policy.

3.3 Line manager guidance

Under this policy managers should be clear on the social media participation for any project and that individual staff members should be identified for managing the agreed social media for the project once appropriate approvals have been received. Managers requiring guidance should contact the appropriate lead for social media in the CCG.
3.4 Guidance for staff given access to social media

Where access has been given to use social media sites, staff must not upload/post the following:

- Personal identifiable information of patients and/or their relatives
- Personal identifiable information of another CCG employee in relation to their employment including judgements of their performance and character
- Photographs of another CCG employee taken in the work situation without permission
- Defamatory statements about the CCG, its staff, services or contractors
- Confidential information on bulletin boards, forums or newsgroups
- “Whistleblowing” posts, without already having raised concerns through the proper channels. All staff should be aware that the Public Interest Disclosure Act 1998 gives legal protection to employees who wish to whistleblow any concerns. HR35 Whistleblowing Policy incorporates the requirements of the Public Interest Disclosure Act 1998 (PIDA) and the Bribery Act 2010.

3.5 Photos and videos

Video is an excellent medium for providing stimulating and engaging content, which can potentially be seen by many people as it is easily shared on social media sites and embedded on other people’s websites.

Images of individuals in photos/videos are treated as personal information where the person’s identity is clear and can reasonably be worked out. In this instance, consent is required to use the images and you must take reasonable steps to tell the individual who you are, what you are taking their picture for and how they can access it. If photos/videos are of the general public in public places then you can use them without obtaining permission.

You must ensure that all video and media (including presentations) are appropriate to share/publish and do not contain any confidential, commercially sensitive or defamatory information.

If the material is official and corporate CCG content then it must be branded appropriately, and be labelled and tagged accordingly. It must not be credited to an individual or production company. Further guidance is available from the Information Labelling & Classification Procedure.
4. Duties and responsibilities

<table>
<thead>
<tr>
<th>Council of Practice</th>
<th>The Council of Practice has delegated responsibility to the Governing Body (GB) for setting the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Officer</td>
<td>The Chief Officer as accountable officer has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements.</td>
</tr>
</tbody>
</table>
| Chief Finance Officer | The Chief Finance Officer (as CCG Governance Lead) will ensure that use of email and the internet will: comply with corporate branding be used in a manner to enhance the CCGs ability to engage with stakeholders comply with statutory and regulatory rules as well as national guidance and best practice They are also responsible for:  
  * generating and formulating this policy  
  * identifying the appropriate process for regular evaluation of the implementation and effectiveness of this policy  
  * identifying the competencies required to implement this policy, and either identifying a training resource or approaching Workforce Learning and Development (Governance Directorate NECS) for assistance |
| All line managers | All line managers are responsible for ensuring that appropriate processes are complied with when using email and the internet. |
| All Staff | All staff, including temporary and agency staff, are responsible for:  
  * Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken.  
  * Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities.  
  * Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly.  
  * Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager.  
  * Attending training / awareness sessions when provided. |
5. Implementation

This policy will be available to all staff for use in relation to the use of social media.

All managers are responsible for ensuring that relevant staff within the CCG have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

6. Training implications

It has been determined that there are no specific training requirements associated with this policy/procedure.

7. Documentation

7.1 Other related policy documents

- Confidentiality and data protection policy
- Information governance and risk policy
- Information security policy
- Safeguarding children policy
- Safeguarding vulnerable adults policy
- Standards of business conduct and declarations of interest policy
- Equality and diversity strategy
- Harassment and bullying policy
- Whistleblowing policy

7.2 Legislation and statutory requirements

- Equality Act 2010
- Data Protection Act 1998
- Freedom of Information Act 1998
- Human Rights Act 1998
- Employment Rights Act 1996
- Computer Misuse Act 1990
- Copyright, Designs and Patents Act 1988
- Bribery Act 2010
7.3 **Best practice recommendations**


8. **Monitoring, review and archiving**

8.1 **Monitoring**

The Accountable Officer will oversee, on behalf of the Governing Body, a method for monitoring the dissemination and implementation of this policy.

Monitoring information will be recorded in the policy database.

8.2 **Review**

The Governing Body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The governing body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

For ease of reference for reviewers or approval bodies, changes should be noted in the ‘document history’ table on the front page of this document.

**NB:** If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

8.3 **Archiving**

The governing body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management: NHS Code of Practice 2009.
9. **Equality Analysis**

A full Equality Impact Assessment has been completed;
Report to: Governing Body Meeting

Date: 22 November 2016  Agenda item: 13.2a

Title of report: Better Care Fund 2016/17

Sponsor: John Wicks, Interim Chief Operating Officer, North Tyneside CCG
Author: John Wicks

Purpose of the report and action required: This report updates the value of the Better Care Fund 2016/17 for approval.

Executive Summary

1. In May 2016 the CCG approved a 2016/17 Better Care Fund pooled budget value of £15.466m, of which £9.458m was approved as a transfer to North Tyneside Council for services provided by the council.

2. A number of adjustments to the plan have been agreed between the Council and CCG regarding intermediate care.

3. These changes have increased the value of the 2016/17 BCF to £15.724m of which £9.982m transfers to the Local Authority.

4. These changes have been approved by Clinical Executive and the financial implications incorporated in to the refreshed Financial Recovery Plan.

5. The plan has been endorsed by the Health and Well-Being Board and received the full assurance of NHS England.

6. The Governing Body are asked to endorse these adjustments to allow final signature of the 2016/17 Better Care Fund.

Governance and Compliance

1. Links to corporate objectives

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
<td>√</td>
</tr>
<tr>
<td>2. Deliver the Financial Recovery Plan, leading to the achievement of the CCG’s statutory financial duties and</td>
<td>√</td>
</tr>
</tbody>
</table>
2. **Consultation and engagement**
There has been a high level of engagement with all providers and stakeholders of intermediate care.

3. **Resource implications**
The resource implications are to increase the total value of the 2016/17 BCF pooled fund by £258,000 and the proportion transferred to the Local Authority by £524,000. These sums are factored in to the revised Financial Recovery Plan.

4. **Risks**
The risks of service interruption or quality deterioration in intermediate care services have been mitigated by the agreed changes to the BCF.

5. **Equality assessment**
The CCG has conducted an equality impact assessment of the BCF.

6. **Environment and sustainability assessment**
There are no environmental or sustainability issues arising from this report.
Report to: Governing Body

Date: 22 November 2016

Agenda item: 13.2b

Title of report: Better Care Fund 2016/17

Sponsor: John Wicks, Interim Chief Operating Officer

Author: John Wicks

Purpose of the report and action required: This report updates the value of the Better Care Fund 2016/17 for approval.

Full report

1. Background / introduction /context

1.1 Better Care Fund 2016/17 final position

In May 2016, the CCG approved the 2016/17 Better Care Fund which involved the creation of a pooled fund with North Tyneside Council to address:

- Number of emergency hospital admissions
- Number of delayed transfers of care
- Effectiveness of reablement
- Number of permanent admissions to residential care

The pooled fund value was £15.466m, of which £9.458m was approved as a transfer to the Local Authority for services provided by the council.

1.2 Revisions to the 2016/17 Better Care Fund

Since May, a number of adjustments have been agreed to reflect changes in intermediate care services, as follows:

- An agreed delay to the closure of the Cedars Care home, from 30th September to 31st December 2016
- The creation of a community rehabilitation team
- The creation of a consolidated intermediate care facility, provided by Akari
- Revised service specifications for intermediate care bed services provided by Northumbria Healthcare NHS Trust

These changes have been endorsed by the Clinical Executive, and the financial implications incorporated into the Financial Recovery Plan.

The reasons for financial adjustment are that changes to NHS intermediate care services required a proportion of savings in that area to be reinvested in services provided by the Local Authority. The mobilisation of changes were also deferred by 3 months to allow more time for the safe transition of services to new arrangements.
The overall financial impact is that the pooled 2016/17 Better Care Fund has increased in value to £15.724m of which £9.982m transfers to the Local Authority.

The Better Care Fund 2016/17 has been endorsed by the Health and Well-Being Board and received the full assurance of NHS England.

2. Recommendations

The Governing Body is asked to approve the adjustment to the value of the Better Care Fund 2016/17.

Appendices and further information

3. Appendices

Better Care Fund 2016/17 investment schedule

4. Further information relevant to the report

N/A

Report author: John Wicks, Interim Chief Operating Officer
Report date: 14 November 2016
<table>
<thead>
<tr>
<th>Service</th>
<th>2016/17 Value (£'000)</th>
<th>Responsible Commissioner</th>
<th>Funder</th>
<th>Funding due</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>CCG Authority</td>
<td>CCG Authority</td>
<td>Quarterly (Jun, Aug, Oct, Jan) when grant received</td>
</tr>
<tr>
<td>Providing proactive care and avoiding unplanned admissions</td>
<td>723</td>
<td>723</td>
<td>723</td>
<td></td>
</tr>
<tr>
<td>End of Life Care</td>
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<td>314</td>
<td>314</td>
<td></td>
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<tr>
<td>Community-based support, including Carepoint, reablement, immediate response and overnight care; adaptations and loan equipment service</td>
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<td>Seven day social work</td>
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<td>Liaison Psychiatry</td>
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<td>Intermediate Care Beds</td>
<td>4,493</td>
<td>4,493</td>
<td>4,493</td>
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<tr>
<td>Intermediate Care - community services[1]</td>
<td>58</td>
<td>58</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>The Cedars</td>
<td>1041</td>
<td>1041</td>
<td>1041</td>
<td>1,041</td>
</tr>
<tr>
<td>Independent Supported Living for people with learning disabilities</td>
<td>600</td>
<td>600</td>
<td>600</td>
<td>600</td>
</tr>
<tr>
<td>Improving access to advice and information</td>
<td>50</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Care Act implementation</td>
<td>597</td>
<td>597</td>
<td>597</td>
<td>597</td>
</tr>
<tr>
<td><strong>Total of pooled fund</strong></td>
<td><strong>15,724</strong></td>
<td><strong>9,924</strong></td>
<td><strong>15,724</strong></td>
<td><strong>2,481</strong></td>
</tr>
<tr>
<td>Non Pooled - Disabled Facilities Grant</td>
<td>1,307</td>
<td>1,307</td>
<td>1,307</td>
<td>1,307</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>17031</strong></td>
<td><strong>11,231</strong></td>
<td><strong>15,724</strong></td>
<td><strong>2,481</strong></td>
</tr>
</tbody>
</table>

[1] In addition to this figure, there will be a non-recurrent payment of £45,000 in 2017/18 to reflect a deferred element of the total service cost, and a recurrent full year cost of £414k.
<table>
<thead>
<tr>
<th>Service</th>
<th>2015/16 Value</th>
<th>Responsible Commissioner</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
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<tr>
<td></td>
<td>CCG Authority</td>
<td>Net contribution from the CCG</td>
</tr>
<tr>
<td>Care Act Implementation</td>
<td>597</td>
<td>✓</td>
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<tr>
<td>Providing proactive care and avoiding unplanned admissions</td>
<td>341</td>
<td>✓</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>306</td>
<td>✓</td>
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<tr>
<td>Falls pathway</td>
<td>194</td>
<td>✓</td>
</tr>
<tr>
<td>Seven day social work</td>
<td>163</td>
<td>✓</td>
</tr>
<tr>
<td>Increased hours of the Elderly Assessment and Admission Avoidance Service</td>
<td>77</td>
<td>✓</td>
</tr>
<tr>
<td>Immediate response and overnight home care</td>
<td>384</td>
<td>✓</td>
</tr>
<tr>
<td>Increased use of telecare</td>
<td>171</td>
<td>✓</td>
</tr>
<tr>
<td>Community Navigators and Support Network</td>
<td>34</td>
<td>✓</td>
</tr>
<tr>
<td>&quot;Halfway home&quot; beds</td>
<td>60</td>
<td>✓</td>
</tr>
<tr>
<td>Improved home care service</td>
<td>68</td>
<td>✓</td>
</tr>
<tr>
<td>Liaison Psychiatry</td>
<td>212</td>
<td>✓</td>
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<tr>
<td>Mental health community pathways</td>
<td>449</td>
<td>✓</td>
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<tr>
<td>Carers Support</td>
<td>560</td>
<td>✓</td>
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<tr>
<td>Reablement</td>
<td>1300</td>
<td>✓</td>
</tr>
<tr>
<td>Adaptations and Loan Equipment Service</td>
<td>494</td>
<td>✓</td>
</tr>
<tr>
<td>The Cedars</td>
<td>544</td>
<td>✓</td>
</tr>
<tr>
<td>NHS support to social care</td>
<td>4285</td>
<td>✓</td>
</tr>
<tr>
<td>Protection of adult social care</td>
<td>2000</td>
<td>✓</td>
</tr>
<tr>
<td>TOTAL</td>
<td>11,636</td>
<td>✓</td>
</tr>
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</table>
Report to: CCG Governing Body

Date: 22\textsuperscript{nd} November 2016

**Agenda item:** 13.3a

**Title of report:** Public Health Core Offer to North Tyneside Clinical Commissioning Group 2016/18

**Sponsor:** Janet Soo Chung, Chief Officer, NT CCG

**Author:** John Wicks, Chief Operating Officer, NT CCG  
Wendy Burke, Director of Public Health, North Tyneside Council

**Purpose of the report and action required:**
The report sets out the content of the proposed ‘core offer’ of public health advice and support to North Tyneside Clinical Commissioning Group for the period up to 31\textsuperscript{st} March 2018.

Members are asked to agree the content of the Public Health Core Offer.

**Executive summary**

There is a statutory duty on upper tier and unitary local authorities to provide NHS commissioners with a public health ‘core offer’ as a means for instituting a ‘population health’ perspective into the CCG activities and duties and incorporates specialist public health advice into decision making and commissioning processes. The purpose of the ‘core offer’ is to ensure that public health skills and expertise in ‘health care’ (e.g. economic evaluation; health services research and evaluation; and evidence-based appraisals of clinical effectiveness) are retained for use by the CCG so that the commissioning of NHS services has the maximum impact on improving the health of people in North Tyneside and reducing health inequalities.

A public health ‘core offer’ has been agreed for 18 months up to 31\textsuperscript{st} March 2018 and is detailed in the attached document. The key work areas include:

- Support development of policies on procedures of limited clinical value and the IFR process for the North IFR panel
- Support to developing the CCG operational plan
- Support the work in relation to diabetes prevention
- Support the reduction in alcohol related and alcohol specific admissions to hospital
- Support the work around the locality cancer plan with a focus upon reducing impact of smoking on health
• Support a programme of work focusing on falls
• Social marketing’, support for self-management and helping patients make better use of available primary, community, social and informal services

Governance and Compliance

Links to corporate objectives

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
<td>✓</td>
</tr>
<tr>
<td>2. Deliver the Financial Recovery Plan, leading to the achievement of the CCG’s statutory financial duties and future sustainability</td>
<td>✓</td>
</tr>
<tr>
<td>3. Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside</td>
<td>✓</td>
</tr>
<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
<td>✓</td>
</tr>
</tbody>
</table>
The ‘Core Offer’ to North Tyneside Clinical Commissioning Group 2016/18

Purpose
There is a statutory duty on upper tier and unitary local authorities to provide NHS commissioners with a public health ‘core offer’ as a means for instituting a ‘population health’ perspective into the CCG activities and duties and incorporates specialist public health advice into decision making and commissioning processes. The purpose of the ‘core offer’ is to ensure that public health skills and expertise in ‘health care’ (e.g. economic evaluation; health services research and evaluation; and evidence-based appraisals of clinical effectiveness) are retained for use by the CCG so that the commissioning of NHS services has the maximum impact on improving the health of people in North Tyneside and reducing health inequalities.

Scope
The DH document “Guidance to support the provision of healthcare public health advice to CCGs” specifies the content of the core offer service and sets out a range of activities which could be offered to CCGs through the phases of the commissioning cycle:

- **Strategic planning**
  - assessing needs
  - reviewing service provision
  - deciding priorities
  - managing IFR

- **Procuring services**
  - designing shape and structure of supply
  - planning capacity and managing demand

- **Monitoring and evaluation**
  - supporting patient choice, managing performance and seeking public and patient views

The functions that could potentially be undertaken locally as part of the delivery of the core offer might include health needs assessment (including helping CCG to contribute to the JSNA); priority setting, providing intelligence to support service redesign; advising on service review methodology, commissioning to meet the needs of marginalised groups, the content of service specifications; critical appraisal of evidence; Health Equity Audit; scenario modelling and forecasting; identifying variation in primary
care and developing effective strategies to understand and reduce unwarranted differences in outcomes; population segmentation and customer insight.

**Work Plan 2016/18**
The following table sets out the ‘Core Offer’ annual work programme for 2016/18 and identifies the work that the CCG and the Local Authority Public Health team will work on collaboratively during 2016/18. The Core Offer is made in the context of the Memorandum of Understanding between the CCG and Local Authority.

The service will be led and delivered by a range of staff with appropriate public health skills and expertise supervised by the Consultant in Public Health. Inputs will be closely linked to the priorities of the Joint Strategic Needs Assessment, the Joint Health and Wellbeing Strategy and the CCG commissioning plans.

**Access to data**
Effective delivery of the core offer relies on access to NHS data. Prior to April 2013 the Public Health team were been able to access datasets (e.g. hospital episode data) and analytical skills to enable it to support healthcare commissioning, via the NHS North of Tyne Information Department. From April 2013 this has no longer been the case, since these resources have been hosted within the North East Commissioning Support (NECS) unit. Continued access to these key resources going forward will be facilitated, via the contract between the CCG and NECS.

**Avoiding duplication between the ‘core offer’ and work provided by NECS**
The Public Health ‘core offer’ will be complementary to the support provided by NECS. There is potential for some crossover or duplication between the ‘core offer’ service and the service that will be provided by NECS, for example in relation to needs assessment and service re-design. The DH guidance on the core offer envisaged that public health teams will provide largely a strategic population focus, whereas commissioning support organisations such as NECS, will focus more on commissioning processes and systems. For example, in relation to needs assessment, NECS might be expected to provide GP practice level data, which the public health team might combine with data from other sources (e.g. Public Health Observatories) to draw out implications for the local population. Clarity around the nature of the services to be provided by NECS and Public Health team will be negotiated for each piece of work.

Wendy Burke  
Director of Public Health
<table>
<thead>
<tr>
<th>Area of work</th>
<th>Public health advice</th>
<th>Objectives</th>
<th>Timescales</th>
<th>Key leads</th>
</tr>
</thead>
</table>
| 1. Support development of policies on Procedures of Limited Clinical Value and the IFR process for the North IFR panel | Strategic planning:  
- Assessing needs  
- Reviewing service provision  
- Deciding priorities  
- Managing IFR | To build on the existing suite of evidence based policies and procedures to ensure a consistent and systematic approach.  
To continue to pay a contribution (together with the other 5 LAs across NoT and SoT) to fund Consultant in Public Health time (Tom Hall South Tyneside Council) to provide PH advice and support to the North IFR panel. The Consultant in Public Health in North Tyneside will provide support to Tom Hall as required. | Ongoing | CCG  
Dr Martin Wright  
NT Council  
Heidi Douglas Consultant in Public Health  
Tom Hall Consultant in Public Health South Tyneside Council part funded by all DsPH North and South of Tyne |
| 2. Support to developing the CCG operational plan | Strategic planning  
- assessing needs  
- reviewing service provision  
- deciding priorities | To provide a narrative in relation to self care and prevention ensuring clear links with the STP and the emerging themes from the Commission on Health and Social Care | Dec 2016 | CCG  
Anya Paradis  
NT Council  
Wendy Burke DPH  
Heidi Douglas Consultant in Public Health  
Paul Murphy Public Health Analyst |
| 3. Support a programme of work in relation to Diabetes Prevention | Strategic planning:  
- Assessing needs  
- Reviewing service provision  
- Deciding priorities  
- Procuring services  
- designing shape and structure of supply  
- planning capacity and managing demand  
- Monitoring and evaluation  
- supporting patient choice, managing performance and seeking public and patient views | Submit expression of interest from both CCG and LA for phase 3 rollout of the national Diabetes Prevention Programme  
Review and develop more integrated pathways for the promotion of healthy weight and weight management programmes in line with the priority of the North Tyneside Health and Wellebging Being Board | October 2016  
April 2017 onwards | CCG  
Anya Paradis  
Dr Caroline Sprake  
NT Council  
Wendy Burke DPH  
Dawn Phillips Senior Manager Public Health  
Paul Murphy Public Health Analyst |
<table>
<thead>
<tr>
<th>4. Support the reduction in alcohol related and alcohol specific admissions to hospital</th>
<th>To review the pathways for those people admitted to hospital for alcohol related harm. To identify opportunities for influencing acute trusts in the management of treatment resistant drinkers. To develop Alcohol Concern Bluelight approach to treatment resistant drinkers in order to reduce the number of admissions. To provide training for a range of staff including GPs in relation to treatment resistant drinkers and moving people to treatment services. To develop multi agency hub approach to treatment resistant drinkers who have repeated hospital admissions. To review treatment service with a view to re procuring the service.</th>
<th>April 2017-March 2018 ongoing</th>
<th>CCG Anya Paradis NTC Christine Jordan Senior Manager Public Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Support the work around the locality cancer plan with a focus upon reducing impact of smoking on health</td>
<td>To contribute and support the work of the North Tyneside Cancer Locality Group. To lead the development of the prevention and public health element of the North Tyneside cancer plan. To work with partners to implement the plan. To ensure that smoking is a key emphasis within the NT Cancer locality plan. To agree an ambition to reduce prevalence of smoking in North Tyneside by 2020 and 2025. To implement the action plan that has resulted from the Tobacco CLeaR assessment. To embed brief interventions for smoking in primary and secondary care. To implement NICE guidance for secondary care and ensure that.</td>
<td>Ongoing to March 2018</td>
<td>CCG Tom Dunkerton Dr Claire Scarlett NTC Heidi Douglas Consultant in Public Health Dawn Phillips Senior Manager Public Health</td>
</tr>
</tbody>
</table>
| 6. Support a programme of work focussing on falls | Strategic planning:  
- Assessing needs  
- Reviewing service provision  
- Deciding priorities  
- Procuring services  
- Designing shape and structure of supply  
- Planning capacity and managing demand  
Monitoring and evaluation  
- Supporting patient choice, managing performance and seeking public and patient views | To analyse the current data on falls and understand the position in relation to North Tyneside.  
To review the provision of services in North Tyneside.  
To develop an action plan with partners to reduce the prevalence of falls. | April – October 2017  
CCG  
Tom Dunkerton  
Dr Claire Scarlett  
NTC  
Heidi Douglas Consultant in Public Health  
Paul Murphy Public Health Analyst |
| 7. ‘Social marketing’, support for self-management and helping patients make better use of available primary, community, social and informal services | Strategic planning  
- Reviewing literature  
- Reviewing service provision  
- Deciding priorities  
- Primary research  
- Develop plans  
- Implement plans | To support progress beyond ‘plans and narrative’ to active promotion of solutions to increase patient self-management and understanding and usage of low-intensity solutions to common health problems.  
Discover why people find it difficult to lose weight, exercise, stop smoking, drink less alcohol.  
Discover what would make it easier to adopt these behaviours.  
Develop materials and marketing to promote the desired behaviour | April 2017  
CCG  
Dr Ruth Evans  
NTC  
Heidi Douglas Consultant in Public Health |
Report to: Governing Body Meeting

Date: 22 November 2016  |  Agenda item: 13.4a

<table>
<thead>
<tr>
<th>Title of report: Commissioning Plans 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sponsor: John Wicks, Interim Chief Operating Officer, North Tyneside CCG</td>
</tr>
<tr>
<td>Author: John Wicks</td>
</tr>
</tbody>
</table>

Purpose of the report and action required: To describe the CCG’s commissioning plans for year one of the Sustainability and Transformation Plan (STP) 2017/18

Executive Summary

1. The CCG is required to produce an Operational Plan 2017/18 – 2018/19 to support the first two years implementation of the Sustainability and Transformation Plan (STP)

2. The STP priorities are to:
   - Scale up prevention and health & well-being
   - Develop models of out-of-hospital care
   - Make best use of acute hospital sector

3. The CCG’s contribution to these strategic priorities will be to develop plans in the following areas:
   - Self-care / supporting patients to make the right choices
   - Reform of the urgent and emergency care system
   - Right Care
   - Development of out-of-hospital care

4. The Governing Body is asked to endorse the summary of CCG priorities for further development and the basis for setting contract values and resource priorities for 2017/18.
Governance and Compliance

1. **Links to corporate objectives**

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
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<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
<td>√</td>
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<td>√</td>
</tr>
<tr>
<td>3. Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside</td>
<td>√</td>
</tr>
<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
<td>√</td>
</tr>
</tbody>
</table>

2. **Consultation and engagement**
   There will be a series of workshops to engage patients in the refinement of these priorities. Any substantive changes may be subject to public consultation.

3. **Resource implications**
   These priorities will drive the setting of the financial plan.

4. **Risks**
   There are risks to the sustainability of current NHS services if progress is not made to reduce the cost and level of activity dependence on hospital services.

5. **Equality assessment**
   The CCG will conduct equality impact assessments for any substantive service changes.

6. **Environment and sustainability assessment**
   There are no environmental or sustainability issues arising from this report.
Report to: Governing Body

Date: 22 November 2016  Agenda item: 13.4b

Title of report: Commissioning Plans 2017/18
Sponsor: John Wicks, Interim Chief Operating Officer
Author: John Wicks

Purpose of the report and action required: To describe the CCG’s commissioning plans for year one of the Sustainability and Transformation Plan (STP) 2017/18

Full report

1. Background

2.1 Context

The Northumberland Tyne & Wear and North Durham Sustainability and Transformation Plan (STP) is the route map for the how the local NHS will make a reality of the Five Year Forward View within the Spending Review financial envelope between now and 2020/21. If nothing changes, the financial gap which is expected to emerge in the next five years between available resources and expected demand for health care is £641m. The CCG has developed commissioning plans which will contribute to the narrowing of this gap in the first year.

2.2 Planning Guidance

Planning guidance requires the CCG to produce an Operational Plan 2016/17 – 2018/19 to cover the first two years’ implementation of the STP. The Plan should cover:

- How we will deliver the national ‘9 Must Dos’ (agree an STP, achieve financial balance, support primary care, A&E and ambulance wait time standards, referral to treatment wait times, cancer standards, mental health standards, transform learning disability services, improve quality)
- How we will support local delivery of the STP
- How we will reconcile finance, activity and workforce to achieve system control totals
- How we will make savings and efficiencies
- How we will manage risks and contingencies
- How we will introduce new models of care
2. Commissioning Plans

2.1 STP Priorities

The STP priorities are to:

- Scale up prevention and health & well-being
- Develop models of out-of-hospital care
- Make best use of acute hospital sector

These are to be delivered within the context of addressing a £641m potential funding shortfall by 2020/21 if nothing changes.

The interventions that the STP expects to be led and delivered locally (ie at CCG / Local Authority level) are to support self-care and health promotion, develop primary care, develop community and other out-of-hospital provision support, secondary care commissioning, collaboration with voluntary sector and public engagement. The CCG’s commissioning plans reflect this contribution.

2.2 Proposed CCG Priorities

a. Self-care / supporting patients to make the right choices

- Support for people to address their common health problems through self-management or using low-intensity solutions to common health problems. Discover why people find it difficult to lose weight, exercise, stop smoking, drink less alcohol and make it easier for them to adopt these behaviours.
- Promotion of ‘patient online’ and other e-solutions to improve the convenience and accessibility of GP services and alternative community provision
- Collaboration with Public Health (North Tyneside Council), third sector and carers organisations to improve health and well-being and awareness of services available
- More intervention to direct people to the right solutions for their problem (eg. directly bookable services through NHS 111, streaming at front-door of A&E, use of community pharmacy for minor ailments)

b. Reform of Urgent and Emergency Care system

- Procurement of integrated urgent care centre and GP Out of Hours service for North Tyneside
- Measures to reduce demand for urgent services (A&E and non-elective admissions) presenting at the Northumbria Specialist Emergency Care Hospital (NSECH)
- Plans that are resilient to winter surges or other sudden increases in demand
- Measures to improve ambulance performance, especially response times and handover times at NSECH
- Change contract incentives to reward activity reductions
- Collaborate with North Tyneside Council to improve effectiveness of Better Care Fund
- Address mental health needs of individuals accessing urgent care services

c. Right Care

- Make best use of comparative information to identify savings opportunities across common pathways (estimated total Rightcare opportunity £12m)
- Prioritise following areas for improvement:
  - Musculo-skeletal
  - Respiratory
  - Circulation
  - Gastrointestinal
  - Cancer
- Work collaboratively with Northumberland CCG & Northumbria Healthcare NHS FT to develop change programmes
- Utilise national support effectively

d. Develop out-of-hospital care

- Implement the CCG / Tynehealth primary care strategy
- Identify services currently provided in hospital settings that could be delivered more cost-effectively in out-of-hospital settings (eg. DMARDS, heart failure etc)
- Evaluation and (if positive) roll-out of Care Plus new models of care to whole of North Tyneside
- Apply planning assumptions to move resources in support of out-of-hospital care

3. Engagement

The CCG proposes to hold patient engagement workshops to refine and develop these proposals further. These will be taken forward with the Patient Forum / Healthwatch.

4. Recommendations

The Governing Body is asked to endorse the summary of CCG priorities as the basis for setting contract values and resource priorities for 2017/18

5. Appendices and further information

N/A

Report author: John Wicks, Interim Chief Operating Officer
Report date: 14 November 2016
Report to: Governing Body

Date: 22 November 2016  
Agenda item: 13.5

Title of report: Primary Care Commissioning Level 3

Sponsor: Dr Martin Wright, Medical Director
Author: James Martin, Commissioning and Performance Manager & Shelagh Cockburn, Programme Management Office

Purpose of the report and action required: This report sets out the benefits and risks relating to primary care commissioning level 3.

Council of Practices discussed primary care commissioning level 3 on 16 November 2016, and the Medical Director will provide verbal feedback of these discussions to Governing Body.

This report is for decision. Governing Body is asked to decide whether the CCG should make an application for level 3 commissioning.

Full report

1. Background / introduction /context

Primary care co-commissioning aims to support the development of high quality integrated out-of-hospital services based around the needs of local people. There are three levels that CCGs could assume from April 1st 2015:

- Level One: Greater CCG Involvement in NHS England (NHSE) decision making
- Level Two: Joint Decision Making (Joint Commissioning) by NHSE and CCGs (North Tyneside CCG is currently at this level)
- Level Three: CCGs taking on delegated responsibilities from NHSE

114 CCGs are now at level 3 nationally, as are the majority of CCGs in the local North East region. NHSE gave a clear steer to North Tyneside CCG at the CCG Q1 Assurance meeting that the CCG should apply for level 3 Primary Care Co-commissioning. Therefore the CCG Executive now seeks to move to level 3. To do this the CCG would be required to submit an application by 5th December 2016 and would take on delegated responsibilities from 1st April 2017.

2. Level 3 CCG Delegated Responsibilities

Under level 3 the role of the CCG will be to exercise the Delegated Functions which include for example:
• decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to:
  o Enhanced Services
  o Local Incentive Schemes including the design of such schemes
  o Establishment of new GP practices and closure of GP practices
• performance management of GP practices, including liaison with the CQC
• management of the Delegated Funds

NHSE retains the residual liability for the performance of primary medical care commissioning as well as exercising the Reserved Functions including:
• management of the performers list
• revalidation and appraisal process
• complaints management
• Capital expenditure functions

3. Benefits and Risks

Benefits
• CCGs will have more power to drive forward the development and implementation of the Tripartite Primary Care Strategy and the GP forward view agenda
• Budget slippage will be retained for the CCG to invest in primary care locally whereas at level 2 budget slippage is retained by NHSE to spend across the area or return as underspend
• Enables CCGs to make decisions to shift investment from acute to primary and community services
• Opportunity for GPs to influence the development and investment in general practice
• Local knowledge and relationships;
  o support collaborative solutions to problems
  o enable more timely resolution of queries
• CCG roles and structures provide easier contact points and ongoing support for practices
• Ability to design local schemes to replace QOF and DESs
• Enable and support new collaborative ways of working with practices

Risks and Mitigations
• Insufficient capacity/expertise in the CCG to deliver with no additional resources coming over from NHSE. This may reduce the ability to innovate, develop and deliver. This is being mitigated by;
  o Maintaining NHSE support
  o The development of a clear agreement of responsibilities with NHSE based on the scheme of delegations
  o Skills development within the CCG
• CCG commissioning, holding and managing GP contracts including performance management could damage or worsen relationships or lead to conflicts of interest. This will be mitigated by the following;
  o In moving to level 3 the Constitution and committee terms of reference will need to be revised
New guidelines on managing conflict of interest which have just been published will help manage this issue.

NHSE will continue to manage and investigate individual performers concerns (ie GPs).

NHSE will also be involved in significant contractual issues as the contract remains with them. Performance investigations would be undertaken by NHSE. NHSE would discuss concerns with the CCG in the first instance and undertake a general assessment for consideration by the CCG. If a formal investigation were to be undertaken NHSE would then provide an outcome report to the CCG who will determine if contract sanctions are to be implemented.

Increased risk of conflicts of interest as CCGs procuring services from members and their own practices. In addition to the first 3 bullets above, commissioning services will be assured by the Primary Care Commissioning Committee which is a committee of the Governing Body, is held in public and is chaired by lay members.

Local schemes to replace QOF and DESs may result in increased workload. The CCG is acutely aware of the pressures practices are under – this is shown in the Primary Care Strategy. Any local schemes would be developed in consultation with practices and the LMC.

Current contracting/procurement models and lack of definition of budgets could stifle financial shifts. This will be mitigated by;

- A drive to increase the understanding nationally of potential models
- The CCG will develop knowledge in these areas and will maintain the support from NECS contracting/procurement experts
- The CCG will work with NHSE to define baseline budgets in time for commencement of level 3 on 1st April

Delegated commissioning means that risk management shifts to CCGs with less risk sharing. There will still be risk sharing for other contracts such as specialised commissioning.

4. Frequently asked questions

- How will the CCG ensure that any potential underspend in the primary care budget is ring fenced/protected to spend in PC?
- Where would any underspend on the primary care budget go?
- How will practice budgets be protected?

Ian Cameron (Assistant Head of Finance, Primary Care, NHSE) has confirmed that the GP budget that is delegated is effectively seen as a funding ‘floor’ – i.e. CCGs must only spend the funds on GP services and cannot divert to other pressures/services.

Level 3 CCGs retain the full delegated allocation – NHSE do not claw back any underspend.
Practice contracts will still be with NHSE and the regulations which underpin the PMS/GMS contracts and the contracts themselves are negotiated nationally, therefore there is no risk to these due to level 3.

- **What happens if we overspend on the primary care budget? Where will the money come from and are the CCG planning for this?**

The CCG will plan for this as part of the transition to level 3. A planned reserve exists in the primary care budget to mitigate against any overspend – this currently stands at £160k.

Should a CCG spend more than their delegated allocation then the CCG would need to find the funding from elsewhere in their wider CCG allocation.

- **How will the money be reinvested into primary care if we underspend?**
- **How would practices be involved in the decision making for spending this budget underspend?**

Money would be reinvested into primary care to meet local priorities, in consultation with practices through existing mechanisms. Applicable regulations and guidance would need to be followed. This would be steered by:
  - The Tripartite Primary Care Strategy whose development has been generated through engagement with practices.
  - The transformation agenda linking to the 5 year forward view and General Practice Forward View
  - The commissioning intentions process whereby national and local priorities are identified - practices are involved in identifying and deciding those commissioning priorities

- **CCG do not have the capacity or expertise – how will this be managed?**

The CCG will continue to work closely with NHSE locally. The NHSE team will remain together to pool expertise to call on as required. The CCG is also developing knowledge in commissioning through training events and knowledge sharing with NHSE.

- **Who would be able to make decisions on estates? Would the process be any simpler than it is now?**

Unfortunately the process will be split between the CCG and NHSE. The CCG will need to support requests for funding at CCG Estates Steering Group. The CCG Estates Plan will underpin this. Decision will be made jointly by NHSE and the CCG at the Primary Care Commissioning Committee based on recommendations from NHSE.

Any request for capital funding for a relocation has to be agreed by NHSE as capital estates budgets remain with NHSE, even though the contractual decision to relocate will be made by the CCG. The CCG also needs to support an improvement grant or Estates Technology Transformation Fund (ETTF) need. However improvement grant funding and ETTF funding also remain with NHSE. Revenue implications are however the responsibility of the CCG.
• Do we have any plans for what we will do first if we went to level 3?

We would intend to focus on the following:
  o The Tripartite Primary Care Strategy whose development has been generated through engagement with practices
  o Priorities identified through the commissioning intentions process
  o Use local knowledge of practice groupings to facilitate working together on, for example, the 10 high impact actions talked on in the General Practice Forward View
  o Scale up IT, estates, workforce developments

• How are we going to ensure all practices across North Tyneside have an equal voice?

Through consultation and engagement via the Locality meetings, GP Fora, PM meetings, etc and by ensuring appropriate PM, GP and LMC representation on key groups.

• How would this affect the proposed move to ACO?

Although the CCG would have delegated responsibilities to manage the Primary Care budget, practice contracts will remain with NHSE. As previously proposed practices would be able to actively participate, as providers, within an ACO. From a commissioning perspective delegated Level 3 Primary Care Co-commissioning would have no impact as the primary care budget would remain separate. The primary care commissioning responsibility would be delegated to the CCG by NHS England and it would not be possible for the CCG to delegate that onwards.

5. Implementation plan/next steps

5.1 Application to NHSE by 5 December 2016 on approval of the application CCG to take on delegated responsibilities from 1 April 2017.

Appendices and further information

6. Appendices

None.

7. Further information relevant to the report


Report author: James Martin, Performance and Commissioning Manager
Report date: 4 November 2016
Governance and Compliance

1. Links to corporate objectives

<table>
<thead>
<tr>
<th>2016/17 corporate objectives</th>
<th>Item links to objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution</td>
<td>✓</td>
</tr>
<tr>
<td>2. Deliver the Financial Recovery Plan, leading to the achievement of the CCG’s statutory financial duties and future sustainability</td>
<td></td>
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<tr>
<td>3. Work collaboratively with partners and stakeholders to develop health and social care fit for the future in North Tyneside</td>
<td></td>
</tr>
<tr>
<td>4. Continue to develop North Tyneside CCG as a patient focused, clinically led commissioning organisation with a continuous learning culture</td>
<td>✓</td>
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</table>
Welcome
Mrs Coyle welcomed everyone to the meeting and introductions were made.

Mrs Coyle advised that there is now a new format to the meeting and invited Mrs Walker to give an overview as to the reason for this change.

Mrs Walker advised the committee that the Council of Practices agreed to a change to the constitution and scheme of delegation for the CCG. The Governing Body is now the decision maker for the CCG with all other committees feeding into the Governing Body and this includes the Quality and Safety Committee. The Governing Body meeting is held in two parts, one public part followed by a private part for confidential agenda items. It is therefore necessary for the Quality and Safety Committee to also be split into two parts to ensure confidentiality is maintained. Mrs Walker advised that this change in format is still a work in progress as discussions are still taking place as to the best way to implement this across the whole CCG.

NTQS/16/001 Agenda Item 1: Apologies for Absence

Apologies were received from:-
Janet Soo-Chung – Interim Chief Operating Officer
Gregor Miller – Senior clinical Quality Manager (NECS)

NTQS/16/002 Agenda Item 2: Declarations of Interest
It was noted that all declarations of interest were recorded in the register of interests on the public website. There were no additional declarations.

NTQS/16/003  Agenda Item 3: Quoracy of Meeting

The committee was confirmed as quorate.

NTQS/16/004  Agenda Item 4: HCAI Report Quarter 1, 2016 – 2017

Mrs Grieveson advised the committee that the purpose of the report is to provide a summary of the HCAI performance covering the period April 2016 to 30 June 2016, and apologised for the typing error on page one, 3oth June 2016 should read 30th June.

Mrs Grieveson advised the committee that all Trusts are within trajectory for Clostridium Difficile.

There have been no episodes of MRSA assigned to NTCCG in Q1.

Mrs Grieveson advised the committee that Northumbria Healthcare NHS Foundation Trust gave an excellent presentation around infection control rates at their last quality review group.

The committee thanked Mrs Grieveson for the report.

NTQS/16/005  Agenda Item 5: Information Governance Strategy

Mrs Walker advised the committee that the Information Governance Strategy Report states that the Quality and Safety Committee is requested to approve the 16/17 Information Governance Strategy document. This should state that the Quality and Safety Committee is asked to recommend approval to the Governing Body.

The Information Governance Strategy has been reviewed and updated with the following changes:-

- The revision of the Equality Impact assessment.
- The addition of a reference to Data Processing Agreements
- The addition of a reference to the monitoring of the embedding of IG knowledge through regular checks.

The committee agreed to recommend approval to the Governing Body.

NTQS/16/006  Agenda Item 6: Complaints Policy

The committee agreed to the withdrawal of the Complaints Policy and following further updating, this will be brought back to the committee on 04 October 2016.

Action 1 – Complaints Policy to be updated and placed on the agenda for the next meeting 04 October 2016.

NTQS/16/007  Agenda Item 7: Local Staff Survey
The committee was asked to consider a proposal to undertake a local staff survey and the questions that would be used in this survey. The committee was advised that the questions have been taken from the national staff survey.

Following a discussion, the committee agreed that at a time of significant change, it is important to carry out this local staff survey as this is an important and useful piece of work, and will help gain an understanding of how staff are feeling.

**NTQS/16/008  Agenda Item 8: Policies**

**NTQS/16/009  HR Policy Report**

The HR Policy Report outlines changes to existing HR policies and new HR policies agreed by the CCG HR Reference Group and CCG HR Partnership Forum on 22 July 2016.

Mrs Walker advised that policy HR06 and Policy HR34 have been withdrawn.

**NTQS/16/010  HR06 Change Management Policy**

This policy was withdrawn.

**NTQS/16/011  HR09 Flexible Working Policy**

The committee agreed to recommend approval to the Governing Body.

**NTQS/16/012  HR17 Maternity Policy**

The committee agreed to recommend approval to the Governing Body.

**NTQS/16/013  HR22 Paternity Leave Policy**

The committee agreed to recommend approval to the Governing Body.

**NTQS/16/014  HR34 Incremental Pay Progression Framework**

This policy was withdrawn.

**NTQS/16/015  HR39 Shared Parental Leave Policy**

The committee agreed to recommend approval to the Governing Body.

**NTQS/16/016  Agenda Item 9: Risk Assurance Framework**

Due to confidentiality reasons, this agenda item has been moved to the private part of this meeting.

**NTQS/16/017  Agenda Item 10: Risk Policy**

Mrs Walker advised the committee that the Risk Management policy requires
monitoring of the Risk Assurance Framework (RAF) by the Governing Body. To support this, the Corporate Risk Register is presented bi-monthly to Finance Committee, Quality & Safety Committee and Clinical Executive Committee for consideration ahead of submission of the risk assurance framework to Audit Committee and to Governing Body for assurance. The Corporate Risk Register is reviewed by Directors on an ongoing basis.

The committee discussed various target risk scores and the scheme of delegation.

The committee agreed to recommend approval to the Governing Body.

**NTQS/16/018 Agenda Item 11: Risk Appetite**

Mrs Walker advised that the Governing Body has responsibility for considering and setting the risk appetite for the organisation, as set out in the CCG risk management policy. Risk appetite is ‘the amount of risk that an organisation is prepared to accept, tolerate or be exposed to at any point in time.’

The CCG’s risk appetite has been reassessed by (8/9) Governing Body members in August 2016, in accordance with the risk policy. It assessed the CCG’s overall risk appetite as ‘open’ with a score of 3.4/5 notwithstanding that in certain areas there is no appetite to tolerate unmitigated risks.

The CCG Governing Body is committed to keeping the CCG risk appetite under review.

The CCG has zero tolerance for unmitigated risk in safeguarding, patient safety, data protection, fraud and regulatory breaches.

The committee discussed the increase in the overall score from 3.2 last year to 3.4 this year.

The committee agreed to recommend approval to the Governing Body.

**NTQS/16/019 Agenda Item 12: PHE Protecting the population of the North East from communicable disease and other hazards. Annual Report 2015/16**

Mrs Grieveson advised the committee that the Public Health England Annual Report on Protecting the population of the North East from communicable disease and other hazards was for their information only.

The committee noted that childhood immunisation take up is higher than the national average.

The committee received the report for information.


Mrs Grieveson advised that in May 2016 the Chief Nursing Officer for England Jane Cummings launched ‘Leading Change, Adding Value’. It is a
framework every nursing, midwifery and care professional, in all settings, can use to ensure we achieve the best quality of experience for our patients and people, the best health and well-being outcomes for our populations, and use finite resources wisely to get best value for every pound spent.

It aims to target three crucial gaps; health and wellbeing, care and quality and funding and efficiency. The overall objective is to develop a high quality, financially sustainable service that delivers the objectives set out under the Triple Aim; better outcomes, better experiences and better use of resources.

The committee received the report for information.

**NTQS/16/021 Agenda Item 14: Minutes to receive**

- NHCFT QRG 09.02.16 Ratified
- NHCFT QRG 08.03.16 Ratified
- NHCFT QRG 10.05.16 Ratified
- NTW QRG 03.02.16 Ratified
- NTW QRG 04.05.16 Ratified
- NuTHFT QRG 24.03.16 Ratified
- NuTHFT QRG 26.05.16 Ratified

The committee received the above minutes.

**NTQS/16/022 Agenda Item 15: Any Other Business**

There was no other business to be discussed and the public part of the Quality and Safety Committee meeting was closed at 10.00 a.m.

**Date and Time of Next Meeting**

- 04 October 2016  09:00 – 11:30
- 01 November 2016  09:00 – 11:30
- 06 December 2016  09:00 – 11:30
Notes of the Meeting of the North Tyneside CCG Council of Practices held on Wednesday 6 July 2016, at The Rising Sun Country Park, 1.40pm – 3.25pm

1 Present: The meeting was chaired by Dr Martin Wright, Medical Director.

Practice Representatives:
49 Marine Avenue Dr Julia Fisher
Appleby Surgery Dr Rachel Firth
Battle Hill Health Centre Dr Jeremy Bruce
Beaumont Park Dr Angela McMenzie
Bewicke Medical Centre Dr Kristin Richardson
Bridge Medical/Monkseaton Medical Ctr Dr Salam
Collingwood Surgery Dr Dave Tomson
Northumberland Park Dr Simon Young
Mallard Medical Practice Dr Austin
Earsdon Park Surgery Dr Rebecca Keogh
Forest Hall Medical Centre Dr James Lunn
Garden Park Surgery Dr Priya Sandhu
Lane End Surgery Dr Richard Davis
Marine Avenue Medical Centre Dr Richard Scott
Nelson Medical Group Dr Will Tufton
Park Parade Surgery Dr Chris Lee
Park Road Medical Practice Dr Kate Carding
Portugal Place Health Centre Dr Angus McColl
Priory Medical Group Dr Tony Stephenson /Dr Andrew Duggan
Redburn Park Medical Centre Dr Mark Tones
Spring Terrace Health Centre Dr Adelle Pears
Swarland Avenue Surgery Dr Clare Mears
Village Green Surgery Dr Mark Westwood
Wellspring Medical Practice Dr Jackie Gray
West Farm Surgery Dr Joanne Lee
Whitley Road Health Centre Dr David Colvin
Wideopen Medical Centre Dr Chris May
Woodlands Park Medical Centre Dr Alan McCubbin

In attendance:
Yvonne Scotland (Battle Hill Health Centre)
Susan Harrison (Beaumont Park)
Ann Crosby (Garden Park Surgery)
Rebecca Ross (Mallard Medical Practice)
Lara Hills (Nelson Medical Practice)
Philip Horsfield (Village Green Surgery)
Liz Brittlebank (Wellspring Medical Practice)
Christine Davidson (West Farm Surgery)
Sharon Fox (Wideopen Medical Centre)

Dr Ruth Evans (Clinical Director)
1.1 Welcome and apologies:

Apologies were noted from Dr John Matthews.

Dr Wright advised members that Jim Hayburn was stepping down as Interim Chief Officer, and his replacement was Janet Soo-Chung, who was welcomed to the meeting. Paul James was also welcomed as the new Interim Chief Finance Officer.

1.2 Notes of Previous Meeting: 18 May 2016

The notes of the previous meeting dated 18 May 2016 were accepted as an accurate record.

1.3 Chair's Report

The Chair’s report had been circulated with the agenda.

Dr Wright asked members to be aware of the financial position of the CCG and the role of GPs to support financial balance. He indicated a lot of work had been done which was making a difference and GPs and practice managers were thanked for their invaluable input.

The meeting would be considering proposed changes to structure and governance within the CCG and would also discuss the urgent care review. There would also be an update on the ACO.

2.0 Accountable Care Organisation (ACO) Update

Drs Evans and Wright gave a presentation on the ACO and a summary was available on tables for members to read which has also been included in the CCG newsletter. The presentation explained the benefits of an ACO and why the CCG was moving in that direction. Comments and questions were invited from members.

A member expressed concern that there seemed to be a move towards a model with individual organisations which would not be an NHS body. Dr Evans confirmed that was the model that was being looked at but there were technical difficulties and they were working on the legalities. Mr Hayburn advised that they were looking at something similar to a section 75 agreement with partners coming together to agree what should be done. The contract would be with the ACO and all partners would be equal signatories. The ACO would not employ staff but would be hosted by one of the partner organisations. The individual partners would not need to change their NHS status.

In response to a question about whether the CCG would hold the budget, Mr Hayburn confirmed that the CCG would still get its allocation and would hold a small amount of
that for setting outcomes and assurance. The rest of the money would be transferred in a contract to the ACO, and the ACO would have to decide how it would be used to commission services and manage within that amount. With regard to the CCG’s deficit and debt, NHS England had fed back that the ACO would have to start to pay back some of the deficit.

The CCG’s deficit of £19.3m included a contingency required by NHS England of 1.5%, (£4.6m). Clarity was needed about what would happen to that contingency in the future, but it was assumed that it would go to the ACO as a surplus.

A member questioned what the benefits were for Northumbria Healthcare NHS FT (NHCFT). Dr Wright said that it would be a risk for the Trust, but they can’t contain what is happening individually and there was pressure to scale things back. There was the opportunity to do things differently to cut waste and duplication in the system by working in a more integrated way.

A member asked what mechanisms would be put in place if there was disagreement with the ACO and Dr Wright advised that this was still being worked through. There were different levels of risk and investment for each organisation.

Mr Hayburn reported that other work was going on, in particular due diligence. The CCG due diligence would focus on arrangements for the ACO and governance. Providers will also carry out due diligence. The CCG would have to be assured that those mechanisms were in place and would be workable before the ACO was signed off. This was taking time because the ACO model was not fully operational anywhere else in the country, so safeguards were important.

Dr Evans clarified that the CCG was leading on the ACO work as a level 2 commissioner. The Programme Board functions as the project board and the chairs of each of the workstreams sit on the Programme Board, chaired by Dr John Matthews, and includes representatives from the provider organisations, as well as NHS England.

Mr Hayburn felt the CCG had not always managed its budget effectively and the work in primary care would help to manage the budget better. The CCG was in financial balance for this year and only in deficit because of the previous year’s debt.

Members were concerned that they were not getting much clarity about ACO development and did not know what it would all mean for individual practices, and that primary care didn’t seem to have much of a voice.

It was stressed that it was still too early to have clarity or structure as the work was still in its infancy, but Dr Wright stressed that General Practice and the Primary Care Strategy were at the heart of the development of the ACO. The practicalities were still being developed and how that should be articulated to have the biggest impact, but there was a need to deliver change across the system.

It would be a challenge to have more people in primary care, and discussions were not at that level of detail yet, but intrinsic to the ACO where mechanisms to move skills and resources to the best place in the whole system. There was a national recognition that primary care was under pressure, but that its role is essential to the NHS. It would be important to ensure support and development of primary care was right and must be addressed as part of the development of the ACO.
Dr Lackey felt it was difficult to answer the question whether there was enough information to be able to support an ACO without knowing what was actually meant by support. It was difficult to see how there could be a greater understanding before September, so timescales could be affected.

Mr Hayburn advised that the April milestone was more critical, and there needed to be sufficient progress to continue the development of the ACO by September, but there was a huge amount of work to be done. In September if we are not in the right position, the ACO won’t be signed off but work would continue and a decision made at a later date.

A member questioned the possibility of a legal challenge from Newcastle upon Tyne Hospitals NHS FT (NuTHFT) in the event of a reduction in PBR income. Mr Hayburn advised that the providers will have to put forward a business case for sign off by NHS Improvement which would include how they would deal with competition and patient choice. NuTHFT was still involved in the discussions and the due diligence work, and will review their position once that is completed, but they don’t want to give up PBR. It was noted that any challenge would be on the contract holder.

Members were asked to send any further questions to a dedicated e-mail address which would be supplied by Dr Young-Murphy.

3.0 Right Care, Time and Place Urgent Care Review: The New Clinical Model

Mr Crowther joined the meeting, and Dr Evans gave a presentation on the urgent care review to consider and decide what the model should be.

The pathway was described. Part was similar to NHS 111, but face to face, which would be a quicker process. Work was going on nationally and locally in relation to NHS 111 which was very risk averse.

The level of staffing was queried, and it was confirmed that there would always be a GP present. The figure of 29% deflecting walk-ins was queried, and Mr Crowther advised that in other areas where similar configurations had been carried out, when access points had been removed the activity disappeared from the system. The system would encourage people to ring first rather than turn up at the walk-in centre.

4.0 Approval of Governance Arrangements

Dr Wright presented the report which looked at the better use of Council of Practices (CoP) time and expertise as agreed at the May 2016 CoP meeting.

The Governing Body would be the main accountable and decision making body of the CCG, with specific matters reserved to the Council of Practices.

Clinical input would be strengthened on the Clinical Executive, with a development and planning role being highlighted. Members felt it would be difficult to arrange cover if they attended the Clinical Executive meetings which were held twice a month, for two hours each. Mr Hayburn said clinical engagement was critical to the working of the CCG and the resources would need to be found to best support this.

He confirmed that the ACO would still be a decision reserved for the Council of Practices.
and not the Governing Body because it would be a structural change. GP representation on the Governing Body was confirmed as two members, which was one more than the statutory requirement, two executive directors, and the Chair is a GP.

Members agreed to support the revision to the constitution without a vote.

5.0 Any Other Business

5.1 PMS Money

A member from the North West locality advised that their locality meeting had asked for clarification re PMS practices. Dr Wright stated that this had been discussed with the LMC. This year the money was being used to support Care Plus. There was an issue about interpretation of the wording of the PMS money as to whether it should be available to everyone at the same time. The CCG’s view was that the money should be used more strategically to move primary care forward. For the future the plan was that the money should be put into the primary care strategy, and will be available to everyone.

Regarding the primary care scheme, it was agreed at the last meeting that there was a need to understand capacity in primary care. Some practices were looking to employ someone to get the data already. Schemes in the past had not got off the ground, and any schemes would need to have outcomes which fit with the CCG.

It was noted that data had previously been requested, but some practices had refused to provide the information or felt it was not accurate. Using an external company ensured that the data was standardised as they have the expertise in that area, although it was acknowledged that there are always limitations with any data. It would then be up to individual practices whether they followed up on the recommendations. It was agreed that practices would consider sharing unanonymised data as the information would give a starting point to move forward the Primary Care Strategy and other developments in General Practice.

A member commented that it was difficult to get in extra resources when the level of funding changed year on year. Dr Wright pointed out that the funding was not recurrent and the money could not be guaranteed.

6.0 Date and Time of Next Meeting

Wednesday 21 September, 1.30pm
Holystone Room, The Rising Sun Country Park
Notes of the meeting of the North Tyneside CCG Patient Forum held on 14 July 2016 held at The Linskill Centre, Linskill Terrace, North Shields, 6pm – 8pm

Present: The meeting was chaired by Eleanor Hayward

Practice Representatives:
Beaumont Park  Victoria Mayes
Northumberland Park David Hall
Lane End Surgery Colin Thomson
Monkseaton Medical Centre John Tanner
Park Road Medical Practice George Mitchell CBE
Priory Medical Group Susan Dawson
Earsdon Park Surgery Ann Appleby
Wellspring Practice Gillian Bennett
49 Marine Avenue Hazel Parrack
Whitley Bay Health Centre Heather Carr
Marine Avenue Jon Routledge
Swarland Avenue Steve Cattle

In attendance:
Chair Eleanor Hayward
North Tyneside CCG Lesley Young Murphy
Chief Exec, TyneHealth Hugo Minney
Community & Health Care Forum Michele Spencer
Community & Health Care Forum Paula Peart (Note taker)

Not in attendance:
West Farm Surgery Patsy Lemin
Nelson Health Group Linda Scott
Portugal Place Health Centre Tina Trowbridge
Spring Terrace Gillian Rayne
Collingwood Health Group Darryl Earnshaw
Marine Avenue Medical Group Pat Tuff
West Farm Surgery Grace Foggin
Wideopen Surgery Craig Harold
Battle Hill Health Centre Dean Stewart

Apologies for absence:
Forest Hall Medical Group Judith McSwain
Collingwood Surgery Bob Davidson
Wellspring Practice Val Telfer
49 Marine Avenue Pat Bottrill MBE
Nelson Health Group Eileen Turner
1. **Welcome and introductions:** Mrs Hayward welcomed members to the Patient Forum and thanked everyone for taking the time to attend. She congratulated members for winning another award the 'North Tyneside Council Chairman’s Commendation Award' which was presented on 9th June at The Council Chamber.

2. **Apologies:** Apologies for absence were received as above.

3. **Confirmation of quoracy:** The meeting was confirmed as quorate.

4. **Declarations of interest:** There were no declarations of interest.

5. **Notes of the previous meeting dated 12 May 2016:** The notes were agreed as a true record. Actions were discussed, concluded or to follow.

6. **Matters arising**
   None

7. **Working Groups Update**
   Notes of all meetings are available on request and new members to the Working Groups are welcome.

**Communications**
- Care Plus North Tyneside – Sandra met with one of the GPs and Gary Charlton to talk through the assessment document used in the patient pathway – she will be part of the evaluation process and meet Gary monthly.
- North Tyneside CCG now has a dedicated section for the Patient Forum newsletter and specific meeting dates have been arranged for drafting and editing future editions – members ideas for topics to be included are welcome.
- Child Health on Line – Marc Rice, CCG, will check the status and feedback to members.
- Winter Campaign planning – Members felt the Priory Medical Group loneliness leaflet could be included.

**End of Life**
- The Rapid Response Team is now in place at North Tyneside General Hospital and operates between 9am and 10pm seven days a week.
- Heather Carr will obtain some ‘Building a Caring Future’ leaflets for the Patient Forum members.
- There is some sharing of the Enhance Care Record data on System One for community and McMillan staff, currently the Emergency Health Care Plan cannot be opened. There will be some analysis later this year.
• A specific survey in relation to the Rapid Response Team will be developed in due course

Health and Well Being
• Vicki passed ‘Eddy’s Haven Health Walks’ leaflets to the members.
• Attended ‘The Let’s Talk about Food’ workshop which was very interesting and informative.
• CQC are now advising that all leaflets in GP surgeries should be laminated as part of infection control

Mental Health
• Anne Carlile is now part of the Mental Health Partnership Board
• Shared Decision Making had not been included in the Mental Health Draft Strategy – this has now been amended
• Northumberland Tyne and Wear Mental Health Trust, Northumberland and North Tyneside CCGs and Northumbria Healthcare Trust are working closely on developing the A&E based liaison psychiatry service operating at the Northumbria Hospital, Cramlington. A 24 hour 7 days a week service will be trialled for 4 months then evaluated

Older People
• Care Plus based at North Tyneside General Hospital is a new multi-disciplinary way of working with patients identified on the frailty index. 1800 people have been identified and currently 54 people have consented to being part of the service.
• Members contributed to two Older People’s Services Pathway events and there are now 10 recommendations to improve and develop patient experience
• Dr Lesley Young-Murphy discussed Patient hydration which was highlighted as crucial to health and well-being and this is now being recorded and monitored in nursing homes using a Hydr8 app. This app shows at a glance 7 days of the patient hydration levels. WIFI connections and strength in homes have been problematic and work continues – when resolved the app will be rolled out to care homes, domiciliary care etc.

Click here for more information

There is no app at present but Gary Charlton, CCG will be happy to demonstrate if members wish.

Self Care
• Back pain is one of the most common reasons in North Tyneside why people see their GP.
• The back pain workshops continue and the two most successful venues are White Swan Centre in Killingworth and the Customer First Centre in North Shields. Posters are being prepared to display in GP Practices
• Members also discussed Health Pledges, an initiative involving patients making pledges to improve their health and well-being in small ways, such as drinking water. The group will consider this as a theme for Self care week in November
Shared Decision Making
- SDM is an approach where clinicians and patients make decisions together using the best available evidence. Dr Lesley Young-Murphy reiterated the fact that it should be a joint decision and that the patient should not just be given the information and left to make the decision.
- Members were asked to take the information back to their Patient Participation Groups to ensure SDM is happening in all practices
- The training programme for GPs takes about 3 hours
- Ask 3 questions cards – this could be a way of making patients aware of SDM who don’t use the practice screens

Maternity
- There is nothing to report.

8. Member Information Sharing
- Alan Troilett advised the group that the last PPG meeting at Northumberland Park was in January
- Action – Michele to contact the Practice to offer support with setting up the PPG to continue
- Mark Hoggan advised the group that Beaumont Park has been given funding to update the Practice and that a Practice twitter account has also been set up

9. CCG Update
Accountable Care Organisation (ACO)
The ACO is a joint programme board working together to plan and deliver the best integrated care for patients. It comprises:
Northumbria Healthcare NHS Foundation Trust
Newcastle Healthcare NHS Foundation Trust
Northumberland Tyne and Wear NHS Foundation Trust
North East Ambulance Service
North Tyneside Council
Federation of GP Practices
Local Medical Committee
CCG

The intention is to contract for care in a different way and rather than activity for population outcomes.
- Action – Dr Lesley Young-Murphy will provide an update after the August ACO meeting

Financial Recovery Plan
As you know last year we achieved out £19.3M control total. This year we have set a further £19.3M control total which we need to achieve through delivery of our FRP.

The underlying causes have been identified as a combination of issues including an increased number of patients attending local hospitals and receiving care which is higher than other areas nationally, and a growing elderly population who need additional community-based care for complex health needs.
The CCG has been proactive in working with its GP members and partner organisations to develop a financial recovery plan, and NHS England is working closely with the CCG to monitor plans to ensure that the CCG can achieve financial balance.

The CCG has three new Interim Officers; Accountable Officer Janet Soo-Chung, Director of Finance Paul James and Chief Operating Officer John Wicks.

**Urgent Care**
The consultation is now closed.
On 6 July 2016 the Council of Practices met to review the business case and make a decision.
On 26 July 2016 the Governing Body approves the decision which will then be communicated to the residents of North Tyneside.

**Workforce Position – GPS and Practice Nurses in North Tyneside**

GP Practices took part in the Health Education North East (HENE) return which showed that some Practices have no problem in attracting and retaining talent. The CCG, LMC and Federation are working together to support the delivery of a primary care strategy and workforce planning and development as a core component.

Other practices have had a challenge in recruitment.

- **Action** – Dr Lesley Young-Murphy to update as information becomes available.

In order for providers to work effectively with Health Education North East (HENE), the CCG will work in collaboration to ensure that future commissioning intentions and large scale change are identified.

There is recognition that a high level of Senior Practice Nurses coming up for retirement and this is being factored into workforce planning. Larger practices have more nurses so it is easier for nurses to move up and take over when someone retires but this is a problem in smaller practices. The Practices do not get paid for having nurses, they pay a general wage to them which is decided by the Practice.

Follow this link for the North Tyneside Primary Care Strategy

**Referral Management System (RMS)**
There have been no formal complaints to date.
Lesley Young-Murphy advised that turnaround is two working days for referrals.

The reviews are undertaken by a consultant across the specialities and are either referred for appropriate secondary care investigation or viewed as needing further support from their GP. Reports are analysed for those people who don’t get referred on to secondary care which will help to keep future inappropriate referral numbers down. It can be seen that when Best Practice guidelines are followed then the referrals go through.

Northumbria Healthcare Trust now manages the RMS and Choose and Book is still applicable.
The system was evaluated on 15 June and net savings of £965k have been made, so this system will be ongoing for the foreseeable future

10. Date and time of next meeting:  
Thursday 15 September 2016  
11am – 1pm  
Linskill Centre  
Linskill Terrace  
North Shields

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**North Tyneside CCG Patient Forum Action Log**

<table>
<thead>
<tr>
<th>Date</th>
<th>Action No.</th>
<th>Action</th>
<th>Person Responsible</th>
<th>Target Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/1/16</td>
<td>1</td>
<td>Circulate the action and development plan in relation to the Five Year Plan</td>
<td>Lesley Young-Murphy</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>12/05/16</td>
<td>2</td>
<td>Invite John Wicks, Financial Officer to the next meeting</td>
<td>Deborah Hayman</td>
<td>14 July</td>
<td></td>
</tr>
<tr>
<td>14/07/16</td>
<td>3</td>
<td>Contact Northumberland Park Practice to offer support for their PPG meetings</td>
<td>Michele Spencer</td>
<td>ASAP</td>
<td></td>
</tr>
<tr>
<td>14/07/16</td>
<td>4</td>
<td>Provide ACO update after the August ACO meeting</td>
<td>Lesley Young-Murphy</td>
<td>15 Sept</td>
<td></td>
</tr>
<tr>
<td>14/07/16</td>
<td>5</td>
<td>Share findings of the HENE return</td>
<td>Lesley Young-Murphy</td>
<td>15 Sept</td>
<td></td>
</tr>
</tbody>
</table>