AGENDA

<table>
<thead>
<tr>
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<th>Item</th>
<th>Action</th>
<th>Lead</th>
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<tbody>
<tr>
<td>NWGB/16/355</td>
<td>Welcome and Introductions</td>
<td>Note</td>
<td>Mr Nigel Hallam</td>
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<tr>
<td>NWGB/16/356</td>
<td>Apologies for absence</td>
<td>Note</td>
<td>Mr Nigel Hallam</td>
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<tr>
<td>NWGB/16/357</td>
<td>Declarations of Interest above those already recorded on the CCG’s Register or as being relevant to this Agenda</td>
<td>Note</td>
<td>All</td>
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<tr>
<td>NWGB/16/358</td>
<td>Questions submitted from Members of the Public</td>
<td>Note</td>
<td>Mr Nigel Hallam</td>
</tr>
<tr>
<td>NWGB/16/359</td>
<td>Minutes of the Governing Body Meeting held on 25 August 2016</td>
<td>Approve</td>
<td>All</td>
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<tr>
<td>NWGB/16/360</td>
<td>Matters Arising and Action Log</td>
<td>Note</td>
<td>All</td>
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<tr>
<td>NWGB/16/361</td>
<td>Lay Chair’s Update (verbal)</td>
<td>Note</td>
<td>Mr Nigel Hallam</td>
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<tr>
<td>NWGB/16/362</td>
<td>Chief Clinical Officer’s Report</td>
<td>Approve</td>
<td>Dr Guy Mansford</td>
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<tr>
<td>NWGB/16/363</td>
<td>Chief Officer’s Report</td>
<td>Note</td>
<td>Mrs Vicky Bailey</td>
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<tr>
<td>NWGB/16/364</td>
<td>Patient Story</td>
<td>Note</td>
<td>Mrs Nichola Bramhall</td>
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<tr>
<td>NWGB/16/365</td>
<td>CCG Annual Assessment for 2015/16</td>
<td>Note</td>
<td>Mr Robert Taylor</td>
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<tr>
<td>NWGB/16/366</td>
<td>Monthly Quality and Performance Report</td>
<td>Note</td>
<td>Mr Robert Taylor</td>
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<tr>
<td>NWGB/16/367</td>
<td>Quarter 1 Contract Update</td>
<td>Note</td>
<td>Miss Maxine Bunn</td>
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<tr>
<td>NWGB/16/368</td>
<td>Contracts List</td>
<td>Note</td>
<td>Miss Maxine Bunn</td>
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<tr>
<td>NWGB/16/369</td>
<td>Revisions to the CCG Committee Structure and Corporate Governance Framework</td>
<td>Approve</td>
<td>Mr Craig Sharplles</td>
</tr>
<tr>
<td>NWGB/16/370</td>
<td>Finance Report</td>
<td>Note</td>
<td>Mr Jonathan Bemrose</td>
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<tr>
<td>NWGB/16/371</td>
<td>Detailed Financial Policies</td>
<td>Approve</td>
<td>Mr Jonathan Bemrose</td>
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<tr>
<td>NWGB/16/372</td>
<td>Annual Audit Letter</td>
<td>Note</td>
<td>Mr Jonathan Bemrose</td>
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<tr>
<td>NWGB/16/373</td>
<td>Patient Reference Group: Highlight Report of the Meeting held on 1 September 2016 and Minutes of the Meeting held on 4 August 2016</td>
<td>Note</td>
<td>Mr Mark Russell</td>
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<tr>
<td>NWGB/16/374</td>
<td>Minutes of the Finance &amp; Information Group (FIG) Meeting held on 16 August 2016</td>
<td>Note</td>
<td>Dr Mike O’Neil</td>
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<td>Agenda Ref</td>
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<tr>
<td>NWGB/16/375</td>
<td>Clinical Development Committee: Highlight Report from the meeting held on 8 September 2016 and approved Minutes of the Meeting held on 14 July 2016</td>
<td>Note</td>
<td>Dr Guy Mansford</td>
</tr>
<tr>
<td>NWGB/16/376</td>
<td>Nottinghamshire Safeguarding Children’s Board: Highlight Report from the meeting held on 7 September 2016 and approved minutes of the meeting held on 16 March 2016</td>
<td>Note</td>
<td>Mrs Nichola Bramhall</td>
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<tr>
<td>NWGB/16/377</td>
<td>Nottinghamshire Safeguarding Adults Board: Approved minutes from the meetings held on 14 January and 14 April 2016</td>
<td>Note</td>
<td>Mrs Nichola Bramhall</td>
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<tr>
<td>NWGB/16/378</td>
<td>Identification of risks in light of Agenda item discussions</td>
<td>Discuss</td>
<td>Mr Nigel Hallam</td>
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<tr>
<td>NWGB/16/379</td>
<td>Agree items for summary feedback</td>
<td>Discuss</td>
<td>Mr Nigel Hallam</td>
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<tr>
<td>NWGB/16/380</td>
<td>Reflection on Governing Body Achievements</td>
<td>Discuss</td>
<td>Mr Nigel Hallam</td>
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</table>

**Confidential Meeting Motion**

The Board will resolve that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1[2] Public Bodies [Admission to Meetings] Act 1960) with the Freedom of Information Act 2000. The minutes and papers from this meeting could be published on the Publication Scheme with your name included. If you do not wish your name to appear within the minutes, you can opt out by informing the Chair before the meeting commences.
# GOVERNING BODY MEMBERS

<table>
<thead>
<tr>
<th>Surname</th>
<th>First Name</th>
<th>Position</th>
<th>Committee/Group Membership in addition to Governing Body and Primary Care Commissioning Committee</th>
<th>Declaration Date</th>
<th>Summary of Interests Including Potential Conflict</th>
</tr>
</thead>
</table>
| Bailey  | Vicky      | Accountable Officer | GB/FIG/CDC                                                                                       | 14.04.16         | - Chief Officer Rushcliffe CCG
- Fellow of Queen’s Nursing Institute |
| Bemrose | Jonathan   | Chief Finance Officer | GB                                                                                               | 19.11.15         | - Role hosted by Nottingham North & East CCG, working across Nottingham West, Nottingham North & East & Rushcliffe CCGs
- Spouse employed as a part time Medical Secretary at Nottingham University Hospitals NHS Trust
- Self, Spouse and family are patients at Westdale Lane Surgery in NNE CCG |
| Bishop  | Susan      | Lay Member - Responsibility for Governance | GB, AGC, REMCON, QRC                                                                         | 22.01.15         | - University hospital of Leicester NHS Trust: Assist in development of Strategic Outline Case for service reconfiguration/review of financial planning Aug-Sept 2013
- Leicester City CCG: Act as a mentor to Governing Body GP Apr-Dec 2014
- Spouse conducts interim freelance work for the NHS
- Spouse is Associate Director of Strategic Planning at Leicestershire Partnership NHS Trust from Mar 2015 to date. Was Interim position from Sept 2014-Mar 2015 |
| Bramhall| Nichola    | Director of Quality & Patient Safety and Executive Nurse | GB, QRC, Safeguarding                                                                        | 09.10.15         | Shared role working across NNE, NW and Rushcliffe CCGs |
| Bunn    | Maxine     | Director of Contracting | Notts Collaborative Commissioning Congress                                                      | 08.10.15         | Shared role working across NNE, NW and Rushcliffe CCGs |
| Hall    | Andy       | Director of Outcomes & Information | Information Governance & Technology Committee Finance & Information Group                  | 21.03.16         | - Single share of Lincolnshire And District Medical Services. Share is less than 5% of company value.
- Shared role working across NNE, NW and Rushcliffe CCGs |
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<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Contact Details</th>
<th>Date</th>
<th>Voluntary Roles with Health connections:</th>
<th>Paid Roles:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallam</td>
<td>Nigel Edwin, Lay Member Chair of GB GB</td>
<td></td>
<td>20.10.15</td>
<td>• Chair of the Park Surgery Heanor Patients Participation Group</td>
<td>• Fee-paid specialist Lay Member of the First-tier tribunal; Health Education and Social Care Chamber (Mental Health)</td>
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<tr>
<td></td>
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<td></td>
<td>• Vice Chair of the Corporation of New College Nottingham (ceased 30.09.15 Served 6 years)</td>
<td>• Panel Chair, Fitness to Practice Conduct and Competence Committee of the Nursing and Midwifery Council</td>
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<tr>
<td></td>
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<td>• Lay Member of the General Chiropractic Council Professional Conduct and Health Committees</td>
<td>• Lay Member of the General Chiropractic Council Professional Conduct and Health Committees</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Self Employed Senior Consultant with Agencia Consulting Ltd, Hessle, East Yorkshire</td>
<td>• Self Employed Senior Consultant with Agencia Consulting Ltd, Hessle, East Yorkshire</td>
</tr>
<tr>
<td>Harris</td>
<td>Kevin, Independent Secondary Care Clinician</td>
<td></td>
<td>26.02.15</td>
<td>• Medical Director of the University Hospitals of Leicester until 31/3/15</td>
<td>• Reader with University of Leicester – no personal current grant funding</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Consultant Clinical Advisor for NICE (Interventional Procedures) from 1/4/15</td>
<td>• but my department holds funding from a number of medical charities and undertakes industry sponsored clinical trials</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Reader with University of Leicester – no personal current grant funding</td>
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</tr>
<tr>
<td>Mansford</td>
<td>Dr Guy, Senior Partner The Oaks Medical Practice; CCG Clinical Lead</td>
<td>GB, CIG</td>
<td>15.10.15</td>
<td>• Spouse is a volunteer at the Treetops Hospice, Sandiacre</td>
<td>• Daughter undertaking PhD funded by Multiple Sclerosis Society</td>
</tr>
<tr>
<td>O'Neil</td>
<td>Dr Mike, GP Member with a Lead for Finance and Information (SIRO)</td>
<td>GB, CIG &amp; Chair of FIG</td>
<td>25.11.15</td>
<td>• Spouse also works at the Surgery</td>
<td>• Self and Spouse each own 1 original Share in NEMS</td>
</tr>
<tr>
<td></td>
<td>GP Partner, Saxon Cross Surgery</td>
<td></td>
<td></td>
<td>• Clinical lead for data Management Team at Rushcliffe CCG</td>
<td>• Clinical lead for data Management Team at Rushcliffe CCG</td>
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<td></td>
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<td></td>
<td>• Designer of eHealthscope</td>
<td>• Designer of eHealthscope</td>
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<tr>
<td>Russell</td>
<td>Mark, Patient Representative Lay GB/AGC/REMCON/ PRG</td>
<td></td>
<td>02.11.15</td>
<td>• Chair of Patient Participation Group, West End Surgery, Beeston</td>
<td>• Chair of South Nottinghamshire CCGs Equality &amp; Diversity Working Group</td>
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<td></td>
<td></td>
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<td></td>
<td>• Sole Proprietor of Social Exploration</td>
<td>• Member of the Citizens Advisory Panel to the South Nottinghamshire Transformation Board</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>• Associate Partner with Ideasmiths LLP</td>
<td>• Member of the PPI Senate of East Midlands Health Sciences Network</td>
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May-16
NOTTINGHAM WEST
Clinical Commissioning Group

DRAFT Minutes of the Meeting of the NHS Nottingham West Clinical Commissioning Group (CCG) Governing Body

Held on 25 August 2016 at 1:00pm
at Stapleford Care Centre, Church Street, Stapleford

Present:

Mr Nigel Hallam  Lay Member for Patient & Public Involvement and Equality & Diversity/Lay Vice Chair
Dr Guy Mansford  Chief Clinical Officer **From 2:20pm**
Mrs Vicky Bailey  Accountable Officer
Mrs Sue Bishop  Lay Member with a Lead for Governance
Mrs Nichola Bramhall  Director of Nursing and Quality
Dr Mike O’Neil  GP, Saxon Cross Surgery
Mr Mark Russell  Patient Representative elected from the Patient Reference Group

In Attendance:

Miss Sarah Allcock  Executive Assistant
Mr Andy Hall  Director of Outcomes and Information
Mr Ian Livsey  Deputy Chief Finance Officer

Cumulative record of Governing Body Members’ Attendance (2016/17)

<table>
<thead>
<tr>
<th>Name</th>
<th>Possible</th>
<th>Actual</th>
<th>Name</th>
<th>Possible</th>
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<tbody>
<tr>
<td>N. Hallam</td>
<td>3</td>
<td>3</td>
<td>K. Harris</td>
<td>3</td>
<td>1</td>
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<tr>
<td>V. Bailey</td>
<td>3</td>
<td>3</td>
<td>J. Bemrose</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>G. Mansford</td>
<td>3</td>
<td>2</td>
<td>M. O’Neil</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>N. Bramhall</td>
<td>3</td>
<td>3</td>
<td>M. Russell</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>S. Bishop</td>
<td>3</td>
<td>2</td>
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Minute Ref  Item

NWGB/16/328  Welcome and Introductions
The Chair welcomed the Governing Body and members of the public to the meeting. Introductions were made.
### NWGB/16/329  
**Apologies**

Apologies were received from Miss Maxine Bunn, Mr Craig Sharples and Mr Jonathan Bemrose.

### NWGB/16/330  
**Declarations of Interest relating to items on this Agenda**

Mr Hallam reminded Governing Body members of their obligation to declare any interest they may have on any issues arising at meetings which might conflict with the business of NHS Nottingham West clinical commissioning group.

Declarations declared by members of the Governing Body 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:


No additional conflicts of interest were declared above those already recorded on the CCG Register of Interests.

### NWGB/16/331  
**Questions Submitted from Members of the Public**

Mr Hallam confirmed that there had been no questions for the Governing Body received members of the public.

### NWGB/16/332  
**Minutes of the Governing Body Meeting held on 28 July 2016**

The minutes of the Governing Body meeting held on 28 July 2016 were presented for approval.

Subject to a number of minor typographical amendments, the Governing Body **Approved** the minutes of the Governing Body meeting held on 28 July 2016.

### NWGB/16/333  
**Matters Arising and Action Log**

The matters arising and action log were considered by the Governing Body.

The Governing Body **NOTED** the Matters Arising and Action Log.

### NWGB/16/334  
**Governing Body Dates 2017**

Mr Hallam presented the proposed dates for Governing Body meetings in 2017, noting that some of the proposed meetings may continue to be held but as more of a development session. Mrs Bramhall requested that any changes be co-ordinated with the other South Nottinghamshire CCGs to help with the production of reports.

The Governing Body **APPROVED** the meeting dates for 2017.
### Lay Chair’s Update

Mr Hallam provided a verbal report to the Governing Body.

He reported that since the last meeting of the Governing Body in July 2016 he had attended:

- 2nd August met with PRG representatives John Crouch and Mark Russell together with Vicky Bailey and Dr Guy Mansford.
- 23rd August conducted a Six Monthly Personal Development Review/Appraisal meeting with Adrian Manhire.
- 25th August conducted a Personal Development Review/Appraisal meeting with Sue Bishop.
- 25th August attended the Remuneration Committee Meeting

He reported the forthcoming events he planned to attend:-

- 30th August Interviews for independent Secondary Care Doctor on the CCG
- 1st September attending the Patient Reference Group Meeting
- 9th September meeting with Anna Soubry MP together with Vicky Bailey
- 26th September conducting a Six Monthly Personal Development Review/Appraisal meeting

Mr Hallam reported that the next public Governing Body meeting will be held at Stapleford Care Centre on Thursday 29 September 2016, commencing at 1pm, and will be followed by the Nottingham West Annual General Meeting at the Haven Centre, Stapleford, commencing at 6pm.

Mrs Bailey informed members that a joint development session has been arranged for October with Rushcliffe CCG due to the shared concerns about the EMAS performance.

The Governing Body **NOTED** the Lay Chair’s Update.

### Chief Clinical Officer’s Report

Dr Mansford informed members that he arrived late for the meeting as he was being interviewed for East Midlands Today about detection rates for dementia in Nottingham West. The interview was being filmed at the Beeston memory café which was funded through the Lifestyle Fund; Dr Mansford stated that this is a good news story for the CCG.

Dr Mansford reported that the transformation work is gathering pace; work is progressing to bring together the clinical leadership in a democratic and supportive
The CCGs are working very closely with Public Health to try and put prevention at the top of the agenda. Mrs Bailey stated that the reason CCGs have been instructed to discuss the transformation work in the confidential session is because the plans are in the developmental stage and potentially controversial.

The Governing Body NOTED the Chief Clinical Officer’s Report.

**Chief Officer’s Report**

Mrs Bailey outlined key pieces of work that were ongoing.

**Supporting the expansion of IAPT services**

Mrs Bailey reported that the Mental Health five year forward view implementation plan set out the expectation that psychological therapies would be expanded in up to a third of all CCGs through building ‘Integrated Improving Access to Psychological Therapies (IAPT)’ services. There is currently a huge amount of focus on mental health and wellbeing nationally with various bidding processes taking place. NHS England (NHSE) invited bids from CCGs to become an ‘Integrated IAPT Early Implementer’, Nottingham West submitted a bid with the support of member practices and were successful, however it is acknowledged that a 3% increase in access will be challenging for the CCG.

Mrs Bishop noted that performance relating to patients recovering is good and questioned if the CCG has done any work to understand what our patients think of the services. Mrs Bailey confirmed that this would form part of the overall quality scrutiny. Mrs Bramhall agreed to speak to Nottingham City CCG as they are the lead for the service. **ACTION NWGB/16/337: Mrs Bramhall to contact Nottingham City CCG regarding the IAPT service to ascertain if any work has been undertaken to gather the views of our patients.**

**2016/17 A&E Improvement Plan**

Mrs Bailey reported that NHSE, NHS Improvement and the Directors of Adult Social Services have written a further letter to the CCG regarding improving performance in A&E departments nationally. The expectation remains to meet the 95% trajectory by the end of 2016/17. The systems requiring the most support based on their performance, including Nottinghamshire, will be the subject of the most intensive support and attention which will be provided by ECIP (Emergency Care Improvement Programme).

The System Resilience Group (SRG) is to be transformed into the Local A&E Delivery Board, which will focus solely on urgent and emergency care and will be attended at executive level by member organisations. The new Board will be in place by 1 September 2016.

Mrs Bramhall talked about the success of the new community model and reported that Nottingham City is looking to replicate the model for the same cohort of patients.
National Tariff: Policy Proposals for 2017/18 and 2018/19

Mrs Bailey informed members that the engagement document on changes to the national tariff, along with other proposals relating to the pricing system has been released; she noted that these potential changes will have a major impact on contracts moving forwards.

Joint CQC/Ofsted Local Area Inspection Special Educational Needs and Disability in Nottinghamshire County

Ofsted and the Care Quality Commission (CQC) undertook a joint inspection of the local area of Nottinghamshire between 20 and 24 June 2016, the purpose being to review the area’s effectiveness in implementing the Special Educational Needs and Disability (SEND) reforms that are set out within the Children and Families Act 2014. Nottinghamshire has received its outcome letter which sets out a number of positive findings. The inspection team acknowledged that the local area’s self-evaluation of its progress in implementing the reforms was broadly accurate. Mrs Bramhall stated that the findings reflect the self-evaluation and where shortfalls were identified; there were actions in place to address them.

Mrs Bailey made members aware of the actions that are currently being taken regarding the financial position. The Nottinghamshire CCGs are going to communicate with stakeholders and patients about some of the decisions that will need to be made. A press release has been published by Mansfield and Ashfield CCG, which is the start of the media management strategy.

The Governing Body NOTED the Chief Operating Officers Report.

Quarter 1 2016/17 Quality Report

Mrs Bramhall presented the Quarter 1 2016/17 Quality Report; she informed members that the report was discussed in detail at the Quality & Risk Committee, who requested that the following issues be brought to the attention of the Governing Body:-

- Health Care Associated Infection (HCAI) – both Nottingham West CCG and Nottingham University Hospitals NHS Trust (NUH) achieved the trajectories for clostridium difficile.
- Methicillin Resistant Staphylococcus Aureus Blood Stream Infection (MRSA BSI) - no cases assigned to Nottingham West CCG, NUH have had three positive MRSA blood infections this year however two of the three have been deemed clinically unavoidable.
- There are concerns regarding the Carillion cleaning contract, the Trust are robustly monitoring the contract at Board level.

Mrs Bramhall noted that the format of the report has changed slightly; new sections have been included to bring the report in line with the new Assessment and Improvement Framework.
Mrs Bailey reported that West End Surgery have now got a date for their Care Quality Commission (CQC) re-inspection.

Mrs Bailey provided members with an update on the Marie Stopes Service; Marie Stopes International (MSI) are a AQP late termination provider, the CQC have raised concerns around surgical/anaesthetic procedures and safeguarding policies for under 18 year olds in MSI services. The CCG has been invited to join national telephone calls. Mrs Bailey confirmed that there have been no Nottingham West patients who have opted for MSI this financial year.

The Governing Body **NOTED** the Quarter 1 2016/17 Quality Report.

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<th>NWGB/16/339</th>
<th><strong>Infection Prevention and Control Annual Report 2015/16</strong></th>
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<tr>
<td></td>
<td>Mrs Bramhall presented the Infection Prevention and Control Annual Report 2015/16; she informed members that the report was discussed in detail at the Quality &amp; Risk Committee on 3 August 2016.</td>
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<td>Mrs Bishop expressed her thanks to Mrs Bramhall and her team for the work they have done with the Local Authority regarding infection control in residential homes; she stated that this is a good example of partnership working between health and social care.</td>
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<td>Mr Hallam echoed Mrs Bishops’ comments and formally thanked Mrs Bramhall and her team for their hard work developing working relationships with the Local Authority.</td>
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<th>NWGB/16/340</th>
<th><strong>Review of CCG Governance Arrangements – Follow Up</strong></th>
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<td>Mrs Bailey presented the Review of CCG Governance Arrangements Follow Up paper; she reflected that the Governing Body received a paper at the July meeting outlining a number of proposals relating to the governance of the CCG. In broad terms there was a consensus that all recommendations, apart from one, were appropriate and it was agreed that a paper would go the Patient Reference Group (PRG) to given them an opportunity to discuss the paper fully and the outcome of the discussion be brought back to the Governing Body.</td>
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<td>Dr Mansford attended the PRG where the paper was discussed; he noted that it was a lively, well attended meeting, with a good discussion. The Group discussed all of the recommendations, which were uncontroversial apart from recommendation 1 - the remuneration of patient representatives, PRG members felt that there should be payment at some level for elected patient representatives. Dr Mansford reported that there was a strong recommendation from the PRG for the Governing Body to reconsider its decision regarding the remuneration.</td>
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<td>Mrs Bailey stated that there has to be absolute clarity in governance terms between Lay representatives and patient representatives, she commented that it would be...</td>
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unusual and different to any other NHS statutory organisation for the role of a patient representative to be remunerated, she believes that the Governing Body should still take the same approach with regard to this recommendation.

It was noted that Nottingham North and East CCG will be removing patient representatives from their Governing Body altogether.

Mrs Bishop suggested that the appointment of the additional Lay members should have an impact of the workload on the elected patient representatives. She encouraged members of the PRG to think about the way they want to be involved in the work of the NHS and whether they feel the role they want to play is more of a Lay member role.

Dr Mansford stated that we need to consider the direction of travel for the organisation as there will be more shared committees going forward and in terms of equity, it would be very difficult if we were reimbursing some members and not others.

Mr Hallam summarised that it is important not to mix up the capabilities of the individual with the role; we should recognise that we will be working more closely with colleagues in other CCGs who have taken a very different approach. Mr Hallam stated that this matter now needs to move forward for the greater good of the CCG and we need to ensure that we get the right people in the right roles to be the most effective.

Mrs Bishop referred to recommendation 7, and stated that we should be establishing the Finance and Performance Committee as soon as possible given the financial situation. Mr Hallam confirmed that he would be meeting with Mrs Bailey and Dr Mansford to agree a way forward. Mrs Bailey confirmed that she is working with Mr Sharples on establishing Terms of Reference for the various committees.

The Governing Body APPROVED all proposals presented in the paper.

### National GP Survey

Mrs Bailey presented the results of the GP Patient Survey, which is an England wide survey, providing practice level data about patients’ experiences of their GP practices. Key highlights from the 2016 national survey include:

- Out of more than 200 CCGs, Nottingham West is:
  - 2nd in the country for Receptionists being very helpful
  - 2nd in the country for appointments being very convenient
  - 4th in the country for overall experience of making an appointment being very good
  - 6th in the country for being very easy to get through by phone
  - 6th in the country for opening hours being very convenient
Mrs Bailey confirmed that a message has been sent to the practices congratulating them, in particular the reception staff. This is really good news for Nottingham West CCG and will feature clearly at the Annual General Meeting in September.

Mr Russell, on behalf of the PRG acknowledged all of the work that has been undertaken around developing access and work on the local survey.

Mrs Bishop asked about practice nurses, and if we are happy that we are exploiting their potential in terms of succession planning. Dr O’Neil stated that the research is mixed on whether it is more useful to invest in practice nurses and upskill them or get doctors working in a different way. He noted that all practices have different ways of approaching this.

Mr Hallam acknowledged the outstanding performance of the CCG, noting that it is the best performing CCG locally.

The Governing Body NOTED the results of the GP Patient Survey July 2016

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**Finance Report**

Mr Livsey presented the Finance Report for the period ending 31 July 2016. The position is similar to last month in that the CCG is in a very difficult financial position and discussions have taken place with NHSE around the delivery of the 1% surplus and the possibility that this may not be achieved.

Mr Livsey summarised that the CCG is forecasting to meet all of its statutory financial duties in 2016/17 however, the level of overspending above budget in acute and Continuing Healthcare (CHC) together with the current shortfall in achievement of savings (QIPP) is posing a significant risk to the delivery of the duty to remain within the revenue resource limit.

CHC actual costs have risen month on month, this is particularly concerning given the level of growth included in the 2016/17 plan, Mr Livsey reported that further work is underway to try and understand the increased costs and a turnaround action plan is being put in place. Mr Livsey talked about the additional pressure of funding the outcome of the NUH local prices review.

It was noted that the significant deterioration in the underlying position has been reported to NHS England.

QIPP is forecast to achieve plan, however this position is supported by non-recurrent QIPP from reserves. Mr Livsey reported that a PMO Collaborative QIPP Group has been established, they are looking to change the payment mechanism for day cases and follow ups to generate further savings.

Mrs Bailey informed members of a change in the payment mechanism for fully funded nursing care, which has resulted in a 40% price increase; this is reflected in the Month 4 accounts.

Mrs Bishop referred to the QIPP section of the Finance Report, bullet point ‘Continued
risk around delivery of non-elective schemes in light of the urgent care vanguard focussing on hubs’, she asked for clarification of what this means. Mr Livsey agreed to look into this and respond to Mrs Bishop. **ACTION NWGB/16/342: Mr Livsey to respond to Mrs Bishop regarding a query about the QIPP section of the Report.**

Mrs Bailey advised that one of the requirements around the National Care Improvement Programme is the requirement to have hubs, we need to cross mark against the national vanguard work and are therefore putting it as a potential financial risk.

The Governing Body **NOTED** the financial position of the CCG for April 2016 to July 2016 and **APPROVED** the Finance Report for April 2016 to July 2016.

**Monthly Quality and Performance Report**

Mr Hall presented the Monthly Quality and Performance Report which detailed performance against a range of local and national performance standards for services commissioned by the CCG.

**Nottingham University Hospitals NHS Trust (NUH)**

Performance against the Accident & Emergency four hour wait target continues to degrade. Issues affecting performance remain the same, flow through the hospital system, appropriate staffing within ED, interaction with other hospitals and the ability to discharge. Mr Hall reported that the CCG and other commissioners continue to progress initiatives, they are having an impact but of insufficient magnitude given the decline in performance.

With regard to Cancer, the two week wait standard has seen an improvement in recent months, the year to date position hasn’t recovered to the 93% standard but Mr Hall is hopeful that this target will be achieved by the end of the financial year.

In terms of the 62 day standard, Mr Hall reported that the progress that has been seen over the last few months has dropped off slightly, the recovery agreed with the Trust for this standard was originally August but this was brought forward to July on the basis of the new National Breach Policy for Shared Tertiary Patients being agreed. Mr Hall confirmed that the Trust won’t achieve the July standard and he believes it will be September at the earliest to recover the position. The CCG continues to have fortnightly performance meetings with the Trust around Cancer services. Mr Hall suggested that the Trusts focus on Cancer performance has dropped off slightly due to the merger with Sherwood Forest Hospitals Foundation Trust.

Elective performance remains good and overall NUH continue to be a well performing Trust in terms of elective care.

**East Midlands Ambulance Service NHS Trust**

As in previous months, performance remains poor with no particular improvement. Mr Hall and Mrs Bramhall are attending an EMAS summit on 30 August, which will focus
specifically on turnaround times, they will report back on the outputs of the summit at the next Governing Body meeting. **ACTION NWGB/16/343**: Mr Hall and Mrs Bramhall to feedback on the outputs of the summit at the next Governing Body meeting.

Mrs Bailey reported that reviewing the performance of all providers was raised at the Quality and Scrutiny Group, a formal request was made for this to be raised at a national level. Mrs Bramhall stated that the focus of the Governing Body development session in October must be around the quality of the service provided overall by EMAS.

Mr Hall reported that the Improvement and Assurance framework for 2016/17 has been published, and he will be producing a summary showing the impact of where we are against the Improvement and Assurance Framework as we go through the year. This information will be included in September report.

Mrs Bishop talked about the delayed transfers of care and asked if there is any intelligence about the impact a delayed transfer of care has on patients’ rehabilitation. Mrs Bramhall does not believe that we currently have this information but she suggested that this could form part of the work with providers. Mrs Bailey suggested having some way of highlighting in the Performance Report what is really relevant in terms of performance monitoring as part of the Improvement and Assurance Framework. Mr Hall agreed to look into this. **ACTION NWGB/16/343.1**: Mr Hall to look at highlighting in future reports what is relevant in terms of performance monitoring at part of the improvement and Assurance Framework.

The Governing Body **NOTED** the Quality and Performance Report.

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**NWGB/16/344**

**Risk Assurance Framework**

Mrs Bailey presented the Risk Assurance Framework, which has been reviewed and updated to reflect the latest position as at July 2016. She informed the Governing Body that it has been agreed to adopt a common approach to risks across the South Nottinghamshire CCGs which will help with the overall risk assurance process.

Mrs Bishop expressed her concern around the time this is taking, she asked about the process and timescales to get this finished and stated that it would be helpful to have it completed by October, in time for the next Audit and Governance Committee.

Mrs Bramhall referred to the home care quality monitoring risk, and advised members that a robust process similar to that which we apply for the care home sector has been developed.

The Governing Body **NOTED** the Risk Assurance Framework

**NWGB/16/345**

**Patient Reference Group: Highlight Report of the meeting held on 4 August 2016 and Minutes of the meeting held on 14 July 2016**

Mr Russell presented the Highlight Report of the Patient Reference Group meeting
<table>
<thead>
<tr>
<th>NWGB/16/346</th>
<th>Minutes of the Finance and Information Group Meeting held on 19 July 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr O'Neil presented the minutes of the Finance and Information Group meeting held on 19 July 2016, he advised members that there was discussion around some of the QIPP proposals and how many are going to be relevant to Nottingham West.</td>
<td></td>
</tr>
<tr>
<td>The Governing Body <strong>NOTED</strong> the minutes of the Finance and Information Group meeting held on 19 July 2016</td>
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</table>

<table>
<thead>
<tr>
<th>NWGB/16/347</th>
<th>Audit and Governance Committee Annual Report 2015/16</th>
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<tbody>
<tr>
<td>Mrs Bishop presented the Audit and Governance Committee Annual Report 2015/16 noting that the purpose of the report is to provide a summary of the work carried out by the Committee in relation to the 2015/16 financial year. Mrs Bishop thanked fellow members of the Committee and the people who service the Committee for their hard work.</td>
<td></td>
</tr>
<tr>
<td>Mrs Bishop stated that the work plan is constantly adapted and updated to reflect the role of the Audit &amp; Governance Committee.</td>
<td></td>
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<tr>
<td>Mr Hallam commented that the report is helpful and shows the effectiveness of the Committee.</td>
<td></td>
</tr>
<tr>
<td>The Governing Body <strong>NOTED</strong> the Audit and Governance Committee Annual Report</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>NWGB/16/348</th>
<th>Highlight Report from the Safeguarding Committee held on 12 July 2016, Minutes of the meeting held on 24 May 2016 and Terms of Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mrs Bramhall presented the Highlight Report from the Nottinghamshire CCGs Safeguarding Committee meeting held on 12 July 2016, she advised members that there are no issues to escalate.</td>
<td></td>
</tr>
<tr>
<td>The Terms of Reference are presented to the Governing Body for approval; Mrs Bramhall advised that they are now more explicit in terms of quoracy to address the concerns raised previously at the Governing Body.</td>
<td></td>
</tr>
<tr>
<td>The Governing Body <strong>NOTED</strong> the Highlight Report from the Safeguarding Committee held on 12 July 2016 and the minutes of the meeting held on 24 May 2016 and...</td>
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</table>
Mrs Bramhall presented the Highlight Report from the Quality and Risk Committee held on 3 August 2016, she informed the Governing Body of the following issues, which required escalation

- **Quality Impact Assessments**: the two QIAs relating to the Critical Care outreach Team were not approved and it was agreed that further discussion with the review team was required in order for the Committee to make a recommendation to the Governing Body. It was also agreed that an extraordinary meeting may need to be held to review any outstanding QIAs related to QIPP/local pricing given the timescales involved. Mrs Bramhall reported that version 3 of the QIA has now been developed and in order to avoid this situation happening again, it has been agreed for phase two to have a quality representative involved in the process from the outset. Discussions are ongoing with Nottingham City CCG regarding a common QIA policy.

- **Provider Quality**: the quality impact of continued failure to achieve operational performance standards at EMAS and NUH ED was discussed.

  Mrs Bramhall reported that further work is required around negotiating to have a single Equality & Diversity policy across the three South Nottinghamshire CCGs, she is confident that there now seems to be a reasonable way forward.

  The Governing Body **NOTED** the Highlight Report from the Quality and Risk Committee meeting held on 3 August 2016.

**Identification of risks in light of the agenda item discussions**

None identified over and above those already recorded in the CCG’s risk management framework.

- Financial position
- Performance of NUH and EMAS
- Strength of feeling of PRG – find a way of moving forward
- Transformation

**Agree items for summary feedback**

The Governing Body **NOTED** the items for summary feedback to stakeholders:

- Quarter 1 2016/17 Quality Report
<table>
<thead>
<tr>
<th>NWGB/16/352</th>
<th><strong>Reflection on Governing Body Achievements</strong></th>
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<tr>
<td></td>
<td>The Governing Body reflected on issues and achievements that had been addressed in the meeting, which included:</td>
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<td>- Listened to the strength of feedback from the PRG on the Governance Review</td>
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<td>- GP Survey Results</td>
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<table>
<thead>
<tr>
<th>NWGB/16/353</th>
<th><strong>Any Other Business</strong></th>
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<tr>
<td></td>
<td>Mr Hallam formally thanked Professor Harris for his contribution to the Governing Body.</td>
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<td></td>
<td>Mrs Bramhall informed members that Gail Colley-Bontoft will be leaving the organisation in October; Mrs Bramhall stated that Gail has transformed processes during her time at the CCG and she wanted to formally record her thanks.</td>
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<td></td>
<td>Mr Hallam reported that Emma Richardson, Data Analyst at Nottingham West CCG is leaving the organisation today; he stated that she has done some fantastic work for the CCG and will be missed.</td>
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</tbody>
</table>
The Chair confirmed the date and time of the next meeting to be:
29 September 2016 at 13:00 in the Stapleford Suite, Stapleford Care Centre, Church Street, Nottinghamshire, NG9 8DB.

**NWGB/16/354**

**Confidential Motion**

The Chair invited the Board to adopt the following resolution: “That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” (Utilising the powers within Section 1(2) Public Bodies (Admission to Meetings) Act 1960). The Board so resolved and the remainder of the meeting was conducted in confidential session.

The Chair brought the meeting to a close at: 16:00
<table>
<thead>
<tr>
<th>Date of Meeting</th>
<th>Minute Ref.</th>
<th>Action</th>
<th>Owner</th>
<th>Due Date</th>
<th>Progress Update</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>29 Jan 16</td>
<td>NWGB/16/198</td>
<td>Mrs Bramhall to talk to City Care about the flow of data in relation to the CHC contract</td>
<td>Dr O'Neil</td>
<td>29 September 2016</td>
<td>Dr O'Neil has met with CityCare; discussions are ongoing about the dataset.</td>
<td>Ongoing</td>
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<tr>
<td>29 Jan 16</td>
<td>NWGB/16/207.1</td>
<td>Mr Sharples to review the best way to capture the risk relating to the long term financial position during the next round of updates</td>
<td>Mr Sharples</td>
<td>29 September 2016</td>
<td>The risk is still to be defined in its entirety, it is expected that the risk will change.</td>
<td>Ongoing</td>
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<tr>
<td>24 Mar 16</td>
<td>NWGB/16/243</td>
<td>Dr Mansford to raise the issue of common text at the next Practice Members Group (PMG) and Mr Hall to take the matter forward on behalf of the CCG with Nottingham West Health Concern</td>
<td>Dr Mansford/ Mr Hall</td>
<td>30 June 2016</td>
<td>Dr O'Neil has written a paper which will be released for use in practices imminently.</td>
<td>Completed</td>
</tr>
<tr>
<td>28 July 16</td>
<td>NWGB/16/318</td>
<td>Mr Sharples to review the overall reporting arrangements regarding the production of minutes and highlight reports and the associated timing issues with these.</td>
<td>Mr Sharples</td>
<td>29 September 2016</td>
<td>A meeting has taken place regarding the PRG minutes and highlight reports. A broader piece of work has been completed to review all committees.</td>
<td>Completed</td>
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<tr>
<td>Date</td>
<td>Memo Number</td>
<td>Action Description</td>
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<tr>
<td>25 August 16</td>
<td>NWGB/16/337</td>
<td>Mrs Bramhall to contact Nottingham City CCG regarding the IAPT service to ascertain if any work has been undertaken to gather the views of our patients.</td>
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<tr>
<td>Mrs Bramhall</td>
<td>29 September 2016</td>
<td>The Mid Notts CCGs are co-ordinating commissioners for the County for IAPT services which are delivered by a range of providers. They have confirmed that they review patient experiences of all our IAPT services through the scrutiny of the PEQ (patient evaluation questionnaire) which all patients are invited to complete at both assessment (questions relevant to journey from referral to assessment) and again at discharge (to look at service experience). This includes the friends and family test. All providers score in the high 90s on all elements of the PEQ and free text is also included in the scrutiny. Any identified themes will be addressed with the providers.</td>
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<tr>
<td>Date</td>
<td>Reference</td>
<td>Description</td>
<td>Owner</td>
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<tr>
<td>25 August 16</td>
<td>NWGB/16/342</td>
<td>Mr Livsey to respond to Mrs Bishop regarding a query about the QIPP section of the Finance Report.</td>
<td>Mr Livsey</td>
<td>ASAP</td>
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</table>

In the original QIPP plan we had assumed funding for three urgent care workstreams as part of the Urgent Care Vanguard Bid, namely:

- Clinical Navigation
- Primary Care in ED
- Development of 111 hubs to include mental health

The funding for the urgent care vanguard was reduced significantly from the original bid and the instruction from the centre was to focus on the development of the 111 hubs, based on poor performance by 111. The development of the 111 hubs is a longer term strategy that will not deliver significant savings in 2016-17. So the quick wins we had around navigation and primary care in ED will not be realised, but they may form part of a bid from System Resilience.

Completed
<table>
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<th>Date</th>
<th>Ref.</th>
<th>Description</th>
<th>TO DO</th>
<th>Completed</th>
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<tbody>
<tr>
<td>25 August 16</td>
<td>NWGB/16/343</td>
<td>Mr Hall and Mrs Bramhall to feedback on the outputs of the EMAS summit at the next Governing Body meeting.</td>
<td>Mrs Bramhall/Mr Hall</td>
<td>29 September 2016</td>
</tr>
<tr>
<td>25 August 16</td>
<td>NWGB/16/343.1</td>
<td>Mr Hall to look at highlighting in future reports what is relevant in terms of performance monitoring as part of the Improvement and Assurance framework.</td>
<td>Mr Hall</td>
<td>29 September 2016</td>
</tr>
</tbody>
</table>
The Clinical Development Committee (CDC) is a Committee of the Governing Body made up of up the CCGs Membership and is constituted to drive forward the CCGs clinical and service development agenda to support the delivery of the CCGs objectives and plans.

Due to the membership of the Committee, there are inherent conflicts of interest, so it was decided that the Committee should hold no decision making powers, but make recommendations to the Governing Body for the approval of clinical and service developments. To further mitigate any potential perceived conflicts of interest, when the Chair of the Committee is also considered to be conflicted, an independent (lay or officer) Chair is called upon to oversee proceedings.

At the meeting on the 8 September 2016, the CDC recommended two proposals be escalated to the Governing Body for decision.

**Pain Management Review Proposal**
Across Nottingham City, Nottingham West, Nottingham North & East and Rushcliffe CCGs, there are different pain management pathways with a lack of clarity over best practice to meet population need and elements of existing service provision that are known not to be consistent with evidence of clinically and cost effective care. It is proposed that a review of the pain pathway is undertaken with the following scope:
- A comprehensive review of the current chronic pain management pathway
- Assessment of the population need for the pain management pathway
- Review of the evidence base for pain management
- Proposal for the future commissioning of the pain management pathway based on population need and evidence of good practice.

The Clinical Development Committee recommended **APPROVING** the proposal for a review of the Pain Management Pathway in Greater Nottingham.

**Reduction of Routine Follow-Ups for the Non-Surgical Management of Ulcerative Colitis**
Ulcerative Colitis and Chron’s Disease are the two most common forms of Inflammatory Bowel Disease; Ulcerative Colitis is a lifelong disease that is associated with significant morbidity. Stephen Andersen, Strategy & Development Manager proposed implementing a new pathway involving the reduction of routine follow up attendances for non-surgical management of ulcerative patients. It is proposed that the pathway be implemented across the four greater Nottingham
CCGs starting in October 2016.

The Clinical Development Committee recommended APPROVING the new pathway.

Community Ophthalmology Proposal

Analysis of the current Community Ophthalmology pathway suggests that it is costing more than it would to allow all referrals to go direct to secondary care. Whilst the current pathway has enhanced the scope of practice in community optometrists there is a significant amount of management time invested in the management of these contracts and accreditation of providers.

There are other models of community ophthalmology both locally and nationally. The ophthalmology service in NUH is already under pressure and the expectation is that the numbers of patients requiring ophthalmology services will continue to increase.

In order to seek to address these issues, a working group including commissioners, secondary care providers and community optometrists was established to consider what further secondary care activity could be transferred to a community ophthalmology service and how that service should be commissioned.

The proposal involves the:

- Transfer of follow up activity from secondary care to community settings
- Increase the cost effectiveness of the current community ophthalmology service
- Create capacity in secondary care to manage those patients that do require secondary care support

The Clinical Development Committee recommended APPROVING the new pathway.

The papers which accompanied each agenda item are appended for information.

<table>
<thead>
<tr>
<th>Implications: (please tick where relevant)</th>
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<tbody>
<tr>
<td>Integration</td>
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<tr>
<td>Reducing inequality</td>
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<tr>
<td>Constitution</td>
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<tr>
<td>Governance</td>
</tr>
<tr>
<td>Innovation</td>
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<tr>
<td>Learning and Development</td>
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</tbody>
</table>

Finance checked by: (initials)

Appendices

Report History
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Pain Management Review Proposal</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>The Clinical Development Committee has recommended that the Governing Body <strong>APPROVE</strong> the proposal for a review of the Pain Management Pathway in Greater Nottingham.</td>
</tr>
</tbody>
</table>

**Reduction of Routine Follow-Ups for the Non-Surgical Management of Ulcerative Colitis**

The Clinical Development Committee has recommended that the Governing Body **APPROVE** the new pathway.

**Community Ophthalmology Proposal**

The Clinical Development Committee has recommended that the Governing Body **APPROVE** the new pathway.
### Executive Summary

Across Nottingham City, Nottingham West, Nottingham North & East and Rushcliffe CCGs, there are different pain management pathways with a lack of clarity over best practice to meet population need and elements of existing service provision that are known not to be consistent with evidence of clinically and cost effective care.

It is proposed that a review of the pain pathway is undertaken with the following scope:

- A comprehensive review of the current chronic pain management pathway
- Assessment of the population need for the pain management pathway
- Review of the evidence base for pain management
- Proposal for the future commissioning of the pain management pathway based on population need and evidence of good practice.

If paper is for approval, have the following impact assessments been completed?

<table>
<thead>
<tr>
<th>Quality Impact Assessment</th>
<th>Yes</th>
<th>☐</th>
<th>No</th>
<th>☐</th>
<th>N/A</th>
<th>☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality Impact Assessment</td>
<td>Yes</td>
<td>☐</td>
<td>No</td>
<td>☐</td>
<td>N/A</td>
<td>☐</td>
</tr>
<tr>
<td>Privacy Impact Assessment</td>
<td>Yes</td>
<td>☐</td>
<td>No</td>
<td>☐</td>
<td>N/A</td>
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</table>

**Implications:** (please tick where relevant)

- Integration ☐ Patient Choice ☐
- Reducing inequality ☐ Patient & Public Involvement ☐
- Constitution ☐ Quality of Services ☒
- Governance ☐ QIPP ☐
- Innovation ☐ Research ☐
- Learning and Development ☐ Sustainability ☐

**Finance checked by:** (initials)
<table>
<thead>
<tr>
<th>Report History</th>
<th>Recommendation</th>
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<tbody>
<tr>
<td><strong>Recommendation</strong></td>
<td>The Clinical Development Committee is asked to:</td>
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<tr>
<td></td>
<td><strong>APPROVE</strong> the proposal for a review of the Pain Management Pathway in Greater Nottingham.</td>
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<tr>
<td></td>
<td><strong>AGREE</strong> to consider the findings of the pathway review.</td>
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<tr>
<td></td>
<td><strong>AGREE</strong> to support implementation of the recommendations across Greater Nottingham subject to CCG approval.</td>
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</table>
Summary
The Greater Nottingham Clinical Commissioning Groups (Nottingham City, Nottingham North and East, Nottingham West, and Rushcliffe) are proposing that a comprehensive review of the chronic pain management pathway is undertaken. The review will involve engagement from the public, existing community and secondary care providers supported by independent clinical advice. It is proposed that the review will consider existing pathway provision commissioned by the four CCGs in Greater Nottingham, including the community services that correspond to individual CCGs only. This will facilitate an understanding of the impact the existing pain management pathway has on the population.

The review will be clinically led, supported by external expert clinical advice to identify the best practice pathway for pain management and to identify opportunities for implementation. Spend on the pain pathway in 2015/16 was £13.1m. Based on the RightCare Commissioning for Value packs, there is a potential financial opportunity of £687k. There is an inherent assumption that changes to the pain management pathway will need to be within the existing financial envelope as an absolute minimum.

Background
The Greater Nottingham partnership is committed to creating a sustainable and high quality health and care system. The four CCGs have identified a need to undertake a comprehensive review of the pain management pathway. The review is focused on delivering a sustainable, high quality model of care that maximises outcomes for the population.

The CCGs are taking a RightCare approach to the review of pain management. This approach seeks to maximise value in terms of:

- The value that the patient derives from their own care and treatment
- The value that the whole population derives from the investment in their healthcare.

A basic tenet of this approach is that the focus is on improving population value including improving outcomes, quality, and releasing capacity and resources for future investment.

The delivery of pain management services in Greater Nottingham has been raised as an issue for consideration for a number of reasons:

- The RightCare Commissioning for Value analysis identified the four Greater Nottingham CCGs as outliers for neurology provision. Nottingham North and East CCG commissioned a deep dive from the Greater East Midlands Commissioning Support Unit which identified that the management of chronic pain was an outlier for the CCG.

- A local price review has been undertaken with Nottingham University Hospitals (NUH) as part of the 2016/17 contracting round. This identified an opportunity to consolidate aspects
of service provision where currently there are multiple teams within the service. There is also an issue with the length of time a person remains within the service receiving treatment. A revised service specification will be developed as an outcome of the review.

- There is potential for **duplication between services**. There is a possible overlap in the service provision delivered through pain management, physiotherapy, community MSK/T&O/spinal and mental health services, in particular IAPT.

- A **differential service offer by CCGs** exists with a lack of clarity over best practice. Both Nottingham West and Nottingham City have commissioned community pain management services. There is merit in reviewing the outcomes achieved by these services to understand the differential impact on the population of Greater Nottingham to support an understanding of the best practice pathway. The proposed review seeks an optimum solution for the Greater Nottingham system while acknowledging the need for flexibility to ensure individual CCG population need is recognised.

- **Multiple providers deliver pain management services** for the population of Greater Nottingham. As highlighted above, there are two community pain management services within the system. The majority of secondary care pain management takes place across two providers with evidence that treatment varies by provider.

- Elements of existing service provision are known not to be consistent with evidence of **clinically and cost effective** care in the pathway e.g. acupuncture, trigger point injections. The review will focus on ensuring that pathways are evidence-based to maximise both the clinical benefits and cost effectiveness of the pathway.

CCGs have previously worked with the pain management service at NUH to understand the pain pathway and attempted to address a number of the issues that appear to make the service an outlier from peer trusts. This earlier work has helped to identify the issues that need to be considered as part of a pathway review.

**Scope**
The review will focus on the following:

- A **comprehensive review of the chronic pain management pathway** commissioned within Greater Nottingham, including community and secondary care commissioned services. The review will focus on the pathway for chronic pain. The pathway for the adult population only will be reviewed, recognising the demand for chronic, non-specialty specific pain management pathways is greatest in this population. The management of pain for children is generally undertaken at a specialty specific level.

- Understand the **population need** for the pain management pathway including needs that can be met by both generalist and specialist clinicians. Where appropriate, care will be delivered in community settings, with only those specialist elements of the pathway being delivered in a secondary care environment.

- Review of the **evidence base for pain management**. Consideration will be given to NICE / SIGN guidelines, Royal College recommendations as well as best practice from other areas of the country including both physical and psychological approaches to pain management.
Proposal for the future commissioning of the pain management pathway based on population need and evidence of good practice. This will include consideration to the contractual mechanisms required to commission an optimal pain pathway that excludes un-evidenced treatments. Alignment with emerging models of care such as Multi-Specialty Community Providers will be considered within the proposal.

Process for review
There are a number of elements to the review:

1. Population need
   Population need will be considered in terms of:
   - Existing need for pain management care across the Greater Nottingham population
   - Level of care that can be self-managed and that which requires specialist intervention(s)
   - Potential impact of demographic growth on future population need.

2. Activity levels
   Current activity across care settings will be considered in terms of:
   - Details of the services commissioned across the system
   - Referral pathways
   - Capacity and utilisation of each service
   - Cost per episode/patient/procedure.

   The activity data will be benchmarked against services provided by peer organisations using RightCare data as well as evidence of good practice from health systems nationally.

3. Alignment of population need and existing activity
   An assessment of the value for money offered by existing services in terms of:
   - Consideration of how existing population need is met through current pain management pathways
   - Review of gaps in commissioned services that result in unmet need.

4. Outcomes
   The outcomes currently being delivered by each service will be reviewed in terms of:
   - Outcomes used by the service to measure patient and clinical outcomes
   - Patient experience – through routine and ad hoc patient feedback, and dedicated focus groups if that is felt to be required
   - Perception of clinicians referring to the service
   - Assessment of value for money of the service.

This will give an overview of the quality of the pathway being delivered. It is recognised that there is little evidence available nationally on clinical outcomes in relation to pain management with most of the recognised outcomes being Patient Reported Outcome
Measures (PROMs). It is recognised there is a risk that outcomes for pain management may not be available in a reliable way.

5. **Best practice**
   A review of the evidence base will be a critical component of the review in terms of:
   
   - NICE / SIGN guidelines, pathways, standards and indicators
   - Royal College guidance and recommendations
   - Delivery of pain pathways locally and nationally that have high quality evidence to demonstrate clinical and cost effectiveness.

6. **Review of best practice with incumbent providers**
   Based on evidence from stages 1 to 5, discussions will be held with incumbent providers to understand adherence to best practice and where there is opportunity for changes to services. These discussions will be led by a subset of the task and finish group with clinical and managerial representatives from providers.

7. **Options for commissioning**
   Following completion of stages 1 to 6, options for the future commissioning of the pain management pathway will be developed for consideration by commissioners. This will be based on the population need and activity analysis and review of outcomes and evidence of best practice.

   The recommendations will be supported by analysis of the impact of implementing any changes to existing service provision in terms of activity, finance and outcomes.

   It is recognised there may be a plurality of providers delivery the pain management pathway across Greater Nottingham, but there will be a single agreed best practice pathway.

**Timescale**

It is proposed the review is undertaken over 6 months from June to December 2016, with recommendations being considered by CCG committees in January 2017.

**Governance**

A task and finish group will be established to undertake the work. This will comprise of the following:

- GP (Chair)
- Contracting lead, South County CCGs contracting team
- Contract and Information Manager, Nottingham North and East Clinical Commissioning Group
- Mental health pathway leads, Nottingham City and Nottinghamshire County
- Programme Manager for Elective Care, Greater Nottingham Health and Care Partners (co-ordinating review)
- Public Health, Nottingham City Council and/or Nottinghamshire County Council
- Service Improvement Managers, Greater Nottingham CCGs
- Finance and analytical support will be provided through the Elective Care workstream
- Prescribing advisor on behalf of Greater Nottingham CCGs
- Quality advisor on behalf of Greater Nottingham CCGs
- Lay leader(s) and/or links to patient groups
In addition to the core membership of the Task and Finish Group, links will be made with relevant groups with a remit for long term conditions as well as with specific specialties where required.

It is acknowledged that an impartial pain management clinician with no conflicting interests may be required to provide independent clinical advice. It is recognised there is an inherent challenge in identifying an independent clinician given they are likely to be delivering pain care in the community, secondary care or both settings outside of Greater Nottingham, and therefore will have an inherent bias. Therefore further consideration will be given to identifying the most appropriate way to access independent clinical advice.

The task and finish group will report to the Greater Nottingham Elective Care Oversight Group. The findings of the review will be submitted to CCG Clinical Cabinets (or equivalent) for consideration.

**Outcomes of review**

The following outcomes for the review are proposed:

1. Understand current population need and provision.
3. Review existing pain management pathway against the best practice model.
4. Make a proposal for the future commissioning intentions for the pain management pathway across Greater Nottingham incorporating best practice and meeting population need.

**Recommendation**

The CCG is asked to:

**APPROVE** the proposal for a review of the Pain Management Pathway in Greater Nottingham.

**AGREE** to consider the findings of the pathway review.

**AGREE** to support implementation of the recommendations across Greater Nottingham subject to CCG approval.
Reduction of routine follow-ups for the non-surgical management of ulcerative colitis patients

1. Introduction

Ulcerative Colitis and Crohn’s Disease are the two most common forms of Inflammatory Bowel Disease. Ulcerative Colitis is a lifelong disease that is associated with significant morbidity. It can also affect a person’s social and psychological wellbeing, particularly if poorly controlled. Typically, it has a relapsing–remitting pattern. Symptoms commonly present in patients in their teens and twenties.

Half of all annual direct healthcare costs from IBD relate to the inpatient management of a minority of patients who need intensive medical or surgical intervention. There are strong arguments both clinically and economically for focussing services towards prompt detection and optimal outpatient management of disease flare-ups and effective maintenance of remission.

Non-surgical management of UC patients in South Notts is carried out at NUH City Campus and the NHS Treatment Centre. Patients in remission are reviewed periodically by consultants and nurse specialists in out-patient clinics and increasingly, telephone appointments. Whether a patient is reviewed by a consultant or nurse specialist depends on severity of condition, patient preference and individual consultant practice. As a result wide variation in patient management has evolved.

The project was instigated at the request of the NUH Clinical Contract Board (CCB). The aim was to:

1. Ensure that condition management is patient centred.
2. Remove clinical variation in patient management.
3. Determine if the number of clinically unnecessary follow-up appointments can be reduced.

The proposed pathway was approved by the CCB on 19\textsuperscript{th} July 2016.

It is intended that the pathway be implemented across the 4 Greater Nottingham CCGs starting in October 2016.

2. Local Context

The incidence rate for UC in Europe is 24.3 per 100,000\textsuperscript{1}. This equates to 179 new UC patients per year across the 4 South Nottinghamshire CCGs (734,712 total population). The prevalence rate is 505 per 100,000\textsuperscript{1} equating to 3,699 patients across the 4 CCGs.
NUH and the Treatment Centre estimate that about 3,000 UC patients are managed across the 2 sites. About 2,000 UC patients are managed without the prescribing of immune-suppressants; the remaining 1,000 are managed with immunosuppression (excluding biologics).

### 3. Pathway Outcomes

The pathway will:-

- Be a more cost effective approach than traditional medical models of follow-up.
- Support self-management for stable patients.
- Eliminate unnecessary hospital based follow-up appointments is more convenient for patients.

### 4. Assumptions/constraints that have been identified

- Delivery of the pathway assumes that NUH will have implemented an IBD registry in order that discharges can be logged and interrogated for clinical management and monitoring purposes. The registry is due to be available in September 2016 after almost 2 years of delays.
- Members of the 2 IBD patient groups consulted said that some patients find their annual review reassuring and to be discharged may make them feel abandoned which in turn could cause a flare up in their condition. This business case assumes that there will be sufficient numbers of patients confident enough in their self-management to be discharged.
- It is assumed that there is sufficient clinic capacity to see all UC patients on the register in 12 months in order to realise all of the potential savings in the first year.

### 5. Project risks and mitigating actions:

- As part of the process to discharge patients, clinics may also seek to make more use of shared care protocols. This is good for patients and decreases outpatient activity but increases primary care prescribing costs. Monitoring measures include number of new patients on shared care protocols.
- Patient groups identified that discharged patients must have quick access to a consultant in event of a flare up and be given individual information packs on discharge. The pathway addresses both issues.
6. An explanation of how the service will be delivered

The pathway has been developed by and will be implemented by both NUH and Circle IBD clinics.

The first 5 elements of the pathway are common to both the current and proposed pathway. The change to the pathway is element 6 – discharge from annual review process.

1. IBD Register
All patients with confirmed IBD should have their details maintained on the Register of IBD patients even when they are no longer regularly attending outpatient clinics. The IBD register is not operational yet. NUH and the Treatment Centre are aiming to have it implemented by September 2016.

2. Inducing and maintaining remission
After diagnosis of UC the focus is on treating the active disease to address symptoms, and improve the quality of life. Once the underlying disease is treated the focus shifts to maintaining remission. The therapy used will depend of the severity of illness. For those patients on immunosuppression monitoring of treatment can be through a Shared Care Protocol with the patient’s GP and secondary care.

3. Patient education / supported self-management
Newly diagnosed patients and their families will be provided with information and support, including dietary / nutritional support, to help them in understanding UC and how it is managed. This will support them in shared decision making and achieving the best quality of life possible within the constraints of the illness.

4. Rapid access to specialist services
Flare-ups of UC need active management instituted quickly to minimise the impact of the relapse on the patient’s well-being and life. The unpredictable nature of relapses requires a responsive service with prompt access to doctors and nurses who are knowledgeable about IBD and can decide with patients which course of action is required. This may be an immediate change of treatment undertaken by the patient at home, an early outpatient appointment or immediate admission. Patients experiencing a possible relapse of their UC should have access to specialist review within a maximum of 5 working days.

5. Annual review
All IBD patients who are not under immediate or ongoing care, including those in remission, should have at least one annual review to assess the need for colorectal cancer surveillance, full blood count, liver and renal function, bone densitometry and full medication review. This may be undertaken in a hospital or community clinic or by telephone follow-up, and should be done by a healthcare professional with recognised competence in IBD including specialist IBD nurses.

6. Discharge from annual review process
Patients with stable distal ulcerative colitis or proctitis (stable defined as in remission > 1 year) and not on immunosuppression should be assessed for discharge from the annual review process.
Patients stable on immunosuppression will remain within the annual review process but be reviewed in a telephone clinic conducted by an IBD specialist nurse rather than a face to face consultant appointment.

Consultants and specialist IBD nurses conducting annual reviews will carry out a needs assessment of patients being considered for discharge. The Health professional must also assure themselves that the patient is able to self-manage. In line with patient centred care, the decision to discharge will be a joint decision between the patient and the Health Professional.

If a flare up occurs discharged patients can access a specialist review within a maximum of 5 working days via the IBD Helpline. Rapid access to a consultant appointment via IBD Helpline was identified as crucial by both IBD patient groups if the proposed pathway is to be implemented.

Exclusions from discharge
- < 18 years.
- Pancolitis due to increased risk of colon cancer.
- Patients on immunosuppression – these will not be discharged but followed up with a telephone clinic.

The pathway is given in Appendix 1.

7. How the proposal will be evaluated and monitored, including the KPI's outcomes that will be monitored.

Nottingham City CCG have stated the following.

Agreed KPI’s are:-
- Number of stable patients not on immunosuppression discharged.
- Number of stable patients on immune-suppressants switched to telephone annual review.
- Number of discharged patients requiring rapid access outpatient appointment.

The following monitoring measures have also been agreed with secondary care:-
- Number of stable patients not on immunosuppression suitable for discharge who decline.
- Number of stable patients on immune-suppressants who could be switched to telephone annual review who decline.
- Number of routine follow-up patients not on immunosuppression requiring rapid access outpatient OP (baseline).
- Follow-up waiting times of all IBD consultants before and after introduction of pilot.
- New case waiting times of all IBD consultants before and after introduction of pilot.
- Number of patients on shared care protocols before and after introduction of pilot.
- Total secondary care IBD-related yearly expenditure of a cohort of discharged patients (n=50) and those on a telephone clinic (n=50) and compared to yearly consultant follow-up.

Data will be collected by NUH and Circle using the new IBD Registry. Performance will be monitored through quarterly steering group meetings.

8. Quality

a. Clinical Effectiveness

The pathway is in line with the recommendations NICE Clinical Guideline 166 (June 2013) and “Service standards for the healthcare of people who have Inflammatory Bowel Disease” (2013).

It has been developed with both primary and secondary care clinical input;

- Dr Gordon Moran – Consultant Gastroenterologist, NUH and Circle
- Dr Aida Jawhari – Consultant Gastroenterologist, NUH and Circle
- Dr Kathy Teahon – Consultant Gastroenterologist, NUH
- Wendy Roome – IBD Specialist Nurse, NUH
- Gill Robinson – IBD Specialist Nurse, Circle
- Dr Matt Jelpke – GP, St George’s MP, Rushcliffe CCG
- Dr Sonali Kinra – GP, Hucknall Road MC, Nottingham City CCG

It was approved by the NUH Clinical Contract Board on 19th July 2016.

b. Patient Experience

The pathway will be delivered from both local IBD clinics, NUH and Circle, so patient choice is maintained. It will be more patient centred than the current situation where all ulcerative colitis patients are recalled for routine reviews whether it is clinically required or not. Attending unnecessary appointments is time consuming, frustrating and costly for patients.

It will also free-up outpatient capacity so that patients with flare ups can be seen more quickly.

IBD patient groups were consulted on the proposed pathway were in favour of discharging stable patients who are confident in self-managing their condition as long as there is a quick and convenient route back into the service. The pathway provides this through access to the IBD Helpline.

c. Value for Money

Overall savings should be generated by reducing the number routine follow-up appointments. There will be some additional costs incurred through discharged patients requiring rapid access to an outpatient appointment. These would be charged at a 1st outpatient tariff of £194.83 as opposed to a FU tariff of £114.98 (2016/17 national tariffs + MFF and CQUIN).
Assumptions

- The total UC case load across NUH and the Treatment Centre of Nottingham City, Rushcliffe, Nottingham North & East and Nottingham West CCG practices is 3,000 patients.
- 2,000 patients are managed without immune-suppressants. About 20% of this caseload would be suitable for discharge and supported self-management. This equates to 400 follow-up appointments / year.
- 10% of discharged patients / year will require a rapid access outpatient appointment due to a flare-up.
- 1,000 patients are managed with immune-suppressants (excluding biologics and bio-similars). About 10% of this caseload would be suitable for annual review by telephone. This equates to 100 follow-up telephone appointments / year.
- 1st outpatient appointment = £194.83 (including MFF and CQUIN)
- FU outpatient appointment = £114.98 (including MFF and CQUIN)
- telephone outpatient appointment = £24.49 (including MFF and CQUIN)

Savings for discharged patients (not on immunosuppression)
- Gross savings = 400 x £114.98 = £45,992 / year
- Additional costs due to rapid access outpatient apt. = (400 x 10%) x £194.83 = £7,793 / year
- Net saving = £45,992 - £7,793 = £38,199 / year across the 4 South Notts CCGs.

Savings for immunosuppression patients switching to telephone appointment
- 100 x (£114.98 - £24.49) = £9,049 / year across the 4 South Notts CCGs.

Total savings = £38,199 + £9,049 = £47,248 / year across the 4 South Notts CCGs.

Estimated annual recurrent savings by CCG prorated based on calculated prevalence figures are given below:

<table>
<thead>
<tr>
<th></th>
<th>Prevalence</th>
<th>Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nottingham City</td>
<td>1,838</td>
<td>£23,477</td>
</tr>
<tr>
<td>Rushcliffe</td>
<td>626</td>
<td>£7,996</td>
</tr>
<tr>
<td>NNE</td>
<td>762</td>
<td>£9,733</td>
</tr>
<tr>
<td>NW</td>
<td>473</td>
<td>£6,042</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,699</strong></td>
<td><strong>£47,248</strong></td>
</tr>
</tbody>
</table>

9. Need for the service

a. Health inequalities

Comparing IBD in ethnic communities to the non-Jewish Caucasian population, IBD occurs more frequently in Ashkenazi Jews, at higher levels in second-generation Indian and Pakistani families, and at about the same levels in families originating in Africa or the Caribbean. Men and women are diagnosed in equal numbers.
IBD is a lifelong condition which commonly present in the teens and twenties (25% present in adolescence; median age at diagnosis is 29.5 years). There is no cure.

The lifetime medical costs associated with the care of a person with IBD can be comparable to those with major chronic diseases such as diabetes mellitus or cancer.

b. Prevalence

The incidence rate for UC in Europe is 24.3 per 100,000. This equates to 79 new UC patients per year in Nottingham City. The prevalence rate is 505 per 100,000 equating to 1,838 patients.

10. Stakeholder engagement

The pathway has been developed with both primary and secondary care clinical input from;

Dr Gordon Moran – Consultant Gastroenterologist, NUH and Circle
Dr Aida Jawhari – Consultant Gastroenterologist, NUH and Circle
Dr Kathy Teahon – Consultant Gastroenterologist, NUH
Wendy Roome – IBD Specialist Nurse, NUH
Gill Robinson – IBD Specialist Nurse, Circle
Dr Matt Jelpke – GP, St George’s MP, Rushcliffe CCG
Dr Sonali Kinra – GP, Hucknall Road MC, Nottingham City CCG

It was also approved by the NUH Clinical Contract Board on 19th July 2016.

The NUH and Circle IBD patient groups have been consulted and their views have influenced the pathway design, for example – rapid access to outpatient appointments in the event of flare up and provision of individual information packs to help patients self-manage after discharge.

11. Recommendation

THE CDC is as asked to APPROVE the pathway detailed in this paper and outlined in Appendix 1.
Appendix 1

Management (non-surgical) of ulcerative colitis patients

Patient stable without immunosuppression

Annual review undertaken by IBD specialist

Patient stable?

Yes

Yes

Patients on the IBD register and GPs can call the IBD helpline at any time for advice and support with self-management.

Annually: colorectal cancer surveillance

No

Failure to continue under specialist care the specialist unless reviewed by consultant. For further advice by the specialist.

Patient stable with immunosuppression including biologics

Annual review undertaken by IBD specialist

Box 1

Annual review can be conducted as a telephone consultation by IBD nurses.

Annual review to include:

- Assessment of need for colorectal cancer surveillance
- Reassess function
- Bowel endoscopy

Box 2

Criteria for stable patient:

- Stable disease: ulcerative colitis in remission for > 1 year.
- Excludes patients at increased risk of colorectal cancer.

Box 3

Clinical criteria for consultant referral via IBD Helpline:

Any patient with a history of colitis/patients who has developed any combination of:

- Disturbance of bowel habit (constipation or diarrhea).
- Rectal bleeding or mucus.
- Abnormal or chronic pain.
- Anorexia and weight loss.

Standards used:

- Service standards for the healthcare of people who have Inflammatory Bowel Disease (IBD) (2009).
- NICE guideline 152 & 196.
Background

Context
The Community Ophthalmology triage and treatment services in the south Nottinghamshire CCGs have been running for a number of years and contracts have been renewed on an annual basis. The current model involves three separate elements and contracts:

- Referral management (via ERS)
- Triage (4 community optometrists)
- Treatment (around 10 separate contracts with individual providers)

Analysis of the current pathway suggests that it is costing more than it would to allow all referrals to go direct to secondary care. Whilst the current pathway has enhanced the scope of practice in community optometrists there is a significant amount of management time invested in the management of these contracts and accreditation of providers.

There are other models of community ophthalmology both locally and nationally. For example, within Nottingham City a lead provider model has been adopted with the support of a consultant ophthalmologist to allow the service to increase the range of patients it is able to support.

The ophthalmology service in NUH is already under pressure and the expectation is that the numbers of patients requiring ophthalmology services will continue to increase. Outpatient activity for NNE grew by 2.2% in 13-14, by 5% in 14-15; with much of the growth within appointments where procedures were carried out.

In order to seek to address these issues, a working group including commissioners, secondary care providers and community optometrists was established to consider what further secondary care activity could be transferred to a community ophthalmology service and how that service should be commissioned.

The Royal College of Ophthalmologists have published a Commissioning Guide for Glaucoma (June 2016) which will be used to inform the development of any future specification for a community based service. The Clinical Council for Eye Health Commissioning have published a Community Ophthalmology Framework (July 2015) which will also be used to inform the development of any future specification.
Strategic Alignment
This project aligns to the CCG QIPP Programme. There is also scope for the project to support the direction of travel within the Sustainability and Transformation Plan, with more care being delivered closer to home and better integration of community and secondary care eye health services.

Evidence to Support Proposal
The working group, which included a GP, secondary care consultant, opticians, commissioners and a patient representative, has reviewed evidence as to what services can be safely delivered in a community setting from other parts of the NHS. As mentioned above there is guidance available to support the commissioning of community eye health services.

The group's recommendation is that the monitoring of ocular hypertension and glaucoma can be safely managed within the community, if the service is supported by a consultant ophthalmologist. Due to the lack of clinical coding in secondary care outpatient settings it is not possible to accurately model the activity that could be transferred out of secondary care. In turn, this makes it difficult to model the funding that could be released from secondary care to support an enhanced community pathway. However, the commissioning leads believe that the procurement of an enhanced community pathway could be structured in such a way as to ensure savings for CCGs. There are also potential savings for NUH as reduced demand for follow up in secondary care should release capacity to meet demand and reduce the need for additional capacity that may be paid for at premium rates.

As mentioned above, the highest growth in activity within ophthalmology has been in outpatient procedures and this has generated a significant cost pressure for the CCG. It is anticipated that this cost pressure will continue to increase in future years unless Commissioning leads believe that there is scope to test the market to identify if there are providers who could deliver these services safely in community setting via a non-PBR contract that reduces the price for these services.

Intended Improvements and Metrics

Aims
- Re-commission a community ophthalmology service with effect from 1st April 2017
- Optimise the scope of the community ophthalmology service
- Increase the ability of the community ophthalmology service to develop and expand its remit over time

Objectives
- Transfer follow up activity from secondary care to community settings
- Increase the cost effectiveness of the current community ophthalmology service
- Create capacity in secondary care to manage those patients that do require secondary care support

Benefits
- Reduction in costs associated with care of those patients managed by the community ophthalmology service
- Reduction in waiting times within secondary care
- Care provided closer to home for patients
NHS Outcomes Framework

<table>
<thead>
<tr>
<th>Domain</th>
<th>Applies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Preventing people from dying prematurely</td>
<td></td>
</tr>
<tr>
<td>2. Enhancing quality of life for people with long-term conditions</td>
<td>✔</td>
</tr>
<tr>
<td>3. Helping people to recover from episodes of ill-health or following injury</td>
<td>✔</td>
</tr>
<tr>
<td>4. Ensuring people have a positive experience of care</td>
<td></td>
</tr>
<tr>
<td>5. Treating and caring for people in safe environment and protecting them from avoidable harm</td>
<td></td>
</tr>
</tbody>
</table>

Outcomes (SMART)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of community ophthalmology service is below comparable secondary care cost</td>
<td>• Comparison of costs in either setting</td>
</tr>
</tbody>
</table>

Options appraisal

**Essential requirements**

- Service is safe and of demonstrable good quality
- Service is cost effective
- Service has ability to maximise scope of community provision now and in the future
- Service reduces demand for secondary care services

**Options**

**Option 1: Retain Current Model (do nothing)**

<table>
<thead>
<tr>
<th>Description</th>
<th>Re-commission the existing services again in 2017-18</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Key criteria</th>
<th>Delivers A/O/B/O</th>
<th>No</th>
<th>Meets essential reqs</th>
<th>Partially</th>
</tr>
</thead>
</table>

**Benefits**

- Easy to implement

**Issues**

- Does not deliver any of the potential benefits identified

**Specific risks**

- Current service model appears to cost more than secondary care referral

**Savings**

- In year: None
- Full year: None
Option 2: Enhance Current Model

Description
Go out to procurement for a lead provider model with referral management and consultant ophthalmologist oversight

Key criteria
<table>
<thead>
<tr>
<th>Deliver A/O/B/O</th>
<th>Meets essential reqs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Benefits
- Delivers benefits identified above
- Reduces CCG overhead in managing the contract
- Allows for future development of community service

Issues
- Need to terminate existing contracts
- NUH won't discharge patients into community service

Specific risks
- Lack of response from the market
- Price bid may exceed available resources
- Secondary care capacity may not reduce so overall costs may increase

Savings
<table>
<thead>
<tr>
<th>In year</th>
<th>Full year</th>
</tr>
</thead>
<tbody>
<tr>
<td>£TBC</td>
<td>£TBC</td>
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</tbody>
</table>

Option 3: Terminate Contracts for Community Ophthalmology Service

Description
At the end of the current contract allow the service to cease

Key criteria
<table>
<thead>
<tr>
<th>Deliver A/O/B/O</th>
<th>Meets essential reqs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partially</td>
<td>Partially</td>
</tr>
</tbody>
</table>

Benefits
- Easy to implement
- Will generate a small cost saving for the CCG

Issues
- Does not maximise potential benefits
- Negative impact on relationships built with community optometrists.

Specific risks
- Secondary care’s ability to absorb the additional workload without impacting on waiting times

Savings
<table>
<thead>
<tr>
<th>In year</th>
<th>Full year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£16k</td>
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</table>

Preferred option
The preferred option is option 2: go out to procurement for a lead provider model with consultant ophthalmologist oversight.

Risk management

<table>
<thead>
<tr>
<th>Risk</th>
<th>Description</th>
<th>Score</th>
<th>Mitigating actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Lack of response from the market</td>
<td></td>
<td>A similar model is already operating in Nottingham City and it is felt that there will be interest from providers</td>
</tr>
<tr>
<td>2</td>
<td>Price bid may exceed resources</td>
<td></td>
<td>The envelope for the procurement is likely to be set at a figure lower than the current costs</td>
</tr>
<tr>
<td>3</td>
<td>Secondary care capacity may not reduce so overall costs may increase</td>
<td></td>
<td>The Elective Care Workstream is considering this issue as it concerns a number of specialties</td>
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</table>
Stakeholders and engagement

Stakeholders

<table>
<thead>
<tr>
<th>Stakeholder/group</th>
<th>Int./Ext.</th>
<th>Engagement method(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG Commissioners</td>
<td>Internal</td>
<td>• Steering Group (South Notts)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sharing Information (City and Mid Notts)</td>
</tr>
<tr>
<td>Optometrists</td>
<td>External</td>
<td>• Steering Group</td>
</tr>
<tr>
<td>NUH</td>
<td>External</td>
<td>• Steering Group</td>
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<tr>
<td>Patients</td>
<td></td>
<td>• Steering Group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Specific Engagement</td>
</tr>
</tbody>
</table>

Level of engagement required

![Level of engagement - change required](image)

Impact assessments

<table>
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<td>Equality Impact Assessment (EIA)</td>
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<tr>
<td>Privacy Impact Assessment (PIA)</td>
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<tr>
<td>Quality Impact Assessment (QIA)</td>
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See appendix 1 for full assessments.
<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
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<tr>
<td>Agreement from CCGs to Proceed</td>
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<tr>
<td>Patient &amp; Stakeholder Engagement in Design of Specification</td>
<td>31st October 2016</td>
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<td>Service Specification Completed</td>
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<td>Procurement Commences</td>
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<td>Contract Award</td>
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<tr>
<td>Contract Commencement</td>
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Project Administration

All parties agree to project enactment after BC stage 1 (bypassing stage 2)

Yes  No

Scope and delegation

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<tr>
<th>CCG</th>
<th>In scope</th>
<th>Lead CCG (tick one)</th>
<th>BC st.2 development delegation (tick level required by each CCG)</th>
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<tr>
<td>Rushcliffe</td>
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Onward (stage 2) approval routes

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Project team

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<th>Role</th>
<th>CCG</th>
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</thead>
<tbody>
<tr>
<td>Project lead/lead CCG rep.*</td>
<td>Stewart Newman</td>
<td>Lead</td>
<td></td>
</tr>
<tr>
<td>Project clinical lead*</td>
<td>Dr Panesar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG representatives*</td>
<td>Stephen Andersen – Nottingham West CCG</td>
<td></td>
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<tr>
<td></td>
<td>Steven Smith – Rushcliffe CCG</td>
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<td>CCG clinical reps</td>
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<td>Finance representative*</td>
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## Stage 1 agreement

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<tr>
<td>Rushcliffe</td>
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</table>
The Chief Officer’s report gives an update on the following items of interest:

- CCG Assurance Process 2016/17
- Sustainability and Transformation Plan
- Managing Conflicts of Interest in the NHS: A consultation
- Quarter 1 Workforce Report

If paper is for approval, have the following impact assessments been completed?

<table>
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<tr>
<th>Quality Impact Assessment</th>
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Implications: (please tick where relevant)

- Integration
- Reducing inequality
- Constitution
- Governance
- Innovation
- Learning and Development

Finance checked by: (initials)

Appendices

Report History

Recommendation

The Governing Body is asked to:

NOTE the Chief Officer’s Report
Chief Officer’s Report

CCG Assurance Process 2016/17

Members of the CCG senior management team attended the first quarterly assurance meeting for 2016/17 with the North Midlands NHS England Team in line with the revised CCG Assurance Process for 2016/17. The supporting letter and action log arising from the review are attached at Appendix A.

Sustainability and Transformation Plan

Following the 30 June 2016 submission and the panel feedback from leaders of the national bodies, work is underway to address the priority areas for action to enable us to re-submit the draft STP by 21 October 2016.

Current activities, all with deadlines of the end of September, are seeing the progression of detailed plans for individual projects to address the quality gap including new models of care and national clinical priorities. Clarity is being sought on our governance structure and delegated decision-making so that we can demonstrate clear evidence of wider stakeholder sign-up and engagement. Working alongside colleagues in public health, we are establishing the prevention plan including the contributions that primary care can make and how we can best fund citizen’s lifestyle changes.

Other ongoing work includes the development of a fully costed workforce plan, and a description of the service and financial benefits of the proposed Sherwood Forest Hospitals/Nottingham University Hospitals merger.

We are working on translating all the financial initiatives into more detailed plans where necessary. These include progressing the detail on the delivery of the cost improvement programmes over the five-year period and ensuring that the majority of change initiatives are turned from outline plans to detailed business cases and implementation plans.

Managing Conflicts of Interest in the NHS: A consultation

Earlier this year, NHS England set out plans to design a stronger, more consistent approach to managing potential and existing conflicts of interest across the system.

Sir Malcolm Grant, Chairman of NHS England, has chaired a cross NHS task and finish group, which has been working to develop a full set of rules. The review sought to consider particular pressure points and refresh the rules and processes so as to ensure more uniformity and enhanced transparency across the NHS. A consultation on the proposed rules is now available - https://www.england.nhs.uk/wp-content/uploads/2016/05/conflicts-of-interest-consultation.pdf

It is hoped the final guidance will be stronger and more consistent, meaning patients and the public can have full confidence in how NHS funding is invested. Feedback can be provided until midnight Monday 31 October.
Quarter 1 Workforce Report

- Staffing Levels

For Quarter 1, the workforce dashboard highlights that the CCG’s headcount has remained steady at 35. The CCG’s WTE numbers have also fallen through Q1, ending the period at 22.47 which represents a fall of 4.1%. The CCG’s WTE figure has also fallen over the last 12 months by 16%. The monthly salary costs have also reduced in Q1 by £3,926 which represents a drop of 4.55%. The CCG’s salary costs have fallen by 17.3% from a year ago.

- Sickness Absence

The CCG’s sickness absence showed a steady fall through Q1 ending the period at 0.82% in June 2016. While the long term absence accounted for almost 87% of the days lost during Q1, it was attributable to just 2 members of staff. HR has provided advice and support to the managers and both individuals have been managed and supported and both staff have now left the CCG. The CCG’s absence in Q1 cost £12,465.

In addition to existing absence measures HR also reports on the reasons for absence reason and over the last year it shows that almost 78% of all absence was for just 3 reasons: anxiety/stress/depression, gastrointestinal problems and chest and respiratory problems. The purpose of collecting this information is to enable the CCG to consider whether there are any trends or patterns in absences and whether preventative measures can be considered, flu jabs for example if there was a high frequency of colds and flu within the CCG.

- Learning Compliance

The learning compliance data shows that overall Nottingham West CCG has an average level of training compliance for mandatory training courses with an overall 66% compliance rate. However, additional effort is required for the CCG to attain 100% compliance.

<table>
<thead>
<tr>
<th>Competence Name</th>
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<th>Achieved</th>
<th>Compliance %</th>
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<tbody>
<tr>
<td>Conflict Resolution - 3 Years</td>
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<td>35</td>
<td>23</td>
<td>65.71%</td>
</tr>
<tr>
<td>Equality, Diversity and Human Rights - 3 Years</td>
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<td>35</td>
<td>22</td>
<td>62.86%</td>
</tr>
<tr>
<td>Fire Safety - 1 Year</td>
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<td>35</td>
<td>21</td>
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</tr>
<tr>
<td>Health and Safety - 3 Years</td>
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<td>Information Governance - 1 Year</td>
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<td>35</td>
<td>35</td>
<td>23</td>
<td>65.71%</td>
</tr>
</tbody>
</table>

- Disciplinary, Performance and Grievance

There are currently no formal disciplinary, performance or grievance cases within Nottingham West CCG, which reflects good management practices, robust policies provided
by HR and appropriate informal interventions from HR to stop issues escalating into formal procedures. HR frequently provides individual managers and employees with support and guidance to help them resolve any issues at the early stage. Where cases have previously escalated, HR has supported the CCG’s managers in reaching appropriate resolutions.

- **Equality and Diversity**

A range of new diversity measures are now included in the HR dashboard so that Nottingham West CCG can understand the diversity of its workforce. The CCG can also compare its own workforce with the local population to establish if it reflects that of the local area.
Sent via email

2nd September 2016

Vicky Bailey
Nottingham West CCG/Rushcliffe CCG
Albert Street
Stapleford
Nottingham
NG9 8DB
Address

Dear Vicky,

Re: CCG Assurance Process 2016/17

Thank you for your attendance and contribution at the first quarterly review meeting which as you are aware is a new requirement in the 2016/17 CCG improvement and assurance framework (IAF).

I would also like to thank you for sharing your presentation which helped us focus discussions on the key achievements and challenges for your CCG over the last quarter.

An action tracker is enclosed which I hope accurately reflects key points and the actions agreed during the discussion. There will be opportunity to discuss progress against the actions in future monthly assurance and quarterly review meetings.

The 2016/17 CCG IAF is an evolving process and at this point it is unclear how the outcome of the quarterly review meetings will inform CCG assurance ratings. We will however keep you informed of further developments with the CCG IAF as they become available.

We also expect NHS England to share the baseline results in relation to the 6 clinical priority areas in coming months which will inform future discussions as part of the assurance process.
The quarter one review meetings were arranged at relatively short notice and we appreciate the CCGs flexibility in accommodating these. We will be in touch shortly to arrange the quarterly review meetings for the remainder of the year. We expect that these will be in October, January and April and wherever possible we would look to extend an existing monthly assurance meeting to accommodate these.

Thank you for a productive discussion at the first quarterly review meeting and we look forward to working with you on the agreed improvement areas in the coming period. In the meantime if you have any queries arising from this process please do raise directly with me or your locality director.

Yours sincerely

Oliver Newbould
Locality Director
NHS England
**ASSURANCE MEETING**

**ACTION TRACKER**
Nottingham West & Rushcliffe CCGs

11th August 2016
Easthorpe House, Ruddington

CCG Attendees: Vicky Bailey (VB), Jonathan Bemrose (JB), Rob Taylor (RT)
NHSE Attendees: Oliver Newbould (ON), Simon Frampton, Cheryl Sherratt (CS),

### ACTION TRACKER

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<th>No:</th>
<th>Risk / Issue:</th>
<th>Responsible Name:</th>
<th>Due by date:</th>
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<tbody>
<tr>
<td></td>
<td>Better Health, Better Care and other quality indicators:</td>
<td></td>
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<tr>
<td></td>
<td>- CCG are trying to get underneath certain issues with the IAF dataset, for example Rushcliffe know there is an issue with the data for 1st episodes of psychosis starting treatment. However they are aware that in Mental Health and Learning Difficulties there is more work to do to understand if there is a service provision issue or a statistical issue with the representation of the data.</td>
<td>RT</td>
<td>All ASAP</td>
</tr>
<tr>
<td></td>
<td>- CCG to review all CCG IAF indicators, understand variation and address any required improvements. This will be reviewed formally at the next meeting.</td>
<td>VB</td>
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<tr>
<td></td>
<td>- ED &amp; Cancer performance was discussed at length, and CCG acknowledged they need to adopt a different approach to system management verses the current organisation management they have been previously used to. It was agreed there is a need to raise specific issues (e.g. NUH workforce, Rotas &amp; minors performance) more formally than has been previously.</td>
<td>VB</td>
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<td></td>
<td>- CCGs agreed that they need to work better together to hold the providers to account where performance issues occur.</td>
<td>CCG</td>
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</table>
### Sustainability
- The CCGs need to ensure that the STP and NUH/SFHFT merger FBC are aligned. CCGs to also ensure that STP is fully reflected in 2017/18 and 2018/19 commissioning intentions, operational plans and contracts.

<table>
<thead>
<tr>
<th>JB</th>
<th>Q2</th>
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### Finance and Activity
- CCG agreed they will need additional QIPP schemes to enable them to hit their control totals, these will need to start delivering in year and continue into 17/18. (both CCGs are currently ~£1.5M short for the year, but have ~£1M in place already)
- Vicky formally raised that Rushcliffe CCG have the same population as Newark & Sherwood CCG but ~£20M per year less funding.

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<th>JB</th>
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### Leadership
- STP work is ongoing on how to effectively integrate the current planning areas of mid and south Nottinghamshire together for the STP, NHSE expressed that the STP plan has to be a cohesive plan, but containing the detail on how this will be delivered, the current plan was assessed as being very light on detail. Local variations are acceptable (and in some cases unavoidable) as long as there are valid reasons detailed for these.

| VB | Ongoing with STP |
This story, rather than being told from the perspective of one individual, provides details the recent closure of a care home which impacted a number of residents, their loved ones and staff. The story reminds us that care homes are people’s homes and people have the right to live there as long as they want. When a home closes (either temporarily or permanently), the process must be handled in a way that supports the people who live there so that, despite the difficult circumstances, people have a good experience of moving to a suitable, safe alternative home or care provision that meets their needs. Moving home can be traumatic even when people plan and choose to do this, so the impact when people have to move at short notice due to unforeseen circumstances or emergencies should not be underestimated. This also applies to people affected indirectly by the closure, such as those already residing in care homes where new people move to. The impact on staff, many of whom have worked at the home for a significant length of time, should also not be forgotten.

The story describes how the Clinical Commissioning Groups’ Quality Team worked in collaboration with partners and relatives to ensure an effective transfer of the residents and positive experience. The outcomes for the residents are outlined including, in one case of a younger adult, the provision of a personal health budget which has enabled the individual to return home with a care package.

Good practice is identified along with lessons learned and the following recommendations are made:

- Promotion of the good practice demonstrated by all stakeholders and the lessons learnt and recommendations made to ensure any future closures or complex patient transfers are made with the minimum disruption and risk to patients.

- Continuation of collaborative work with Local Authority colleagues to ensure the lessons learned from this event are promoted and the learning in relation to safe and effective monitoring is progressed.
### Implications: (please tick where relevant)

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<th>Integration</th>
<th>Patient Choice</th>
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<td>Reducing inequality</td>
<td>Patient &amp; Public Involvement</td>
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### Finance checked by: N/A

### Appendices

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### Report History

Patient stories are presented regularly to the Governing Body.

### Recommendation

The Governing Body is asked to:

NOTE the contents of this report.
Patient Story

Subject: Care Home Closure

Presented by: Nichola Bramhall, Director of Nursing and Quality

Report prepared by: Marlea Kennedy, Patient Experience Coordinator and Gail Colley-Bontoft, Head of Quality and Adult Safeguarding

Summary: The actions taken to ensure an effective transfer of residents and positive experience following the closure of a care home.

1. Introduction

Bringing patients or their carers' stories into the Board is welcomed by the Governing Bodies as a mechanism for understanding the impact of the services we commission, positive and negative, on service users. Patient Stories are advocated as a powerful catalyst for change by the Institute for Healthcare Improvement (www.ihi.org).

Patient stories are a key feature of our ambition to revolutionise patient experience. They provide a focus on how, through listening and learning from the patient voice, we can continually improve the quality of services and transform patient and carer experience.

2. Context

All care homes are monitored, inspected and regulated by the Care Quality Commission (CQC) to make sure they meet fundamental standards of quality and safety. In addition, and often in collaboration with Nottinghamshire County Council, the Clinical Commissioning Groups’ (CCGs’) Quality Team regularly undertake quality monitoring visits to care homes providing nursing care within the Nottinghamshire County area.

These visits are unannounced to ensure the quality of service delivery can be assessed at any time without prior notice or preparation by the care home and to ensure it is meeting the needs of residents requiring nursing care.

A visit report is completed and submitted by the CCG Care Home Quality Lead to the provider with an account of the findings. All recommendations made as a result of the visit require an action plan to be completed by the provider with set timescales to ensure they meet the required standards of care.

Failure to address any concerns may lead to the care home being subject to further action by the CCG in partnership with other agencies to ensure the safety and welfare of the residents in the home e.g. issuing of warning notices or implementation of contract suspensions.

The matrix below is used by the Care Home Quality Leads to identify where homes are to be recorded on the Care Home Risk Register and to ensure other agencies and the CCGs’ governing bodies are aware of any concerns.
Level 1  Care homes identified to have low level concerns / Care Quality Commission (CQC) compliance issues but not requiring CCG input as there are no nursing clients  Blue risk

Level 2  Care homes with a history of concerns that are being resolved but require some monitoring to ensure progress maintained. Visit will be carried out by the LA (Local Authority)/CCG  Green risk

Level 3  Care Homes with on-going concerns around quality of care delivery / lack of compliance with CQC standards - care home requires regular monitoring of standards of care and action plans by CQC/CCG/LA  Amber risk

Level 4  Care Homes with serious concerns raised / contract suspensions in place / non-compliance with CQC standards – care home requires frequent monitoring of standards of care and action plans by CQC/LA/CCG.  Red risk

3. Background

Following a CQC inspection in 2014 of Hallcroft Care Home, which identified 4 areas of non-compliance, Four Seasons Healthcare (FSHC), the owners of Hallcroft, along with the Local Authority (LA) and CCG collaborated to deliver improvements within the home. This involved support in developing action plans, quality monitoring and facilitation of relatives’ and provider meetings.

The care home sat within the Nottingham North and East CCG boundary and had capacity for 40 residents. It was a dual registered home with capacity for both nursing and residential clients. Monitoring visits throughout 2015 identified that whilst improvement was being made in some areas and there was some evidence of sustainability of these improvements, there remained concern that progress with documentation and other elements was not being achieved at the required rate or to the necessary standard.

On 31 March 2016 FSHC informed the authorities of their decision to close the home as they were unable to recruit a manager and/or registered nurses. There were 22 residents living in Hallcroft at this time, 19 in nursing beds and 3 in residential beds. Formal notification of the closure was undertaken by FSHC to residents, families, and staff on 25 April 2016. The LA and members of the CCGs’ Quality Team were present in order to ensure immediate support was in place for all those affected.

Of the 22 residents, 19 were in receipt of Funded Nursing Care (a fixed rate payment towards the overall placement cost which supports registered nurse oversight of the patients’ needs) and 3 were in receipt of Continuing Healthcare funding as a result of having a primary health need. 11 residents were in receipt of funding from Nottinghamshire County Council, 3 from Nottingham City Council, 2 were funded from out of county and 6 were self-funders. Therefore all residents had some element of health funding towards their placement.

The average age of residents was 83 years with an age range of 46 years to 100 years. The residents had a variety of care needs including those associated with physical frailty as well as some with cognitive difficulties associated with dementia.

The impact of home closures on residents, their loved ones and the staff should not be underestimated. In this instance many of the residents had been at the home for a significant
length of time and this was truly their home. It is imperative that home closure is as far as possible the last resort and that when home closure becomes necessary all agencies work together to minimise the impact on residents, their loved ones and staff.

4. Action Taken By Providers:

Four Seasons Healthcare

To ensure effective working relationships between all parties during the closure, a Resident Experience Manager (REM) was assigned by FSHC to work in the home to co-ordinate and manage the home closure and ensure residents safety. They also had a key role in keeping residents' loved ones updated and involved. This improved effective partnership working between the home and the commissioners. Feedback from the REM reported the process had been managed effectively, collaboratively, with a sensible and practical approach.

Throughout the process the care home staff demonstrated a commitment to the residents and to the company and remained employed by the home until the closure. It is evident the company supported their workforce through this difficult transition and it was noted that the 33 staff employed by the home were either re-deployed to neighbouring FSHC homes or chose to retire.

CityCare

As part of the process residents that were assessed as requiring nursing care were assessed by the provider CityCare, who is commissioned by the CCG, to assess, manage and review continuing health care (CHC) funded residents.

A dedicated Nurse Assessor from CityCare was allocated to oversee CHC funded patients within the home, which included the case management of a younger adult aged 46 years. This enabled continuity of care and a single point of contact for the provider, CCG and LA.

All of the CHC funded residents were found appropriate, alternative placements that met with theirs and their loved ones approval. Alternative placements included The Beeches in Arnold, Charnwood Court in Carlton, Park House in the City (for the City funded residents) and Tudor Grange in Hucknall (for the residents requiring residential beds).

In the case of the younger adult, following assessment and discussion regarding preferences with her and her husband, an alternative to care home placement was identified. The outcome was to enable this younger person to return to her own home with a Personal Health Budget (PHB).

The PHB was used to employ a personal assistant (PA). The PA had previously worked at Hallcroft, and so had therefore already established a working relationship with the resident and her family, and was aware of the young person’s individual needs. This person is now able to have her needs met in her own home and her and her husband have greater flexibility and control with regards to how her ongoing needs are met. We are currently in discussion with this individual and hope to be able to present her individual story in future.

Follow up visits are being undertaken for all of the residents to ensure that they have settled in to their new homes and that their care needs are being met.

Nottinghamshire County Council/Clinical Commissioning Group

The Local Authority and the Clinical Commissioning Groups worked collaboratively to ensure residents were assessed in a timely manner, this was co-ordinated with the home to
minimise the impact of residents’ assessments in the home and reduce the number of assessors attending at any given time.

5. Good Practice

- A checklist to support the home with safe transfers informed new providers of key aspects of the residents’ individual care required and ensured all relevant stakeholders were informed of the changes to the resident’s placement.

- Medication was ordered in advance and repeat prescriptions obtained to ensure new placements were prepared to ensure on-going care.

- The residents’ tissue viability was noted to be thoroughly managed, and the home ensured all residents’ skin integrity was checked prior to transfer and FSHC ensured appropriate pressure relieving equipment accompanied the resident to their new placements.

- All residents were provided with a nominated carer to support the move to the new placement and ensure a comprehensive handover of residents’ needs was provided. Relatives have provided positive feedback on the support during the transitional period, despite their disappointment that the home had to close. No safeguarding concerns were identified throughout the process.

- A collaborative approach by all parties involved was taken to ensure residents, carers and families were fully supported and to ensure residents at the home were appropriately assessed and relocated to the most appropriate alternative placements.

- Feedback was received from the Resident Experience Manager who concluded that the whole process had been managed effectively, collaboratively, in a sensible and practicable approach. It was commented on that the initial meeting with the residents and relatives was critical and that good representation was available to relatives to provide advice and assurance.

A compliment from the Resident Experience Support Manager for FSHC has also been included, identifying the efforts provided by the collaborative team and in particular, Dawn Browning, Clinical Lead at Citycare:

‘I would like to thank you for your help and support in the last couple of months with the closure of Hallcroft Care Home. I have found the home closure check list extremely useful.

I am not sure if the CCG have any mechanism for recognising colleagues that go above and beyond what might be expected of them. Dawn Browning was outstanding in terms of the sensitive manner in which she carried out the assessments of those people living at Hallcroft. She appeared to take everything in her stride. She would arrive at the home to assess an individual. Dawn would start by reassuring them that she was there to support them. Dawn dealt with the individual’s representatives in a calm and professional manner a number of whom were displaying distress reactions.

Dawn took a common sense approach to the manner in which she undertook the assessments she was sensitive and supporting of the staff all of whom at the time face redundancy. But she still addressed practice issues in a direct and professional manner.'
I would be grateful if you could offer my thanks for her support and advice.’

This information has been shared in person with Dawn and her manager, along with thanks from the CCG for the work undertaken by CityCare on behalf of the CCGs in ensuring that residents’ needs were appropriately assessed and met.

6. Lessons learnt:

- To ensure the transfer of residents is not carried out on Fridays in order to manage any complex issues before a weekend as multiagency staff are not available to support the process which increases the risks to residents (fortunately this did not occur as part of this home closure).

- To update the Care Home Escalation / Home Closure policy to ensure it is in date and reflects the needs of the residents.

- To consider alternative transport arrangements as the company commissioned to carry out the move were not able to take all the residents belongings and were late on transferring residents.

- To ensure the medicine management team from the CCG are available to carry out an audit visit to ensure all medicines are safely transferred.

- To develop a different quality monitoring model which enables a more proactive and supportive approach and provides specialist support and knowledge to care homes that require improvement in order to achieve appropriate standards of quality and minimise the risk of home closures.

- To ensure that all options for alternative provision are considered to ensure that residents have the most appropriate ongoing care including the use of PHBs and home care packages where appropriate.

7. Contextual Information and Triangulation with Other Data Sources

CQC Inspections

The CQC regulates all health and social care services in England, including care homes. Their overarching framework, principles and operating model includes the five key questions that the CQC ask of all services (see below) and results in an overall rating:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive?
- Are they well-led?

The table below shows how the CQC position for local care homes inspected under this model of inspection compares with the Midlands and East Region and England (those inspected under the previous regime are not included in the table below). Rushcliffe
compares favourably with the majority of homes inspected to date good with none rated inadequate whilst NNE and NW have a slightly higher proportion of homes rated requires improvement and inadequate. The majority of Nottinghamshire homes have now been inspected under this model and therefore contribute to the table below.

A local enhanced service (LES) ‘One Care Home, One GP’ was incorporated into the primary care contracts across Rushcliffe CCG some time ago. This includes a model in which dedicated practices cover each care home, provide weekly GP ward rounds and regular quality meetings between the care home and GP practice staff. A similar LES is now being incorporated into primary care contracts across both Nottingham North and East CCG and Nottingham West CCG to increase the quality of its service delivery in these areas.

<table>
<thead>
<tr>
<th>Geography</th>
<th>Outstanding</th>
<th>Good</th>
<th>Requires improvement</th>
<th>Inadequate</th>
<th>% Inspected</th>
</tr>
</thead>
<tbody>
<tr>
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<td>4.6%</td>
<td>76.8%</td>
</tr>
<tr>
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<td>87.1%</td>
</tr>
<tr>
<td>Rushcliffe</td>
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<td>14.7%</td>
<td>0.0%</td>
<td>79.1%</td>
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<tr>
<td>Midlands and East Region</td>
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<tr>
<td>England</td>
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<td>69.0%</td>
<td>27.8%</td>
<td>2.5%</td>
<td>76.0%</td>
</tr>
</tbody>
</table>

**Good Practice for Care Home Closures**

We should be reminded that care homes are people’s homes and people have the right to live there as long as they want. When a home closes (either temporarily or permanently), the process must be handled in a way that supports the people who live there so that, despite the difficult circumstances, people have a good experience of moving to a suitable, safe alternative home or care provision that meets their needs. Moving home can be traumatic even when people plan and choose to do this, so the impact when people have to move at short notice due to unforeseen circumstances or emergencies should not be underestimated. This also applies to people affected indirectly by the closure, such as those already residing in care homes where new people move to. The impact on staff, many of whom have worked at the home for a significant length of time, should also not be forgotten.

Managing care home closures must ensure that, where temporary or permanent care home closure situations arise, there is a joined-up and effective response from all partners involved. This will ensure as minimal, adverse impact as possible on people using services, their families, carers and advocates and to keep them as fully informed and involved as possible throughout the changing situation.

The CQC in partnership with NHS England (NHSE), the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and the Care Provider Alliance (CPA) has provided good practice guidance for Local Authorities, Clinical Commissioning Groups, NHS England, CQC, providers and partners.

The Guide should help these partners to co-ordinate action, avoid duplication and prevent confusion for providers and health and care staff in the homes that are closing or that receive residents from homes that close. It recognises both that the care home provider retains primary responsibility for residents, wherever possible, and local authorities’ statutory duties.

7. Recommendations

The following recommendations are made:

The Governing Body is asked to note the contents of the story.

Promotion of the good practice demonstrated by all stakeholders and the lessons learnt and recommendations made to ensure any future closures or complex patient transfers are made with the minimum disruption and risk to patients.

Continuation of collaborative work with Local Authority colleagues to ensure the lessons learned from this event are promoted and the learning in relation to safe and effective monitoring is progressed.

8. Update on Actions Taken Following Previous Patient Stories

I. Story presented at July 2016 Governing Bodies: A relative’s perspective of services associated with end of life care.

This patient story has now been included as learning within the South Nottinghamshire Clinical Commissioning Groups Quality and Patient Safety quarterly newsletter “Quality Counts” which is disseminated to a wide audience, including all GP practices. It will also be used within Protected Learning Time (PLT) sessions; this is dedicated time for the training of both staff and GPs.

The Nottinghamshire Guideline for Care in the Last Year of Life 2015 has been disseminated to all GP practices and is actively being promoted by our community provider.

We are currently promoting the Electronic Palliative Care Co-ordination Service (EPaCCS) which is also commissioned by CCGs. EPaCCS enable the recording and sharing of people’s care preferences and key details about their care with those delivering their care. The systems support co-ordination of care and the delivery of the right care, in the right place, by the right person, at the right time. The EPaCCS templates should be completed by GPs/CHP staff and patients' wishes shared with other professionals. It also contains prompts for anticipatory prescribing of medications etc.
### Executive Summary
This paper provides the Governing Body with an update on the outcome of the annual assessment of the CCG Assurance Framework for 2015/16. Members are reminded a summary of the Nottingham West position was reported in the Chief Officer’s Report to the last meeting.

For the 2015/16 financial year NHS Nottingham West CCG was assessed overall as **GOOD**

If paper is for approval, have the following impact assessments been completed?

<table>
<thead>
<tr>
<th>Quality Impact Assessment</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tr>
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<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>Privacy Impact Assessment</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Implications:** *(please tick where relevant)*

- Integration
- Reducing inequality
- Constitution
- Governance
- Innovation
- Learning and Development
- Patient Choice
- Patient & Public Involvement
- Quality of Services
- QIPP
- Research
- Sustainability

*Finance checked by: [initials]*

**Recommendation**
The Governing Body is asked to:

**NOTE** NHS England’s assessment of the CCG for the 2015/16 financial year;

**NOTE** the continued need to improve services for patients which will result in the required improvements for subsequent years.
NOTE the plans discussed as part of the STP, corporate plans and performance management processes to improve this position; and

NOTE future Quality and Performance reports to the Governing Body will be enhanced to include a summary of the project assessment under the 2016/17 CCG Improvement & Assurance Framework.
Introduction

1. This paper provides the Governing Body with an update on the outcome of the annual assessment of the CCG Assurance Framework for 2015/16. Members are reminded a summary of the Nottingham West position was reported in the Chief Officer’s Report to the last meeting.

Background

2. NHS England conducts an annual performance assessment of CCGs. The assurance framework for 2015/16 assessed CCGs against five components of assurance. The criteria for assessing each component during the year are set out in the CCG assurance framework. The year-end component assessment balances an overview of the CCG’s performance during the year with the level of risk it is carrying forward in to the next year.

3. CCGs may be assessed into one of four categories:
   - Outstanding;
   - Good;
   - Requires Improvement; and
   - Inadequate

4. The principles used to create headline assessments from the five components of assurance are:
   a. **OUTSTANDING** is applied where at least one component is outstanding and the others are all good;
   b. **GOOD** is applied if:
      i. all components are good; or
      ii. at least four components are rated as good (or good and outstanding) and one component is requires improvement, unless requires improvement is in the finance, planning or well led component;
   c. the headline is **REQUIRES IMPROVEMENT** if:
      i. four components are rated as good (or good and outstanding) and the finance, planning or well led components are assessed as requires improvement or inadequate;
      ii. there is more than one requires improvement component rating; and
      iii. no more than one component is assessed as inadequate;
   d. A CCG is **INADEQUATE** overall if:
      i. more than one component is rated as inadequate;
      ii. it already has directions (under section 14.z.21 of the NHS Act 2006, as amended) in force.
Outcome for 2015/16

5. For the 2015/16 financial year NHS Nottingham West CCG was assessed overall as GOOD under the above criteria.

6. Each of the five domains were individually assessed as:

<table>
<thead>
<tr>
<th>Component of Assurance</th>
<th>Assessment</th>
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</thead>
<tbody>
<tr>
<td>Well Led</td>
<td>Good</td>
</tr>
<tr>
<td>Delegated Functions</td>
<td>Good</td>
</tr>
<tr>
<td>Finance</td>
<td>Good</td>
</tr>
<tr>
<td>Performance</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Planning</td>
<td>Good</td>
</tr>
</tbody>
</table>

7. The delivery of the 4-hour A&E standard remains a challenge for all Nottinghamshire CCG and this is reflected in the assessment of the Performance component.

8. Appendix A shows the assurance rating of each CCG nationally. Of particular note are:

<table>
<thead>
<tr>
<th>CCG</th>
<th>Headline Assessment</th>
</tr>
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<tbody>
<tr>
<td>Mansfield &amp; Ashfield</td>
<td>GOOD</td>
</tr>
<tr>
<td>Newark &amp; Sherwood</td>
<td>GOOD</td>
</tr>
<tr>
<td>Nottingham City</td>
<td>REQUIRES IMPROVEMENT</td>
</tr>
<tr>
<td>Nottingham North &amp; East</td>
<td>GOOD</td>
</tr>
<tr>
<td>Nottingham West</td>
<td>GOOD</td>
</tr>
<tr>
<td>Rushcliffe</td>
<td>GOOD</td>
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</table>

9. A summary of the assessment nationally show:

<table>
<thead>
<tr>
<th>Assessment</th>
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<tbody>
<tr>
<td>OUTSTANDING</td>
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<tr>
<td>GOOD</td>
<td>82</td>
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<tr>
<td>REQUIRES IMPROVEMENT</td>
<td>91</td>
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<tr>
<td>INADEQUATE</td>
<td>26</td>
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</table>

Recommendations

10. The Governing Body is asked to:
   a. Note NHS England’s assessment of the CCG for the 2015/16 financial year;
   b. Note the continued need to improve services for patients which will result in the required improvements for subsequent years;
   c. Note the plans discussed as part of the STP, corporate plans and performance management processes to improve this position; and
   d. Note future Quality & Performance Reports to the Governing Body will be enhanced to include a summary of the project assessment under the 2016/17 CCG Improvement & Assurance Framework.

Andy Hall
Director of Outcomes & Information
06 September 2016
<table>
<thead>
<tr>
<th>CCG</th>
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<th>Delegated functions</th>
<th>Finance</th>
<th>Performance</th>
<th>Planning</th>
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<tbody>
<tr>
<td>NHS Airedale, Wharfedale and Craven CCG</td>
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<tr>
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<td>Good</td>
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<tr>
<td>NHS Barking and Dagenham CCG</td>
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<tr>
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<tr>
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## 2015/16 components of assurance

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<td>NHS City and Hackney CCG</td>
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<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>NHS Wirral CCG</td>
<td>Requires improvement</td>
<td>Good</td>
<td>Good</td>
<td>Inadequate</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
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<tr>
<td>NHS Wokingham CCG</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
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<tr>
<td>NHS Wolverhampton CCG</td>
<td>Outstanding</td>
<td>Outstanding</td>
<td>Good</td>
<td>Outstanding</td>
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<td>NHS Wyre Forest CCG</td>
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### Executive Summary

#### CCG

Indicators out of trajectory -
- **Cancer** (page 3) – Performance for July 2016 highlights that Nottingham West CCG is below standard for the following pathways -
  - 62 Day Urgent RTT (76.67% against a standard of 85%)
  - 2 Week Wait (92.16% against a standard of 93%)
- **A&E** (Page 5) – Nottingham West CCG failed to achieve the A&E standard for July 2016 with performance at 70.29% against a standard of 95%

#### NUH

Indicators out of trajectory -
- **Cancer** (Page 6-7) – The following pathways failed to meet their respective standards during July 2016 -
  - 62 Day Urgent RTT - 75.17% (standard = 85%)
  - 31 Day DTT - 95.28% (standard = 96%)
  - 2 Week Wait - 90.66% (standard = 93%)
- **18 Week RTT** (Page 8) – NUH achieved the 92% Incomplete standard, however the Trust were below standard for the following specialty -
  - T&O – 91.69%
- **A&E** (Page 9-10) – August 2016 A&E performance was below standard at 69.38%
- **Cancelled Ops** (Page 11) - The number of operations not rebooked within 28 days exceeded 7 working days to arrange an appointment was not met with performance at 58%. The 100% standard for patients waiting less than 14 workings days was also missed with NUH achieving 97%
- **Ambulance Handovers** (Page 13) - Performance for July 2016 shows that 1134 handovers took longer than 30 minutes and 134 exceeded 60 minutes. This is against a standard of 0
- **Never Events** (Page 14) - NUH experienced one Never Event in July 2016 against a standard of 0
- **Falls** (Page 15) - NUH exceeded the 0.98 standard in July 2016 with 1 fall per 1000 occupied bed days resulting in harm

#### Circle (Page 17-21) - Circle performance is available on pages 17-21

#### NHCT (Page 22-24) - Nottinghamshire Health Care Trust performance is available on pages 22-24

#### EMAS (Page 25-30) – Red 1 and Red 2 performance remains below standard for the 8 and 19 minute targets. Comparative performance and outcomes across ambulance trusts is shown on pages 29 & 30

#### Arriva (Page 31) - Performance for Arriva patient transport services is now available

#### NHS 111 (Page 32-33) – Performance is available for the key NHS 111 indicators

#### Quality Premium (Page 34) - Performance against the quality premium is summarised for the CCG

#### Better Care Fund (Page 35-38) - BCF monitoring at Nottinghamshire County Local Authority Level
If paper is for approval, have the following impact assessments been completed?

<table>
<thead>
<tr>
<th>Quality Impact Assessment</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Equality Impact Assessment</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Privacy Impact Assessment</th>
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**Implications:** (please tick where relevant)

- Integration
- Reducing inequality
- Constitution
- Governance
- Innovation
- Learning and Development
- Patient Choice
- Patient & Public Involvement
- Quality of Services
- QIPPP
- Research
- Sustainability

Finance checked by:  (initials)

**Appendices**

**Report History**

**Recommendation** The Governing Body is asked to:

NOTE the Monthly Quality and Performance Report
### CCG Performance Snapshot

#### Latest period data

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator Standard</th>
<th>Latest data</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>4 Hour Standard % Achievement</td>
<td>80.39% 80.74% 79.42% 81.08% 80.65% 80.45%</td>
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<tr>
<td></td>
<td>Left without being seen</td>
<td>3.75% 2.86% 4.31% 3.72% 3.14% 3.67%</td>
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<tr>
<td></td>
<td>Unplanned Re-attendance rate</td>
<td>0.6% 0.6% 0.57% 0.69% 0.81% 0.79%</td>
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<td></td>
<td>Time to initial assessment</td>
<td>01:09 01:09 01:09 01:09 01:09 01:09</td>
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</tr>
<tr>
<td></td>
<td>Time to treatment decision</td>
<td>00:51 00:51 00:51 00:51 00:51 00:50</td>
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<td></td>
<td>Time to departure (non-admitted)</td>
<td>05:16 05:25 05:27 05:12 05:20 05:20</td>
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<tr>
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<td>Time to departure (admitted &amp; non-admitted)</td>
<td>07:52 07:56 08:17 08:11 08:13 08:21</td>
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<tr>
<td>Cancer Waiting Times</td>
<td>Cancer 2ww</td>
<td>96% 95.95% 96.00% 92.73% 97.65% 96.30%</td>
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</tr>
<tr>
<td></td>
<td>Cancer 31d DTT</td>
<td>95% 95.95% 96.00% 92.73% 97.65% 96.30%</td>
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</tr>
<tr>
<td></td>
<td>62d Urg RTT</td>
<td>85% 85.37% 76.67% 80.56% 85.88% 78.90%</td>
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<tr>
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<td>Cancer 31d DTT - Breast Symptoms</td>
<td>93% 87.52% 94.44% 77.92% 92.86% 92.96%</td>
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<td>Cancer 31d DTT - Subs: Surgery</td>
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<tr>
<td></td>
<td>Cancer 31d DTT - Subs: Drugs</td>
<td>96% 89.47% 100.00% 100.00% 94.96% 94.64%</td>
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<tr>
<td></td>
<td>Cancer 31d DTT - Subs: Radiotherapy</td>
<td>94% 100.00% 100.00% 100.00% 94.83% 88.99%</td>
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<tr>
<td></td>
<td>% patients waiting longer than 6 weeks</td>
<td>1% 0.53% 0.21% 0.24% 0.52% 0.32% 0.41%</td>
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<td>Diagnostics</td>
<td>Red 1 calls responded to within 8 minutes</td>
<td>75% Aug-16 67.66% 77.78% 54.33% 65.22% 63.44% 52.58%</td>
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<tr>
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<td>Red 2 calls responded to within 8 minutes</td>
<td>75% Aug-16 55.02% 53.88% 47.57% 50.59% 49.91% 43.02%</td>
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<tr>
<td></td>
<td>Red 1 calls responded to within 18 minutes</td>
<td>90% Aug-16 95.83% 94.44% 91.67% 97.82% 97.95% 93.81%</td>
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<tr>
<td></td>
<td>Red 2 calls responded to within 18 minutes</td>
<td>91% Aug-16 95.83% 94.44% 91.67% 97.82% 97.95% 93.81%</td>
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<tr>
<td></td>
<td>% Admitted Adjusted</td>
<td>80% Jul-16 88.94% 82.74% 87.32% 88.93% 86.74% 86.23%</td>
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<tr>
<td></td>
<td>% Admitted Adjusted number of specialties failing</td>
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<td>% Admitted Adjusted number of 52 week waiters</td>
<td>0% 0% 0% 0% 0% 0%</td>
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</tr>
<tr>
<td></td>
<td>% NonAdmitted</td>
<td>80% Jul-16 96.21% 95.38% 95.81% 96.40% 96.35% 95.89%</td>
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<tr>
<td></td>
<td>% NonAdmitted number of specialties failing</td>
<td>0% 0% 0% 0% 0% 0%</td>
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<tr>
<td></td>
<td>% NonAdmitted number of 52 week waiters</td>
<td>0% 0% 0% 0% 0% 0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Incomplete</td>
<td>92% Jul-16 96.73% 95.15% 95.43% 96.25% 95.26% 95.51%</td>
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<tr>
<td></td>
<td>% Incomplete number of specialties failing</td>
<td>0% 0% 0% 0% 0% 0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Incomplete number of 52 week waiters</td>
<td>0% 0% 0% 0% 0% 0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>% Audiology</td>
<td>95% Jul-16 100.00% 100.00% 100.00% 100.00% 100.00% 100.00%</td>
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<tr>
<td>Psychological Health</td>
<td>Care Programme Approach: 7 day follow up</td>
<td>100% Q1 2016-17 100% 100% 100% 100% 100%</td>
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<tr>
<td></td>
<td>Crisis Resolution Home Treatment: Gate kept by CR Teams</td>
<td>100% Q1 2016-17 100% 100% 100% 100% 100%</td>
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<tr>
<td></td>
<td>IAPT - Standard: NNE = 1.26% NW = 1.26% Rush = 1.26%</td>
<td>100% Q1 2016-17 100% 100% 100% 100% 100%</td>
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<tr>
<td>BP</td>
<td>Treated within two weeks %</td>
<td>100% Aug-16 100.00% 100.00% 100.00% 100.00% 100.00% 100.00%</td>
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<tr>
<td></td>
<td>Incomplete waiting less than two weeks %</td>
<td>100% Aug-16 66.67% 60.00% 66.67%</td>
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<td>Continuing Healthcare</td>
<td>Newly eligible in quarter</td>
<td>100% Q1 2016-17 99 63 81</td>
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<td>Newly eligible at end of quarter</td>
<td>100% Q1 2016-17 178 67 145</td>
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<tr>
<td>Dementia</td>
<td>Dementia Diagnosis Rate</td>
<td>67% Jul-16 69.36% 72.76% 78.94%</td>
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</table>

The table above displays a current view of performance against a range of standards for Nottingham North & East, Nottingham West and Rushcliffe Clinical Commissioning Groups. Indicators where a national standard has not been defined are not traffic lighted. A summary of key issues and concerns can be found overleaf.
Summary – Key issues and concerns

CCG
Indicators out of trajectory -
• **Cancer** (page 3) – Performance for July 2016 highlights that Nottingham West CCG is below standard for the following pathways -
  • 62 Day Urgent RTT (76.67% against a standard of 85%)
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NUH
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Better Care Fund (Page 35-38) - BCF monitoring at Nottinghamshire County Local Authority Level
1.1 Cancer - CCG

All three South Nottinghamshire CCGs experienced breaches of standard for July 2016. Please see the table below for a breakdown of patients seen and breaches by CCG.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>NNE Perf</th>
<th>NW Perf</th>
<th>Rush Perf</th>
<th>Last 12 months</th>
<th>2016/17 YTD</th>
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<tbody>
<tr>
<td>62d Urg RTT</td>
<td>62 Day Urgent RTT</td>
<td>Jul-16</td>
<td>85%</td>
<td>85.37%</td>
<td>76.67%</td>
<td>92.66%</td>
<td>88.56%</td>
<td>78.50%</td>
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</tr>
<tr>
<td>62d Urg RTT - Screening Service</td>
<td></td>
<td>Jul-16</td>
<td>90%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>90.00%</td>
<td>90.00%</td>
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<tr>
<td>62d Urg RTT Cons Upgrade</td>
<td></td>
<td>Jul-16</td>
<td>N/A</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>90.00%</td>
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<tr>
<td>Cancer 31d DTT</td>
<td>Preventing people from dying prematurely</td>
<td>Jul-16</td>
<td>96%</td>
<td>95.95%</td>
<td>95.06%</td>
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<tr>
<td>Cancer 31d DTT - Subs: Surgery</td>
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<td>Jul-16</td>
<td>94%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>98.89%</td>
<td>98.88%</td>
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</tr>
<tr>
<td>Cancer 31d DTT - Subs: Drugs</td>
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<td>Jul-16</td>
<td>98%</td>
<td>89.47%</td>
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<td>100.00%</td>
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<tr>
<td>Cancer 2ww</td>
<td>Positive experience of care</td>
<td>Jul-16</td>
<td>93%</td>
<td>91.11%</td>
<td>92.16%</td>
<td>92.79%</td>
<td>92.27%</td>
<td>92.75%</td>
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</tr>
<tr>
<td>Cancer 2ww - Breast Symptoms</td>
<td></td>
<td>Jul-16</td>
<td>93%</td>
<td>93.33%</td>
<td>94.44%</td>
<td>92.96%</td>
<td>92.96%</td>
<td>92.96%</td>
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</table>

All three South Nottinghamshire CCGs experienced breaches of standard for July 2016. Please see the table below for a breakdown of patients seen and breaches by CCG.

<table>
<thead>
<tr>
<th>Patients seen</th>
<th>Breaches</th>
<th>%</th>
<th>Patients seen</th>
<th>Breaches</th>
<th>%</th>
<th>Patients seen</th>
<th>Breaches</th>
<th>%</th>
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<tbody>
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<td>62d Urg RTT</td>
<td></td>
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<td>41</td>
<td>6</td>
<td>85.37%</td>
<td>30</td>
<td>7</td>
<td>76.67%</td>
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<td>62d Urg RTT - Screening Service</td>
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<td>5</td>
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<td>100.00%</td>
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<td>100.00%</td>
<td>0</td>
<td>0</td>
<td>100.00%</td>
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<td>Cancer 31d DTT</td>
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<td></td>
<td>74</td>
<td>3</td>
<td>95.95%</td>
<td>51</td>
<td>2</td>
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<td>8</td>
<td>0</td>
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<td>19</td>
<td>2</td>
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<td>7</td>
<td>0</td>
<td>100.00%</td>
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<td>18</td>
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<td>100.00%</td>
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<td>268</td>
<td>21</td>
<td>92.16%</td>
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<td>Cancer 2ww - Breast Symptoms</td>
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<td>15</td>
<td>1</td>
<td>93.33%</td>
<td>18</td>
<td>1</td>
<td>94.44%</td>
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</table>

NHS Nottingham West CCG failed two standards in July 2016, details of the breaches for these pathways are below.

**62 Day Urgent RTT:** 7 Breaches
- 5 x NUH - 3 x Capacity, 1 x Patient Unfit, 1 x Patient Choice
- 1 x NUH (First seen at Circle) - 1 x Patient Choice
- 1 x Circle - 1 x Complex Case

**2 Week Wait:** 21 Breaches
- 13 x NUH - 7 x Capacity, 4 x Patient Choice, 1 x Admin Error, 1 x Unknown
- 8 x Circle - 8 x Patient Choice
1.2 Referral To Treatment (RTT) - CCG

<table>
<thead>
<tr>
<th>CCG</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>CCG</th>
<th>Period Perf</th>
<th>Last 12 months</th>
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<tbody>
<tr>
<td></td>
<td>RTT - Incomplete pathways (% within 18 weeks)</td>
<td>Jul-16</td>
<td>92%</td>
<td>NNE</td>
<td>92.19%</td>
<td>Rush 89.19%</td>
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<tr>
<td></td>
<td>RTT - Incomplete pathways with a Decision to Admit (% within 18 weeks)</td>
<td>Jul-16</td>
<td>N/A</td>
<td>NNE</td>
<td>91.36%</td>
<td>NW 88.86%</td>
</tr>
<tr>
<td></td>
<td>New RTT Periods During the Month</td>
<td>Jul-16</td>
<td>N/A</td>
<td>Rush</td>
<td>2932</td>
<td></td>
</tr>
</tbody>
</table>

**Referral to Treatment Standards**

Nottingham West CCG achieved the 92% Incomplete standard in July 2016 with performance at 95.15%. However, two specialties performed below the standard. These were General Surgery (90.08%) and Dermatology (91.54%).

The table below shows the performance of individual specialties for Nottingham West CCG in July 2016:

| Number of patients waiting over 18 Weeks | Nottingham West |
|-----------------------------------------|-----------------
<p>| <strong>Incomplete Standard = 92%</strong>          | <strong>Incomplete With Decision to Admit</strong> | <strong>New RTT Periods</strong> |</p>
<table>
<thead>
<tr>
<th>Patients</th>
<th>18Wks+</th>
<th>Perf</th>
<th>Patients</th>
<th>18Wks+</th>
<th>Perf</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>129</td>
<td>10</td>
<td>92.25%</td>
<td>30</td>
<td>4</td>
<td>86.67%</td>
</tr>
<tr>
<td>Urology</td>
<td>174</td>
<td>11</td>
<td>93.68%</td>
<td>43</td>
<td>7</td>
<td>83.72%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>572</td>
<td>27</td>
<td>95.28%</td>
<td>251</td>
<td>20</td>
<td>92.03%</td>
</tr>
<tr>
<td>ENT</td>
<td>308</td>
<td>9</td>
<td>97.08%</td>
<td>61</td>
<td>6</td>
<td>90.16%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>706</td>
<td>29</td>
<td>95.89%</td>
<td>208</td>
<td>25</td>
<td>87.98%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>34</td>
<td>2</td>
<td>94.12%</td>
<td>7</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>23</td>
<td>1</td>
<td>95.56%</td>
<td>7</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>5</td>
<td>1</td>
<td>80.00%</td>
<td>3</td>
<td>1</td>
<td>66.67%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>84</td>
<td>5</td>
<td>94.05%</td>
<td>8</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>381</td>
<td>27</td>
<td>92.91%</td>
<td>50</td>
<td>1</td>
<td>98.00%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>201</td>
<td>24</td>
<td>88.08%</td>
<td>48</td>
<td>14</td>
<td>70.83%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>323</td>
<td>18</td>
<td>94.43%</td>
<td>159</td>
<td>15</td>
<td>90.57%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>140</td>
<td>11</td>
<td>92.14%</td>
<td>1</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Neurology</td>
<td>98</td>
<td>1</td>
<td>98.98%</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>63</td>
<td>2</td>
<td>96.83%</td>
<td>2</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>26</td>
<td>0</td>
<td>100.00%</td>
<td>1</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>186</td>
<td>3</td>
<td>98.39%</td>
<td>65</td>
<td>3</td>
<td>95.38%</td>
</tr>
<tr>
<td>Other</td>
<td>926</td>
<td>29</td>
<td>96.87%</td>
<td>135</td>
<td>12</td>
<td>91.11%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4379</strong></td>
<td><strong>210</strong></td>
<td><strong>95.20%</strong></td>
<td><strong>1079</strong></td>
<td><strong>108</strong></td>
<td><strong>89.99%</strong></td>
</tr>
</tbody>
</table>
1.3 Diagnostics Waiting Times - CCG

<table>
<thead>
<tr>
<th>CCG</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>CCG</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>NNE</td>
<td>Diagnostics (% of patients waiting over six weeks)</td>
<td>Jul-16</td>
<td>1%</td>
<td>NW</td>
<td>0.21%</td>
<td></td>
</tr>
<tr>
<td>NW</td>
<td></td>
<td></td>
<td></td>
<td>Rush</td>
<td>0.24%</td>
<td></td>
</tr>
<tr>
<td>Rush</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In July 2016 Nottingham West CCG achieved the 1% national standard with performance at 0.21%. Nottingham North & East CCG and Rushcliffe CCG were also within the standard at 0.53% and 0.24% respectively.

1.4 A&E 4 hour waiting time standard - CCG

<table>
<thead>
<tr>
<th>CCG</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>CCG</th>
<th>Period Perf</th>
<th>Last 12 months</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>NNE</td>
<td>Positive experience of care</td>
<td>Jul-16</td>
<td>95%</td>
<td>NNE</td>
<td>70.58%</td>
<td></td>
<td>72.49%</td>
</tr>
<tr>
<td>NW</td>
<td>A&amp;E waiting time</td>
<td></td>
<td></td>
<td>NW</td>
<td>70.29%</td>
<td></td>
<td>71.09%</td>
</tr>
<tr>
<td>Rush</td>
<td></td>
<td></td>
<td></td>
<td>Rush</td>
<td>69.28%</td>
<td></td>
<td>71.76%</td>
</tr>
</tbody>
</table>

NUH performance was below standard during July 2016, which caused failure to achieve 95% for all three South Nottinghamshire CCGs. Please see Level 2 (page 9-10) for details of actions to improve NUH performance.

The graphs below show the level of A&E Type 1 (major A&E department) performance at each CCG since April 2013 and the volume of attendances in the lower graph.
In July 2016, NUH failed to achieve the Cancer 62 day standard with performance at 75.17% against the national standard of 85%. This is the 11th breach in the last 12 months.

Other standards not met by NUH in July 2016 include 31 day decision to treat to treatment (95.28% against a standard of 96%) and 2 week wait (90.66% against a standard of 93%). However, for the third consecutive month the 2 week wait - breast symptoms standard of 93% has been achieved.

The table above shows NUH 2ww activity broken down by suspected tumour site for 2015-16 and 2016-17. All but 2 tumour sites have seen an increase in activity. In terms of activity breast cancer has seen the largest increase with 270 (15.59%) extra people from dying prematurely.

The table above details 2 week wait performance at NUH compared to peer hospitals up to July 2016, and shows the change in activity compared to the same period in 2015-16.
NUH 2.1 Cancer Waiting Times (cont.)

Cancer 62 day RTT Performance by Tumour Site

<table>
<thead>
<tr>
<th>NUH Tumour Site</th>
<th>Period</th>
<th>Standard</th>
<th>Latest Period</th>
<th>Last 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Patients</td>
<td>%</td>
<td>Chart</td>
</tr>
<tr>
<td>Brain/Central Nervous System</td>
<td>Jul-16</td>
<td>85%</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Breast</td>
<td>Jul-16</td>
<td>85%</td>
<td>32.5</td>
<td>96.92%</td>
</tr>
<tr>
<td>Gynaecological</td>
<td>Jul-16</td>
<td>85%</td>
<td>8.5</td>
<td>82.35%</td>
</tr>
<tr>
<td>Haematological (Excluding Acute Leukaemia)</td>
<td>Jul-16</td>
<td>85%</td>
<td>12</td>
<td>91.67%</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>Jul-16</td>
<td>85%</td>
<td>11.5</td>
<td>47.83%</td>
</tr>
<tr>
<td>Lower Gastrointestinal</td>
<td>Jul-16</td>
<td>85%</td>
<td>12</td>
<td>66.67%</td>
</tr>
<tr>
<td>Lung</td>
<td>Jul-16</td>
<td>85%</td>
<td>18</td>
<td>36.11%</td>
</tr>
<tr>
<td>Other</td>
<td>Jul-16</td>
<td>85%</td>
<td>1</td>
<td>0.00%</td>
</tr>
<tr>
<td>Sarcoma</td>
<td>Jul-16</td>
<td>85%</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Skin</td>
<td>Jul-16</td>
<td>85%</td>
<td>4.5</td>
<td>100%</td>
</tr>
<tr>
<td>Upper Gastrointestinal</td>
<td>Jul-16</td>
<td>85%</td>
<td>13</td>
<td>80.77%</td>
</tr>
<tr>
<td>Urological (Excluding Testicular)</td>
<td>Jul-16</td>
<td>85%</td>
<td>28</td>
<td>73.21%</td>
</tr>
<tr>
<td>Total (Excluding Rare Cancers)</td>
<td>Jul-16</td>
<td>85%</td>
<td>145</td>
<td>75.17%</td>
</tr>
</tbody>
</table>

The above table shows the performance of 62 day cancer (excluding rare cancers) at NUH for all patients by tumour site for July 2016. There are three tumour sites where performance has been consistently below standard over the last 12 months—Lower Gastrointestinal, Lung and Upper Gastrointestinal.

Escalation
Due to continued below standard performance a Remedial Action Plan (RAP) is in place for both 2 week wait and 62 day, actions include:

**Actions for 2 Week Wait and 62 Day**
- Actions target main breach reasons and tumour sites with the highest number of breaches
- Contract penalties in place
- Fortnightly meetings to review progress of the RAPs

**2 Week Wait specific actions**
- Focus on Breast, Upper GI and Lower GI

**62 Day specific actions**
- Focus on Diagnostics, Endoscopy, Lung, Upper GI and Lower GI
- Particular focus on endoscopy waits with increased capacity in the private sector being utilised
During July 2016 the 92% Incomplete standard was achieved for all specialties with the exception of Trauma & Orthopaedics (91.69%). Incomplete with Decision to Admit does not currently have a national standard, but does show that 87.92% of patients with a decision to admit are currently waiting under 18 weeks.

The table below shows the number of patients still waiting at NUH at the end of July 2016 segmented by time band and upload specialty.

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RTT - Incomplete pathways (% within 18 weeks)</td>
<td>Jul-16</td>
<td>92%</td>
<td><strong>96.43%</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RTT - Incomplete pathways with a Decision to Admit (% within 18 weeks)</td>
<td>Jul-16</td>
<td>N/A</td>
<td><strong>87.92%</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>New RTT Periods During the Month</td>
<td>Jul-16</td>
<td>N/A</td>
<td><strong>15010</strong></td>
<td></td>
</tr>
</tbody>
</table>

**New RTT Periods During the Month**

<table>
<thead>
<tr>
<th>Patients 18Wks+ Perf</th>
<th>Patients 18Wks+ Perf</th>
<th>Patients 18Wks+ Perf</th>
<th>Patients 18Wks+ Perf</th>
<th>Patients 18Wks+ Perf</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>357 18 94.96%</td>
<td>87 12 86.21%</td>
<td>213</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>1139 60 94.73%</td>
<td>288 42 85.42%</td>
<td>646</td>
<td></td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>3612 300 <strong>91.69%</strong></td>
<td>1403 224 84.03%</td>
<td>1242</td>
<td></td>
</tr>
<tr>
<td>ENT</td>
<td>2860 100 96.50%</td>
<td>543 71 86.92%</td>
<td>1277</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>5094 192 96.23%</td>
<td>1471 186 87.36%</td>
<td>1907</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>1294 28 97.84%</td>
<td>199 17 91.46%</td>
<td>640</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>527 27 94.88%</td>
<td>138 11 92.03%</td>
<td>177</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>351 10 97.15%</td>
<td>155 9 94.19%</td>
<td>196</td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>183 14 92.35%</td>
<td>122 12 90.16%</td>
<td>79</td>
<td></td>
</tr>
<tr>
<td>General Medicine</td>
<td>357 4 98.88%</td>
<td>14 0 100.00%</td>
<td>177</td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1089 56 94.86%</td>
<td>268 5 98.13%</td>
<td>490</td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>1902 134 92.95%</td>
<td>407 83 79.61%</td>
<td>671</td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>0 0</td>
<td>0 0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>359 3 99.16%</td>
<td>7 0 100.00%</td>
<td>268</td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td>1246 9 99.28%</td>
<td>5 0 100.00%</td>
<td>610</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0 0</td>
<td>0 0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>192 2 98.96%</td>
<td>2 0 100.00%</td>
<td>151</td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>1065 8 99.25%</td>
<td>161 8 95.03%</td>
<td>601</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>8844 124 98.60%</td>
<td>928 69 92.56%</td>
<td>5665</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>30471 1089 <strong>96.43%</strong></td>
<td>6198 749 87.92%</td>
<td>15010</td>
<td></td>
</tr>
</tbody>
</table>

The table below shows the number of patients still waiting at NUH at the end of July 2016 segmented by time band and upload specialty.

<table>
<thead>
<tr>
<th>Jul-16</th>
<th>26-40 Wks</th>
<th>40-48 Wks</th>
<th>48-52 Wks</th>
<th>52 Wks+</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgery</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Urology</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>88</td>
<td>10</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ear, Nose &amp; Throat (ENT)</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>27</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>10</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cardiology</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Neurology</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>213</td>
<td>13</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

During July 2016 NUH had 2 breaches of the 52 week standard, these were in T&O (Southern Derbyshire CCG patient) and Oral Surgery (commissioned by NHS England). Several factors led to delays in both pathways including capacity, admin error and patient choice.
NUH 2.3.1 A&E 4 hour waiting time standard

In August 2016 the national 95% performance level was not met with NUH performance at 69.38%, the standard has not been met in any of the last 12 months.

There is a Remedial Action Plan (RAP) in place. Actions being taken to improve performance are bulleted below -

- Deliver 95% non-admitted performance by the end of September 2016
- Reduce non-admitted breaches related to medical wait to be seen
- Implementation of GP Front Door at weekends and evenings
- Implementation of Frailty Service resilience bid
- Average triage time to be 30 minutes or below and 80% of patients to have a triage time of 40 minutes or less
- Average time from arrival to earliest seen by doctor to be 60 minutes or below
- Review “To Take Out” process
- Roll out of the Exemplar Ward programme
- Reduce inappropriate use of assessment areas and increase availability of assessment beds pre-noon
- Implementation of Professional Standards
  - Patients ready for pick up by Patient Transport Services at arranged time
  - TTO completed by 3pm day prior to expected discharge
  - Where NUH is responsible for provision, equipment shall be provided to the patient 24 hours prior to medical fitness date

In August 2016 the national 95% performance level was not met with NUH performance at 69.38%, the standard has not been met in any of the last 12 months.

There is a Remedial Action Plan (RAP) in place. Actions being taken to improve performance are bulleted below -

- Deliver 95% non-admitted performance by the end of September 2016
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- Average triage time to be 30 minutes or below and 80% of patients to have a triage time of 40 minutes or less
- Average time from arrival to earliest seen by doctor to be 60 minutes or below
- Review “To Take Out” process
- Roll out of the Exemplar Ward programme
- Reduce inappropriate use of assessment areas and increase availability of assessment beds pre-noon
- Implementation of Professional Standards
  - Patients ready for pick up by Patient Transport Services at arranged time
  - TTO completed by 3pm day prior to expected discharge
  - Where NUH is responsible for provision, equipment shall be provided to the patient 24 hours prior to medical fitness date
NUH 2.3.1 A&E 4 hour waiting time standard (cont.)

As well as the Remedial Action Plan there continues to be bi-weekly monitoring of the updated System Resilience Plan, which is centred around the following themes -

- **Front Door**
  - New model of front door primary care
  - Development of integrated urgent care
- **Internal Flow**
  - NUH led actions to embed Safer bundle across Trust wards
  - Multi agency discharge events have in place on Trust wards, these have identified opportunities for improvement
- **External Flow**
  - Focus on interface with external capacity for medically fit for discharge patients
  - System-wide capacity and flow review
- **Enablers**
  - Development of system wide dashboard
  - Development of System Resilience Group process for allocation of resilience funding

The chart below shows A&E performance and attendances at NUH between 1st August 2015 and 18th September 2016.

**NUH A&E Performance Aug15-Sep16**

<table>
<thead>
<tr>
<th>Period</th>
<th>Attendances</th>
<th>Breaches</th>
<th>Performance</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jul-16</td>
<td>1000</td>
<td>1</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>Aug-16</td>
<td>900</td>
<td>2</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>Sep-16</td>
<td>800</td>
<td>3</td>
<td>80%</td>
<td>70%</td>
</tr>
</tbody>
</table>

**NUH 2.3.2 A&E 12 Hour Trolley Waits**

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>NUH Responsible Breaches in period</th>
<th>NUH Responsible Breaches Last 12 months</th>
<th>NUH Responsible Breaches YTD</th>
<th>Non-NUH Responsible Breaches YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of 12 hour trolley waits in A&amp;E</td>
<td>Jul-16</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

During July 2016 there was one breach of the 12 hour trolley wait standard at NUH, this was a City CCG patient and occurred due to severe bed pressure. Year to date there has been one non-NUH responsible breach, and one NUH responsible breach.
In total, there were 303 cancelled operations in July 2016 of which 67 were on the day of admission and 236 were cancelled prior to the day of admission. There were 8908 elective procedures undertaken at NUH during the same period, which equates to a total of 3.4% of elective admissions being cancelled either on the day or prior to the day of admission.

The cancelled operations national standard was achieved during July 2016 in which there were 67 cancellations. The main reasons for these were other (26) and administrative error (12). The majority of cancelled operations classified as being due to “other” relate to overheating problems in Elective Orthopaedic theatres. This led to the theatres being closed.

There was 1 cancelled operation that was not rebooked within 28 days which is a breach of the national standard of 0.

The table below shows the total number of cancelled operations for NUH over the most recent 12 month period available.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<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>Administrative Error</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>9</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>12</td>
<td>74</td>
</tr>
<tr>
<td>Equipment Unavailable</td>
<td>6</td>
<td>14</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>3</td>
<td>65</td>
</tr>
<tr>
<td>Hospital Clinical Cancellation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>External Issues</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>ICU/HDU Bed Unavailable</td>
<td>3</td>
<td>0</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>List overrun - clinical reasons</td>
<td>8</td>
<td>0</td>
<td>16</td>
<td>16</td>
<td>9</td>
<td>8</td>
<td>13</td>
<td>8</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>107</td>
</tr>
<tr>
<td>List overrun - non-clinical reasons</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>13</td>
<td>9</td>
<td>2</td>
<td>28</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>21</td>
<td>0</td>
<td>1</td>
<td>11</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>26</td>
<td>26</td>
</tr>
<tr>
<td>Replaced by emergency patient</td>
<td>14</td>
<td>3</td>
<td>17</td>
<td>9</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>12</td>
<td>9</td>
<td>7</td>
<td>95</td>
</tr>
<tr>
<td>Replaced by other patient</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Staffing</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>13</td>
<td>9</td>
<td>6</td>
<td>4</td>
<td>15</td>
<td>7</td>
<td>75</td>
</tr>
<tr>
<td>Theatre unavailable</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Ward Bed Unavailable</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>13</td>
<td>16</td>
<td>8</td>
<td>9</td>
<td>6</td>
<td>10</td>
<td>4</td>
<td>0</td>
<td>80</td>
</tr>
<tr>
<td>Unknown</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>43</td>
<td>35</td>
<td>56</td>
<td>77</td>
<td>33</td>
<td>41</td>
<td>64</td>
<td>53</td>
<td>41</td>
<td>63</td>
<td>62</td>
<td>67</td>
<td>635</td>
</tr>
</tbody>
</table>

In total, there were 303 cancelled operations in July 2016 of which 67 were on the day of admission and 236 were cancelled prior to the day of admission. There were 8908 elective procedures undertaken at NUH during the same period, which equates to a total of 3.4% of elective admissions being cancelled either on the day or prior to the day of admission.

The table below shows the number of on the day cancellations at NUH broken down by reason.

<table>
<thead>
<tr>
<th>Level 2 – NUH Performance</th>
<th>NUH 2.4 Cancelled Operations</th>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive experience of care</td>
<td>Cancelled Ops - % of elect act</td>
<td>Jul-16</td>
<td>0.8%</td>
<td>0.75%</td>
<td>67</td>
<td>303</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cancelled Operations - Rebooked 28 days+</td>
<td>Jul-16</td>
<td>0</td>
<td>1</td>
<td>67</td>
<td>303</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of urgent operations cancelled for a second time</td>
<td>Jul-16</td>
<td>0</td>
<td>0</td>
<td>67</td>
<td>303</td>
<td></td>
</tr>
</tbody>
</table>

The cancelled operations national standard was achieved during July 2016 in which there were 67 cancellations. The main reasons for these were other (26) and administrative error (12). The majority of cancelled operations classified as being due to “other” relate to overheating problems in Elective Orthopaedic theatres. This led to the theatres being closed.

Over the past 12 months, list overrun - clinical reasons, and replaced by emergency patient are the most common reasons given for on the day cancellations at NUH. Ward bed unavailable, staffing, and administrative error are also cited by NUH as frequent reasons for cancellation.
NUH 2.5 Diagnostics Waiting Times

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diagnostics (% of patients waiting over six weeks)</td>
<td>Jul-16</td>
<td>1%</td>
<td>0.23%</td>
<td></td>
</tr>
</tbody>
</table>

NUH achieved the Diagnostics standard for the seventh consecutive month in July 2016 with performance at 0.23%. There were 16 breaches in July with 8 relating to Gastroscopy, 6 to MRI, and 2 to Cardiology - echocardiography.

NUH 2.6 NHS E-Referral Report

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients waiting less than 7 working days to arrange an appointment</td>
<td>Aug-16</td>
<td>95%</td>
<td>58%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients waiting less than 14 working days to arrange an appointment</td>
<td>Aug-16</td>
<td>100%</td>
<td>97%</td>
<td></td>
</tr>
</tbody>
</table>

The NHS E-Referral report details how long it takes the Trust to contact patients who have had slot issues. During August 2016, 338 patients had slot issues, 188 of these were waiting less than 7 working days with 141 patients being contacted within 14 working days. However, 9 patients were not contacted within 14 working days to arrange an appointment.

The main specialty affected by slot issues was Neurology with 113 patients waiting over 7 working days and 9 patients waiting 14 or more working days to arrange an appointment. All patients waiting 14 or more days had a wait time of exactly 14 working days.

Please note: Low performance in Neurology is the result of the service being closed at Sherwood Forest Hospitals, increasing the number of patients at NUH.

NUH 2.7 Delayed Transfers of Care

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DToC - Acute/Non-Acute 18+ - Delays</td>
<td>Jul-16</td>
<td>Minimum</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DToC - Acute/Non-Acute 18+ - Days Delayed</td>
<td>Jul-16</td>
<td>Minimum</td>
<td>2572</td>
<td></td>
</tr>
</tbody>
</table>

The number of delays is measured as at midnight on the last Thursday of the reporting month. During July 2016 there were 53 delays, which is above the average of 32 per month during 2015/16.

The number of days delayed in July 2016 was above the average of 1421 per month during 2015/16 with 2572 days delayed during the month. This indicator is a total of delayed days in the month as opposed to a snapshot.

NUH 2.8 Healthcare Associated Infections (HCAIs)

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>YTD Standard</th>
<th>Period Perf</th>
<th>Last 12 months</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MRSA (Full year standard = 0)</td>
<td>Aug-16</td>
<td>0</td>
<td>1</td>
<td>TBC</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>C-Diff (YTD standard = 36) (Current month standard = 7)</td>
<td>Aug-16</td>
<td>36</td>
<td>14</td>
<td>TBC</td>
<td>42</td>
</tr>
</tbody>
</table>

Please be aware that the trust will only be penalised for MRSA that are considered avoidable and Clostridium Difficile infections that are considered to be due to lapses in care.

During August 2016 NUH had 14 Clostridium Difficile infections, further information is currently being sought as to whether these were due to lapses in care. Year to date there have been 6 Clostridium Difficile infections due to lapses in care, this is against a standard of 36.

NUH had one case of MRSA during August 2016, the CCG are investigating whether this was clinically avoidable or not. Year to date there has been 2 cases of MRSA that were deemed clinically avoidable.
Level 2 – NUH Performance

NUH 2.9 Mixed Sex Accommodation Breaches (MSA)

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mixed Sex Accommodation Breaches</td>
<td>Aug-16</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

During August 2016, there were no Mixed Sex Accommodation breaches at NUH.

NUH 2.10 Ambulance Handovers

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ambulance A&amp;E handovers over 30 minutes</td>
<td>Jul-16</td>
<td>0</td>
<td>1134</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ambulance A&amp;E handovers over 60 minutes</td>
<td>Jul-16</td>
<td>0</td>
<td>134</td>
<td></td>
</tr>
</tbody>
</table>

Ambulance handovers to the Emergency Department (ED) remain above the national standards, the key reasons for this include:
- High levels of occupancy in ED cubicles
- Continuing increase in ambulance attendances
- There are a high proportion of vacancies

To improve performance there is an action plan in place.

NUH 2.11 Venous Thromboembolism (VTE)

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of patients assessed for risk of VTE on admission</td>
<td>Jun-16</td>
<td>95%</td>
<td>94.44%</td>
<td>93.50%</td>
<td></td>
</tr>
</tbody>
</table>

June 2016 performance is below standard for the eleventh consecutive month with performance at 94.44%. Actions to improve performance include:
- Analysis undertaken highlights that VTE assessment performance at 36 and 48 hours is approximately 97%
- Weekly speciality-based feedback including performance and financial impact
- Discussion regarding performance at monthly Divisional performance meetings
- Real-time register of non assessed patients made available to Divisions
- Qlikview real time VTE performance dashboard at ward, speciality, and division level implemented in July 2016 - will assist in prioritising patients for assessment
NUH 2.12 Friends & Family Test

The Friends and Family score is calculated using the proportion of patients who would strongly recommend minus those who would not recommend, or who are indifferent.

The Trust failed to achieve Friends and Family response rate standards for Maternity Questions 1, 2, and 3 during July 2016.

The Trusts’ formulary is published by the Nottinghamshire Area Prescribing Committee. The formulary aims to provide information on medicines available to prescribers in Nottinghamshire reflecting safe, evidence-based and cost-effective choices.

NUH 2.13 Publication of Formulary

The Trusts’ formulary is published by the Nottinghamshire Area Prescribing Committee. The formulary aims to provide information on medicines available to prescribers in Nottinghamshire reflecting safe, evidence-based and cost-effective choices.

NUH 2.14 Duty of Candour breaches

NUH have had no Duty of Candour breaches during 2016/17.

NUH 2.15 Never Events

There was one Never Event reported during July 2016. This concerned an incorrect administration of insulin. The error was recognised several hours later and an immediate review was undertaken and treatment given. The patient was transferred to Medical High Dependency, recovered, and later discharged. Duty of candour has been initiated and a safety alert has been circulated to all clinical staff. A serious incident investigation is currently in progress. Year to date there has been three Never Events at NUH.
## NUH 2.16 Summary Hospital Level Mortality Indicator (SHMI)

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Summary Hospital Level Mortality Indicator (SHMI)</td>
<td>Apr-16</td>
<td>Not higher than expected</td>
<td>1.03</td>
<td></td>
<td>1.03</td>
</tr>
</tbody>
</table>

The Summary Hospital Level Mortality Indicator (SHMI) standard has been achieved during April 2016.

## NUH 2.17 Pressure Ulcers

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reduction of grade 2 Pressure Ulcers per 1000 Occupied Bed Days</td>
<td>Jun-16</td>
<td>0.33</td>
<td>0.25</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td>Reduction of grade 3 Pressure Ulcers per 1000 Occupied Bed Days</td>
<td>Jun-16</td>
<td>0.06</td>
<td>0.00</td>
<td>[ ]</td>
</tr>
<tr>
<td></td>
<td>Reduction of grade 4 Pressure Ulcers per 1000 Occupied Bed Days</td>
<td>Jun-16</td>
<td>0.00</td>
<td>0.00</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

NUH have achieved the reduction in pressure ulcers standard for June 2016.

## NUH 2.18 Falls

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Falls per 1000 Occupied Bed Days resulting in harm</td>
<td>Jul-16</td>
<td>0.98</td>
<td>1.00</td>
<td>[ ]</td>
<td>1.00</td>
</tr>
</tbody>
</table>

The Trust are not achieving the Falls per 1000 Occupied Bed Days resulting in harm indicator for July 2016 with performance at 1.00 against a standard of 0.98. The standard was revised down from 1.70 to 0.98 in June 2016.

## NUH 2.19 Mandatory Training

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Perf</th>
<th>Last 12 single months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mandatory Training</td>
<td>12 Months to Jul-16</td>
<td>90%</td>
<td>87%</td>
<td></td>
</tr>
</tbody>
</table>

The Trust are not achieving the rolling 12 months to July 2016 with performance at 87% against a standard of 90%. The reason for below standard performance is a result of operational pressures. To improve performance HR staff are working with managers to identify individuals needing to attend training and plans are being identified to release people to attend. Additionally, the Learning & Education Committee have asked all areas to submit recovery plans which will be discussed at their next meeting.

## NUH 2.20 Appraisals

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Perf</th>
<th>Last 12 months</th>
<th>Rolling Months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Appraisals</td>
<td>Jul-16</td>
<td>90%</td>
<td>84%</td>
<td></td>
<td>87%</td>
</tr>
</tbody>
</table>

The Trust has a target to deliver appraisals to 90% of staff over a rolling 12 month period. The past rolling twelve months from August 2015 — July 2016 period is below the 90% standard at 87%, with July 2016 performance at 84%.
## NUH Performance

### NUH Peer Hospital Performance

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target</th>
<th>Basis</th>
<th>Period</th>
<th>Cambridge University Hospitals</th>
<th>Central Manchester University Hospitals</th>
<th>Manchester Teaching Hospitals</th>
<th>Nottingham University Hospitals</th>
<th>Oxford Radcliffe Hospitals</th>
<th>Royal Liverpool and Broadgreen University Hospitals</th>
<th>Shefffield Teaching Hospitals</th>
<th>Sheffield Teaching Hospitals</th>
<th>Southampton University Hospitals</th>
<th>The New castle Upon Tyne Hospitals</th>
<th>University Hospital Birmingham</th>
<th>University Hospitals Bristol</th>
<th>University Hospitals of Leicester</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E achievement</td>
<td>95%</td>
<td>Month</td>
<td>Jul-16</td>
<td>82.75%</td>
<td>92.45%</td>
<td>88.69%</td>
<td>86.83%</td>
<td>72.16%</td>
<td>87.60%</td>
<td>92.01%</td>
<td>86.49%</td>
<td>92.54%</td>
<td>97.35%</td>
<td>86.46%</td>
<td>89.33%</td>
<td>76.91%</td>
</tr>
<tr>
<td>Cancer 62d Urg RTT</td>
<td>85%</td>
<td>Month</td>
<td>Jul-16</td>
<td>79.85%</td>
<td>85.29%</td>
<td>81.74%</td>
<td>79.69%</td>
<td>75.76%</td>
<td>73.02%</td>
<td>91.43%</td>
<td>82.72%</td>
<td>72.94%</td>
<td>82.59%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 62d Urg RTT-Screening Service</td>
<td>90%</td>
<td>Month</td>
<td>Jul-16</td>
<td>92.50%</td>
<td>91.00%</td>
<td>91.67%</td>
<td>96.88%</td>
<td>100.00%</td>
<td>90.00%</td>
<td>95.60%</td>
<td>92.33%</td>
<td>66.67%</td>
<td>92.31%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 62d Urg RTS-Cons Upgrade</td>
<td>94%</td>
<td>Month</td>
<td>Jul-16</td>
<td>100.00%</td>
<td>94.29%</td>
<td>90.38%</td>
<td>96.00%</td>
<td>100.00%</td>
<td>92.34%</td>
<td>90.48%</td>
<td>78.95%</td>
<td>90.51%</td>
<td>90.00%</td>
<td>94.12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 31d DTT</td>
<td>96%</td>
<td>Month</td>
<td>Jul-16</td>
<td>96.92%</td>
<td>100.00%</td>
<td>97.09%</td>
<td>97.32%</td>
<td>95.28%</td>
<td>92.38%</td>
<td>96.69%</td>
<td>98.00%</td>
<td>96.88%</td>
<td>98.05%</td>
<td>99.03%</td>
<td>90.37%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31d DTT - Subs: Surgery</td>
<td>94%</td>
<td>Month</td>
<td>Jul-16</td>
<td>100.00%</td>
<td>91.67%</td>
<td>94.00%</td>
<td>96.20%</td>
<td>97.18%</td>
<td>100.00%</td>
<td>96.78%</td>
<td>100.00%</td>
<td>96.67%</td>
<td>99.12%</td>
<td>97.14%</td>
<td>74.39%</td>
<td></td>
</tr>
<tr>
<td>Cancer 31d DTT - Subs: Drugs</td>
<td>98%</td>
<td>Month</td>
<td>Jul-16</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>98.04%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>99.10%</td>
<td>98.38%</td>
<td>97.50%</td>
<td>90.00%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 31d DTT - Subs: Radiotherapy</td>
<td>94%</td>
<td>Month</td>
<td>Jul-16</td>
<td>97.38%</td>
<td>100.00%</td>
<td>99.43%</td>
<td>100.00%</td>
<td>96.07%</td>
<td>100.00%</td>
<td>98.10%</td>
<td>100.00%</td>
<td>99.39%</td>
<td>98.02%</td>
<td>96.65%</td>
<td>92.52%</td>
<td></td>
</tr>
<tr>
<td>Cancer 2aw</td>
<td>93%</td>
<td>Month</td>
<td>Jul-16</td>
<td>94.34%</td>
<td>95.46%</td>
<td>94.56%</td>
<td>90.66%</td>
<td>95.14%</td>
<td>94.49%</td>
<td>94.61%</td>
<td>96.27%</td>
<td>95.72%</td>
<td>93.72%</td>
<td>95.29%</td>
<td>94.34%</td>
<td></td>
</tr>
<tr>
<td>Cancer 2aw - Breast Symptoms</td>
<td>93%</td>
<td>Month</td>
<td>Jul-16</td>
<td>96.54%</td>
<td>92.21%</td>
<td>96.97%</td>
<td>93.04%</td>
<td>95.45%</td>
<td>95.85%</td>
<td>98.84%</td>
<td>98.31%</td>
<td>95.21%</td>
<td>94.12%</td>
<td>98.68%</td>
<td></td>
<td></td>
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<tr>
<td>Diagnostic Test WT</td>
<td>1%</td>
<td>Month</td>
<td>Jul-16</td>
<td>9.96%</td>
<td>1.96%</td>
<td>0.54%</td>
<td>2.75%</td>
<td>0.23%</td>
<td>0.95%</td>
<td>0.39%</td>
<td>1.53%</td>
<td>0.47%</td>
<td>1.14%</td>
<td>0.51%</td>
<td>3.91%</td>
<td>0.59%</td>
</tr>
<tr>
<td>DFcOC - Acute/Non Acute 18+ Minimum</td>
<td>Month</td>
<td>Jul-16</td>
<td>59</td>
<td>112</td>
<td>99</td>
<td>24</td>
<td>54</td>
<td>34</td>
<td>35</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer 2aw - Friends &amp; Family - % Recommended</td>
<td>Local</td>
<td>Month</td>
<td>Jul-16</td>
<td>88.90%</td>
<td>86.40%</td>
<td>85.52%</td>
<td>81.03%</td>
<td>88.87%</td>
<td>83.31%</td>
<td>82.03%</td>
<td>84.09%</td>
<td>96.40%</td>
<td>90.97%</td>
<td>85.34%</td>
<td>71.84%</td>
<td>87.32%</td>
</tr>
<tr>
<td>Cancer Friends &amp; Family - A&amp;E Response Rate</td>
<td>20%</td>
<td>Month</td>
<td>Jul-16</td>
<td>22.16%</td>
<td>9.53%</td>
<td>15.87%</td>
<td>34.76%</td>
<td>21.59%</td>
<td>22.39%</td>
<td>20.16%</td>
<td>23.39%</td>
<td>8.93%</td>
<td>3.43%</td>
<td>16.58%</td>
<td>11.98%</td>
<td>8.74%</td>
</tr>
<tr>
<td>Cancer Friends &amp; Family - PIP (%) Recommended</td>
<td>20%</td>
<td>Month</td>
<td>Jul-16</td>
<td>95.80%</td>
<td>95.12%</td>
<td>90.92%</td>
<td>94.95%</td>
<td>97.50%</td>
<td>96.39%</td>
<td>91.72%</td>
<td>96.32%</td>
<td>96.24%</td>
<td>97.48%</td>
<td>96.89%</td>
<td>95.91%</td>
<td>96.79%</td>
</tr>
<tr>
<td>Cancer Friends &amp; Family - PIP (Response Rate)</td>
<td>20%</td>
<td>Month</td>
<td>Jul-16</td>
<td>11.27%</td>
<td>11.66%</td>
<td>28.48%</td>
<td>27.03%</td>
<td>39.10%</td>
<td>16.77%</td>
<td>30.31%</td>
<td>28.99%</td>
<td>19.29%</td>
<td>12.76%</td>
<td>23.57%</td>
<td>36.48%</td>
<td>31.88%</td>
</tr>
<tr>
<td>MDSA Local</td>
<td>Month</td>
<td>Jul-16</td>
<td>15</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSA Breaches Minimum</td>
<td>Month</td>
<td>Jul-16</td>
<td>100</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MSA Breaches Rate (per 1000 fin cons apps) Minimum</td>
<td>Month</td>
<td>Jul-16</td>
<td>0.07</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>RTT - Admitted</td>
<td>90%</td>
<td>Month</td>
<td>Jul-16</td>
<td>72.74%</td>
<td>61.41%</td>
<td>66.49%</td>
<td>77.48%</td>
<td>85.62%</td>
<td>80.96%</td>
<td>73.56%</td>
<td>84.86%</td>
<td>94.74%</td>
<td>91.65%</td>
<td>85.44%</td>
<td>81.47%</td>
<td>90.97%</td>
</tr>
<tr>
<td>RTT - Non admitted</td>
<td>95%</td>
<td>Month</td>
<td>Jul-16</td>
<td>88.40%</td>
<td>91.70%</td>
<td>82.89%</td>
<td>89.23%</td>
<td>97.22%</td>
<td>88.64%</td>
<td>87.96%</td>
<td>92.47%</td>
<td>90.70%</td>
<td>95.58%</td>
<td>85.54%</td>
<td>88.17%</td>
<td>90.03%</td>
</tr>
<tr>
<td>RTT - Incomplete</td>
<td>92%</td>
<td>Month</td>
<td>Jul-16</td>
<td>90.77%</td>
<td>92.07%</td>
<td>84.73%</td>
<td>89.88%</td>
<td>96.43%</td>
<td>90.02%</td>
<td>90.32%</td>
<td>92.83%</td>
<td>92.09%</td>
<td>94.69%</td>
<td>92.47%</td>
<td>92.01%</td>
<td>92.38%</td>
</tr>
</tbody>
</table>

### Peer Performance

Please note that the indicators in the table above may show different periods to the same indicators in the rest of Level 2, this is because data for peer hospitals is only available once it is made public, whereas we can obtain NUH data direct from the trust.

NUH have achieved the target for 11 of the 16 indicators that have national targets.

Of the indicators NUH failed, the following number of other trusts also failed that indicator – A&E Achievement = 11 out of 12, Cancer 62 day Urgent RTT = 8 out of 12, Cancer 31 day DTT = 2 out of 12, Cancer 2 week wait = 2 out of 12, RTT — Admitted = 11 out of 12.
Circle 2.1 Cancer

Circle achieved all the standards during July 2016.

The graph above shows a breakdown of how long patients at Circle waited on the 2 week wait pathway, please note that this is the total days waited and not the number of days over 14 waited. Patients seen within 14 days are not shown. The one patient waiting over 50 days had a wait time of 61 days. This breach was due to patient choice.

Cancer 31 day DTT Performance by Tumour Site

The above table shows the performance of 31 day cancer at Circle for all patients by tumour site for July 2016 and for the last twelve months. It should be noted that small numbers for tumour sites besides skin have a negligible impact upon overall 31 day DTT performance for the last 12 months. Circle has achieved the standard in July 2016 with performance at 97.30%. However, over the last twelve months, performance is 93.25% which is slightly below the standard.
The above table shows the performance of 62 day cancer (excluding rare cancers) at Circle for all patients by tumour site for July 2016 and the last twelve months. There is one tumour site where performance has been consistently below standard over the last 12 months—Lower Gastrointestinal.

During July 2016, 62 day RTT performance at Circle has surpassed the 85% national standard with performance at 86.08%. However, performance over the past twelve months is below the standard at 84.18%.
The only national standard for 2016/17 is the Incomplete 92% of patients to be waiting less than 18 weeks at the end of the month. Circle have achieved this for each of the last 12 months.

The table below shows Incomplete, Incomplete With Decision to Admit and New RTT Periods by specialty:

<table>
<thead>
<tr>
<th>Month = Jul-16</th>
<th>Incomplete Standard = 92%</th>
<th>Incomplete With Decision to Admit</th>
<th>New RTT Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients</td>
<td>18Wks+</td>
<td>Perf</td>
</tr>
<tr>
<td>General Surgery</td>
<td>326</td>
<td>12</td>
<td>96.32%</td>
</tr>
<tr>
<td>Urology</td>
<td>383</td>
<td>13</td>
<td>96.61%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>2427</td>
<td>169</td>
<td>93.04%</td>
</tr>
<tr>
<td>ENT</td>
<td>0</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>9</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>General Medicine</td>
<td>397</td>
<td>49</td>
<td>87.66%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1533</td>
<td>123</td>
<td>91.98%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>31</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>3093</td>
<td>192</td>
<td>93.79%</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>647</td>
<td>53</td>
<td>91.81%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td>751</td>
<td>38</td>
<td>94.94%</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>1038</td>
<td>15</td>
<td>98.55%</td>
</tr>
<tr>
<td>Other</td>
<td>1533</td>
<td>83</td>
<td>94.59%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12168</td>
<td>747</td>
<td>93.86%</td>
</tr>
</tbody>
</table>

Three specialties breached the 92% Incomplete standard in July 2016, these were General Medicine, Gastroenterology, and Thoracic Medicine.

Please note RTT performance is reported at provider level not contract level. Therefore Ophthalmology is included for completeness although not commissioned via this contract.
Level 2 – Circle Performance

Circle 2.3 Diagnostics Waiting Times

<table>
<thead>
<tr>
<th>Circle</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diagnostics (% of patients waiting over six weeks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Period</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Jul-16</td>
<td></td>
<td>1%</td>
<td>0.00%</td>
<td></td>
</tr>
</tbody>
</table>

Circle achieved the Diagnostics standard in July 2016, during the month there were no breaches of the six week standard.

Circle 2.4 Cancelled Operations

<table>
<thead>
<tr>
<th>Circle</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive experience of care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cancelled Ops - % of elect act</td>
<td>Jul-16</td>
<td>0.8%</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cancelled Operations - Rebooked 28 days+</td>
<td>Jul-16</td>
<td>5%</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of urgent operations cancelled for a second time</td>
<td>Jul-16</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

During July 2016, Circle achieved the 0.8% national standard with 0.00% of operations cancelled. No operations were cancelled at Circle, in the same month there were 1250 elective admissions. The table below shows that the main reason for cancellation during the last 12 months is staffing followed by clinical priority.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Administrative Error</td>
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<td>2</td>
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<td>2</td>
<td>1</td>
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<td>9</td>
<td>9</td>
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<tr>
<td>Clinical Priority</td>
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<td>2</td>
<td>4</td>
<td>2</td>
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<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>12</td>
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<td>ICU/HDU Bed Unavailable</td>
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<td>0</td>
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<td>1</td>
<td>1</td>
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<td>0</td>
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<tr>
<td>Total</td>
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<td>7</td>
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<td>8</td>
<td>3</td>
<td>8</td>
<td>0</td>
<td>78</td>
</tr>
</tbody>
</table>

In July 2016 all cancelled operations at Circle were rebooked within 28 days, achieving the national standard.

Circle 2.5 Complaints

<table>
<thead>
<tr>
<th>Circle</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Standard</th>
<th>Period Perf</th>
<th>Last 12 months</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience</td>
<td>Number of Complaints</td>
<td>Jul-16</td>
<td>Minimum</td>
<td>8</td>
<td></td>
<td>42</td>
</tr>
</tbody>
</table>

Circle had 8 complaints during July 2016. Circle have a culture of encouraging patients to raise concerns and any complaints made are used to increase the quality of clinical care and provide the best possible patient experience.
Circle 2.6 HCAIs

<table>
<thead>
<tr>
<th>Circle</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Standard</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAIs</td>
<td>MRSA Bacteraemia</td>
<td>Jul-16</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C Difficile</td>
<td>Jul-16</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Circle have not had any cases of MRSA or C-Diff during the last 12 months.

Circle 2.7 Venous Thromboembolism (VTE) Risk Assessment

<table>
<thead>
<tr>
<th>Circle</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percentage of patients assessed for risk of VTE on admission</td>
<td>Jun-16</td>
<td>95%</td>
<td>98.48%</td>
<td>98.11%</td>
<td>98.11%</td>
</tr>
</tbody>
</table>

Circle have achieved the VTE Risk Assessment standard every month for the last 12 months.

Circle 2.8 Never Events

<table>
<thead>
<tr>
<th>Circle</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>Period Perf</th>
<th>Last 12 months</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never Events</td>
<td>Jul-16</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

There were no Never Events reported during July 2016.

Circle 2.9 Friends & Family Test (FFT)

<table>
<thead>
<tr>
<th>Circle</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Basis</th>
<th>Standard</th>
<th>Performance</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FFT - Inpatient Score</td>
<td>Aug-16</td>
<td>Monthly</td>
<td>N/A</td>
<td>92.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FFT - Inpatient Response Rate</td>
<td>Aug-16</td>
<td>Monthly</td>
<td>N/A</td>
<td>44.54%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FFT - Outpatient Score</td>
<td>Aug-16</td>
<td>Monthly</td>
<td>N/A</td>
<td>83.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>FFT - Outpatient Response Rate</td>
<td>Aug-16</td>
<td>Monthly</td>
<td>N/A</td>
<td>23.67%</td>
<td></td>
</tr>
</tbody>
</table>

There are currently no national standards for the FFT. However, Circle are consistently achieving high scores for both inpatient and outpatient.
### NHCT 2.1 IAPT

<table>
<thead>
<tr>
<th>NHCT</th>
<th>Description of Standard</th>
<th>CCG</th>
<th>Target</th>
<th>Jul-16</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAPT</td>
<td>The percentage of people who have depression and/or anxiety disorders who receive psychological therapies</td>
<td>NNE</td>
<td>1.25%</td>
<td>1.51%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NW</td>
<td>1.25%</td>
<td>1.42%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rush</td>
<td>1.25%</td>
<td>1.55%</td>
<td></td>
</tr>
</tbody>
</table>

The CCGs have set a target for 3.76% of patients who have depression and/or anxiety disorders to be seen each quarter during 2016/17. This equates to 194 patients per month for Nottingham North & East, 126 for Nottingham West and 127 for Rushcliffe.

Nottingham West CCG achieved the required quarter to date standard of 1.25% for the first month of Quarter 2 2016/17 with performance at 1.42%. To achieve the standard for Quarter 2, the CCG requires 234 further patients to be seen this quarter.

#### IAPT - Patient Moving Towards Recovery (Recovery Rate)

<table>
<thead>
<tr>
<th>NHCT</th>
<th>Description of Standard</th>
<th>CCG</th>
<th>Target</th>
<th>Jul-16</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAPT</td>
<td>IAPT Recovery Rates</td>
<td>NNE</td>
<td>50%</td>
<td>53.96%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NW</td>
<td>50%</td>
<td>51.06%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rush</td>
<td>50%</td>
<td>64.91%</td>
<td></td>
</tr>
</tbody>
</table>

The recovery rate is the number of people who are moving to recovery, divided by the number of people who have completed treatment, minus the number of people who have completed treatment who were not at “caseness” at initial assessment. An individual is said to be at caseness when their outcome score exceeds the accepted threshold for a standardised measure of symptoms.

The CCG has an IAPT recovery rate standard of 50%. During July 2016 Nottingham West CCG achieved the 50% standard at 51.06%, this is the twelfth consecutive month that the CCG has achieved the standard.

### NHCT 2.2 EIP

<table>
<thead>
<tr>
<th>CCG</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Target</th>
<th>CCG</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Early Intervention in Psychosis (% of patients starting treatment with a NICE-recommended package of care within 2 weeks of referral)</td>
<td>Aug-16</td>
<td>100%</td>
<td>NNE</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NW</td>
<td>50.00%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rush</td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Early Intervention in Psychosis (% of patients awaiting treatment with a NICE-recommended package of care within 2 weeks of referral)</td>
<td>Aug-16</td>
<td>100%</td>
<td>NNE</td>
<td>66.67%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NW</td>
<td>60.00%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Rush</td>
<td>66.67%</td>
<td></td>
</tr>
</tbody>
</table>

There is a national target for all patients referred onto the early intervention in psychosis pathway to be treated within 2 weeks with a NICE-recommended package of care.

In August 2016, two of the three CCGs achieved the standard. During the month, Nottingham West CCG had 50.00% of patients starting treatment within two weeks following referral. The CCG has achieved the standard four times in the last nine months. Of the Nottingham West CCG patients waiting to begin treatment 60.00% had been waiting less than two weeks at the end of the reporting period.
NHCT 2.3 Care Programme Approach

<table>
<thead>
<tr>
<th>NHCT</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Standard</th>
<th>Period Perf</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPA</td>
<td>% of patients having a review last 12 months</td>
<td>Jun-16</td>
<td>95.0%</td>
<td>96.60%</td>
<td></td>
</tr>
<tr>
<td>CPA</td>
<td>% of patients receiving follow-up contact within 7 days of discharge</td>
<td>Jun-16</td>
<td>95.0%</td>
<td>98.10%</td>
<td></td>
</tr>
</tbody>
</table>

The Trust achieved the percentage of patients receiving follow-up contact within 7 days of discharge during June 2016.

CPA is usually for patients that have severe mental health problems and is a particular way of assessing, planning and reviewing their mental health needs. There should be a formal written care plan outlining any risks and including details of what should happen in an emergency or crisis, this should be reviewed annually.

NHCT 2.4 Dementia

During the planning round completed by CCGs in April 2016, Nottingham West CCG set ambitions to maintain their Dementia Diagnosis Rate at a minimum of 67% throughout 2016/17.

The table below shows that as at the end of August 2016 Nottingham West CCG has a Dementia Diagnosis Rate of 73%, which is above the 67% plan.
NHCT achieved the 7.5% standard for Delayed Transfers of Care during July 2016 with performance at 6.40%. The number of days patients have been delayed during the month has shown a decrease from last month with 815 days delayed in July 2016.

A reason for delay breakdown of the DTOCs for July 2016 is shown below, this also shows whether the NHS or Social Care was responsible for the delay.

<table>
<thead>
<tr>
<th>Nottinghamshire Healthcare Trust</th>
<th>NHS Responsible for Delay</th>
<th>Social Care Responsible for Delay</th>
<th>Both NHS &amp; Social Care Responsible for Delay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason For Delay July 2016</td>
<td>Number of Patients Delayed (last Thursday of month snapshot)</td>
<td>Number of Days Delayed (total during month)</td>
<td>Number of Patients Delayed (last Thursday of month snapshot)</td>
</tr>
<tr>
<td>A) Completion of assessment</td>
<td>1</td>
<td>34</td>
<td>0</td>
</tr>
<tr>
<td>B) Public Funding</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C) Further non acute NHS care</td>
<td>2</td>
<td>101</td>
<td>0</td>
</tr>
<tr>
<td>(including intermediate care, rehab, etc)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>D) Awaiting Residential Care Home Placement</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Dii) Awaiting Nursing Home Placement</td>
<td>2</td>
<td>62</td>
<td>0</td>
</tr>
<tr>
<td>E) Care package in own home</td>
<td>3</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>F) Community Equipment/adaptions</td>
<td>2</td>
<td>23</td>
<td>0</td>
</tr>
<tr>
<td>G) Patient or family choice</td>
<td>2</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>H) Disputes</td>
<td>2</td>
<td>62</td>
<td>0</td>
</tr>
<tr>
<td>I) Housing - patients not covered by NHS and Community Care Act</td>
<td>8</td>
<td>206</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>524</td>
<td>5</td>
</tr>
</tbody>
</table>
Monthly Performance of the Ambulance Indicators Red 8 minutes and Red 19 minutes

Performance against standard for Red 1 and Red 2 calls.

<table>
<thead>
<tr>
<th>CCG Level</th>
<th>Description of Standard</th>
<th>Target</th>
<th>CCG</th>
<th>August 2016</th>
<th>Last 12 months performance</th>
<th>Year to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Responses</td>
<td>Performance</td>
<td>Responses</td>
</tr>
<tr>
<td>Red 1 - Life threatening requiring defibrillation</td>
<td>8 Minute Response Time</td>
<td>75%</td>
<td>M&amp;A</td>
<td>36</td>
<td>77.78%</td>
<td>232</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N&amp;S</td>
<td>18</td>
<td>77.78%</td>
<td>112</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City</td>
<td>109</td>
<td>88.07%</td>
<td>522</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NNE</td>
<td>28</td>
<td>67.86%</td>
<td>138</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NW</td>
<td>18</td>
<td>77.76%</td>
<td>93</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rush</td>
<td>12</td>
<td>58.33%</td>
<td>97</td>
</tr>
<tr>
<td></td>
<td>19 Minute Response Time</td>
<td>95%</td>
<td>M&amp;A</td>
<td>36</td>
<td>100%</td>
<td>232</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N&amp;S</td>
<td>18</td>
<td>100%</td>
<td>112</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City</td>
<td>109</td>
<td>100%</td>
<td>521</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NNE</td>
<td>28</td>
<td>67.86%</td>
<td>138</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NW</td>
<td>18</td>
<td>54.44%</td>
<td>93</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rush</td>
<td>12</td>
<td>61.67%</td>
<td>97</td>
</tr>
<tr>
<td>Red 2 - Life threatening requiring defibrillation</td>
<td>8 Minute Response Time</td>
<td>75%</td>
<td>M&amp;A</td>
<td>1045</td>
<td>67.46%</td>
<td>5473</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N&amp;S</td>
<td>474</td>
<td>76.65%</td>
<td>2587</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City</td>
<td>2058</td>
<td>70.51%</td>
<td>10639</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NNE</td>
<td>607</td>
<td>55.02%</td>
<td>3161</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NW</td>
<td>464</td>
<td>33.88%</td>
<td>2250</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rush</td>
<td>370</td>
<td>47.57%</td>
<td>1948</td>
</tr>
<tr>
<td></td>
<td>19 Minute Response Time</td>
<td>95%</td>
<td>M&amp;A</td>
<td>1044</td>
<td>96.17%</td>
<td>5470</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>N&amp;S</td>
<td>472</td>
<td>80.72%</td>
<td>2571</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>City</td>
<td>2056</td>
<td>85.96%</td>
<td>10622</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NNE</td>
<td>606</td>
<td>91.91%</td>
<td>3157</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>NW</td>
<td>463</td>
<td>94.17%</td>
<td>2248</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rush</td>
<td>369</td>
<td>86.72%</td>
<td>1934</td>
</tr>
</tbody>
</table>

The table above shows the EMAS performance for local CCGs against the Red 1 and Red 2 standards. During August 2016 Nottingham West CCG achieved the Red 1 8 minute 75% standard with performance at 77.78% from 18 responses, this is the first time the CCG has achieved the standard since July 2015. However, Nottingham West CCG failed to achieve the Red 2 8 minute 75% standard. During August 2016 there were 464 responses of which 53.88% arrived within 8 minutes, 94.17% arrived within 19 minutes which is below the standard of 95%.

The chart above shows EMAS red call volumes for the three South Nottinghamshire CCGs, comparing 2016-17 volumes to the same periods of 2015-16. All three South Nottinghamshire CCGs have seen an increase in call volumes; Nottingham North & East has increased by 21.24%, Nottingham West by 19.66% and Rushcliffe by 37.16%.
Level 2 – EMAS Performance

Percentiles
The chart below shows the EMAS 75th percentile response time for Red calls for each of the South Nottinghamshire CCGs by month. The standard is 8 minutes and, as can be seen from the chart, none of the CCGs have achieved this (please note, April 2014 data is unavailable).

Time to Respond
The following chart shows the year to date response times for Red 1 & Red 2 calls across Nottingham West CCG. The green line shows the expected performance if the 75% 8 minute and 95% 19 minute targets were to be met, the blue line shows the current CCG performance.

The table within the chart shows the actual number of calls. During the specified period in total there has been 2343 Red 1 and Red 2 calls in Nottingham West CCG, 939 have been responded to within 8 minutes. 87 Red 1 and Red 2 calls have been responded to in more than 19 minutes, and three calls have been responded to in over 1 hour.

Some calls are responded to within a minute, this is due to a number of reasons including - A defibrillator and someone who can use it being close to the scene (which immediately stops the clock) and first responders arriving on the scene quickly.
Remedial Action Plan

To improve performance a Remedial Action Plan (RAP), which details issues and actions, is in place. These are shown below -

**Issue - Demand - Increased Red Activity**

*Actions*
- Level of clinical input into the Clinical Assessment Team (CAT) desk to be increased
- CAT desk ability to triage Red 999 calls to be protected, this will enable more calls to be downgraded to Green
- Collaboration with Derbyshire Health United to pilot a Ambulance Liaison Desk in NHS 111, utilising EMAS Clinical Hub staff, to reduce number of calls transferred to EMAS
- Peer review of current activity/demand to identify any additional actions required

**Issue - Resources - Resource Availability**

*Actions*
- Increase utilisation of Private and Voluntary Ambulance Services, whilst ensuring patient safety
- Development of a workforce plan and trajectory to ensure 2193 WTE staff trained and operational by March 2017
- Reduction of the number of staff on alternative duties to support operational delivery

**Issue - Quality & Performance - Improved Performance**

*Actions*
- Analysis of the impact of revised Ambulance Quality Indicators on Red performance
- Monitor impact of capacity management plan on performance and quality

**Issue - Handovers - Handover Delays**

*Actions*
- Work with commissioners and providers in Leicestershire to implement actions specific to that area
- Ensure rollout programme of 164 defibrillators matches requirements of each division, reduce vehicle downtime
Turnaround times
The table below shows the average times of ambulance turnover for the latest month at QMC and City hospital.

The pre-handover time is the responsibility of the hospital and is the time between the ambulance arriving at the hospital and the patient being handed over. The post-handover time is the responsibility of EMAS and is the time between the patient being handed over and the ambulance being ready for the next call.

<table>
<thead>
<tr>
<th>NUH</th>
<th>Description of Standard</th>
<th>Period</th>
<th>Standard</th>
<th>Last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Queens Medical Centre - Pre-Handover</td>
<td>Aug-16</td>
<td>&lt;15 mins = G</td>
<td>28:59</td>
</tr>
<tr>
<td></td>
<td>Queens Medical Centre - Post-Handover</td>
<td>Aug-16</td>
<td>&gt;20 mins = R</td>
<td>12:45</td>
</tr>
<tr>
<td></td>
<td>Queens Medical Centre - Total</td>
<td>Aug-16</td>
<td>&lt;30 mins = G, &gt;40 mins = R</td>
<td>41:44</td>
</tr>
<tr>
<td></td>
<td>Nottingham City Hospital - Pre-Handover</td>
<td>Aug-16</td>
<td>&lt;15 mins = G, &gt;20 mins = R</td>
<td>19:42</td>
</tr>
<tr>
<td></td>
<td>Nottingham City Hospital - Post-Handover</td>
<td>Aug-16</td>
<td>&lt;15 mins = G, &gt;20 mins = R</td>
<td>12:53</td>
</tr>
<tr>
<td></td>
<td>Nottingham City Hospital - Total</td>
<td>Aug-16</td>
<td>&lt;30 mins = G, &gt;40 mins = R</td>
<td>32:34</td>
</tr>
</tbody>
</table>

The main issue affecting performance remains outflow from the Emergency Department (ED), patients are continuing to wait in ED for inpatient beds. This creates capacity issues within Majors and the Initial Assessment Unit (IAU), which are then unable to receive all Majors referrals, with the exception of direct to Resus and Children’s. Subsequently, staff are unable to move away from the Majors area, and the escalation process to move staff to IAU can not be enacted.

Actions to improve performance include -
- Actively recruiting to nursing vacancies, any current shortfall covered by agency staff
- Reduction in ambulance waiting space caused by building works is monitored on a daily basis to ensure safe and effective transfers
- If the ambulance crew is waiting more than 10 minutes then there is an internal escalation to the ED Nurse in charge
- An additional 30 minute escalation to nurse in charge to reduce chances of 60 minute turnaround delays
Ambulance Service Performance Comparison

System Indicators

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Latest Month</th>
<th>Period</th>
<th>Target</th>
<th>EMAS Rank (out of 11)</th>
<th>Best 1 = Best 11 = Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A Calls</td>
<td>Proportion of Red 1 calls responded to within 8 minutes</td>
<td>Month</td>
<td>75%</td>
<td>3</td>
<td>69.14%</td>
<td>69.70%</td>
</tr>
<tr>
<td></td>
<td>95th centile of response time for Red 1 calls (in minutes)</td>
<td>Month</td>
<td>7</td>
<td>16.0</td>
<td>17.1</td>
<td>25.3</td>
</tr>
<tr>
<td></td>
<td>Proportion of Red 2 calls responded to within 8 minutes</td>
<td>YTD</td>
<td>75%</td>
<td>7</td>
<td>67.73%</td>
<td>61.83%</td>
</tr>
<tr>
<td></td>
<td>95th centile of response time for Red 2 calls (in minutes)</td>
<td>YTD</td>
<td>7</td>
<td>16.0</td>
<td>17.1</td>
<td>25.3</td>
</tr>
<tr>
<td></td>
<td>Proportion of Category A calls responded within 19 minutes</td>
<td>Month</td>
<td>95%</td>
<td>8</td>
<td>84.91%</td>
<td>92.91%</td>
</tr>
<tr>
<td></td>
<td>95th centile of response time for Category A calls (in minutes)</td>
<td>YTD</td>
<td>95%</td>
<td>11</td>
<td>94.91%</td>
<td>92.91%</td>
</tr>
<tr>
<td>Call Abandonment</td>
<td>Proportion of calls abandoned before being answered</td>
<td>Month</td>
<td>9</td>
<td>2.0%</td>
<td>0.6%</td>
<td>1.9%</td>
</tr>
<tr>
<td></td>
<td>YTD</td>
<td>8</td>
<td>1.4%</td>
<td>0.5%</td>
<td>1.6%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Timeliness</td>
<td>Time to answer call (in seconds)</td>
<td>Median</td>
<td>9</td>
<td>47</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>95th Percentile</td>
<td>Month</td>
<td>9</td>
<td>47</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Time to treatment for Category A calls (in minutes)</td>
<td>Median</td>
<td>11</td>
<td>12</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>95th Percentile</td>
<td>Month</td>
<td>11</td>
<td>26</td>
<td>18</td>
<td>0</td>
</tr>
</tbody>
</table>

Ambulance Service Performance Comparison: System Indicators

Out of 11 Ambulance service’ EMAS are ranked 9th or worse in 6 out of the 11 monthly indicators and 2 out of the 4 year to date indicators shown above. EMAS are failing to achieve the standards for Proportion of Red 1 calls responded to within 8 minutes monthly (69.14%) & YTD (67.73%), Proportion of Red 2 calls responded to within 8 minutes monthly (53.78%) & YTD (56.53%) and Proportion of Category A calls responded to within 19 minutes monthly (82.09%) & YTD (84.91%).
## Ambulance Service Performance Comparison

### Clinical Outcomes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Arrest (Utstein group)</td>
<td>Return of Spontaneous Circulation</td>
<td>Month</td>
<td>10</td>
<td>38.10%</td>
<td>50.00%</td>
<td>50.00%</td>
<td>60.00%</td>
<td>76.93%</td>
<td>60.99%</td>
<td>45.36%</td>
<td>61.11%</td>
<td>56.41%</td>
<td>40.48%</td>
<td>37.50%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>YTD</td>
<td>11</td>
<td>15.00%</td>
<td>26.92%</td>
<td>50.00%</td>
<td>37.50%</td>
<td>38.46%</td>
<td>23.63%</td>
<td>16.67%</td>
<td>25.71%</td>
<td>26.32%</td>
<td>21.43%</td>
<td>37.50%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Survival to Discharge</td>
<td>Month</td>
<td>11</td>
<td>15.00%</td>
<td>26.92%</td>
<td>50.00%</td>
<td>37.50%</td>
<td>38.46%</td>
<td>23.63%</td>
<td>16.67%</td>
<td>25.71%</td>
<td>26.32%</td>
<td>21.43%</td>
<td>37.50%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>YTD</td>
<td>11</td>
<td>15.00%</td>
<td>26.92%</td>
<td>50.00%</td>
<td>37.50%</td>
<td>38.46%</td>
<td>23.63%</td>
<td>16.67%</td>
<td>25.71%</td>
<td>26.32%</td>
<td>21.43%</td>
<td>37.50%</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>Proportion of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyperacute stroke unit within 60 minutes</td>
<td>Month</td>
<td>7</td>
<td>52.82%</td>
<td>43.10%</td>
<td>75.00%</td>
<td>64.63%</td>
<td>55.26%</td>
<td>47.27%</td>
<td>36.36%</td>
<td>76.42%</td>
<td>36.67%</td>
<td>57.00%</td>
<td>54.45%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>YTD</td>
<td>7</td>
<td>52.82%</td>
<td>43.10%</td>
<td>75.00%</td>
<td>64.63%</td>
<td>55.26%</td>
<td>47.27%</td>
<td>36.36%</td>
<td>76.42%</td>
<td>36.67%</td>
<td>57.00%</td>
<td>54.45%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of suspected stroke patients assessed face to face who received an appropriate care bundle</td>
<td>Month</td>
<td>3</td>
<td>99.13%</td>
<td>99.16%</td>
<td>97.15%</td>
<td>95.56%</td>
<td>99.03%</td>
<td>99.48%</td>
<td>98.46%</td>
<td>95.79%</td>
<td>95.17%</td>
<td>98.79%</td>
<td>98.66%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>YTD</td>
<td>3</td>
<td>99.13%</td>
<td>99.16%</td>
<td>97.15%</td>
<td>95.56%</td>
<td>99.03%</td>
<td>99.48%</td>
<td>98.46%</td>
<td>95.79%</td>
<td>95.17%</td>
<td>98.79%</td>
<td>98.66%</td>
<td></td>
</tr>
<tr>
<td>Acute STEMI</td>
<td>Proportion of patients with definite ST-elevation myocardial infarction who received primary angioplasty within 150 minutes of call connecting to ambulance service</td>
<td>Month</td>
<td>4</td>
<td>92.59%</td>
<td>94.51%</td>
<td>0.00%</td>
<td>94.85%</td>
<td>90.91%</td>
<td>76.12%</td>
<td>81.82%</td>
<td>94.23%</td>
<td>78.99%</td>
<td>86.57%</td>
<td>91.18%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>YTD</td>
<td>4</td>
<td>92.59%</td>
<td>94.51%</td>
<td>0.00%</td>
<td>94.85%</td>
<td>90.91%</td>
<td>76.12%</td>
<td>81.82%</td>
<td>94.23%</td>
<td>78.99%</td>
<td>86.57%</td>
<td>91.18%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of patients with ST-elevation myocardial infarction who received an appropriate care bundle</td>
<td>Month</td>
<td>3</td>
<td>88.46%</td>
<td>89.29%</td>
<td>58.33%</td>
<td>69.35%</td>
<td>88.46%</td>
<td>88.07%</td>
<td>70.24%</td>
<td>69.15%</td>
<td>81.96%</td>
<td>82.68%</td>
<td>88.65%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>YTD</td>
<td>3</td>
<td>88.46%</td>
<td>89.29%</td>
<td>58.33%</td>
<td>69.35%</td>
<td>88.46%</td>
<td>88.07%</td>
<td>70.24%</td>
<td>69.15%</td>
<td>81.96%</td>
<td>82.68%</td>
<td>88.65%</td>
<td></td>
</tr>
</tbody>
</table>

### Ambulance Service Performance Comparison: Clinical Outcomes

Only the Utstein group is shown in the Cardiac Arrest indicators. The 'Utstein comparator group' provides a comparable and specific measure of the management of cardiac arrests for the subset of patients where timely and effective emergency care can particularly improve survival (e.g. 999 calls where the arrest was not witnessed and the patient may have gone into arrest several hours before the 999 call are excluded from the Utstein comparator group figure).

Out of 11 Ambulance service’ EMAS are ranked 9\(^{th}\) or worse in 2 out of the 6 monthly indicators and 2 out of the 6 year to date indicators shown above.
Arriva Patient Transport Services

The table above shows the Arriva Patient Transport Service (PTS) performance over the past 12 months for the 5 KPIs for Nottinghamshire.

The performance for KPI1, the time in which a patient spends in the vehicle split by the distance that the patient lives from the point of care, has achieved each standard for this month. This includes the standard that patients within 10 miles of the point of care spend no longer than 60 minutes on the vehicle. Prior to this, this standard had failed in four of the previous twelve months.

To improve performance Arriva have created a Service Improvement Plan for Nottinghamshire which has identified several areas for improvement:

- Improve partnership working along the patient pathway
  - Improve partnership working with points of care
  - Reduce number of aborted journeys at hospital for hospital triggered reason codes
  - Reduction in Crew wait times for patient at pick up from Unit
  - On the day patient transport changes - changes to patient clinic locations and patient collection points
  - Support the discharge pathway to improve the co-ordination of transport & TTOs
  - Improve understanding of mobility types when booking journeys
  - Confirmation required on the Patient support provided when a clinic has closed but the patient is not yet due to be collected by transport

- Renal transport
  - Improve Renal performance

- Improve call centre performance
  - Improve site/HPs access to Cleric to book transport and making patients ready for collection
  - Reduce the number of abandoned calls and call waiting times into the Call Centre

- Improve performance of patient inward KPIs
  - Patients travelling in on crews first run not always meeting KPIs

- Improve internal performance management processes
  - The resource vs. demand peaks are only escalated on the day of travel, resulting in third party resources being engaged too late to be optimised efficiently and meet demand
  - More focus needed on how individual roles support and impact the KPIs

- Internal communication
  - Improve the internal communication & resolution of reoccurring service delivery issues that impact the KPIs
The following pages detail performance of key indicators for the NHS 111 service across the Midlands and East region. All data is approximate as Derbyshire Health United (DHU) assign calls based on the STD Code/location of mobile phone mast, and therefore there will be cross border calls and residents of other areas calling from within Nottinghamshire included in the figures. Additionally, the phone system is unable to identify the location of 5-10% of all calls nationally, these calls are allocated to any one of the 111 centres who answer them under their local contracts (this should balance out as other providers will answer calls from Nottinghamshire residents).

DHU are working to provide CCG level reports but the same caveats as above will apply.

### Access & Quality, Costs and Patient Experience Performance Comparison

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Latest Month</th>
<th>Notts Rank (out of 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nottingham</td>
<td>Calls per year per 1,000 people</td>
<td>236</td>
<td>7</td>
</tr>
<tr>
<td>Derbyshire</td>
<td>Calls via 111 per year per 1,000 people</td>
<td>-</td>
<td>17</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>% abandoned calls after 30 seconds waiting time</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>% calls answered in 60 seconds</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>% answered calls triaged</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>% transferred calls transferred to clinical advisor</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>% transferred calls live transferred</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Norfolk</td>
<td>Average NHS 111 live transfer time (mins)</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Hertfordshire</td>
<td>Average warm transfer time (awaits clinician pickup)</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>% answered call passed for call back</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>% call backs within 10 minutes</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Average episode length (secs)</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Costs</td>
<td>% handling time by clinical staff</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>% delayed with 111 experience</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>% very or fairly satisfied with 111 experience</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>% callers who fully complied with advice</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>% callers where problem resolved or improved</td>
<td>11</td>
<td>8</td>
</tr>
</tbody>
</table>

NCA = Not currently available

**Access & Quality, Costs and Patient Experience Performance Comparison**

Nottinghamshire are performing within the top 10 for 2 of the 4 Patient Experience indicators. 90% of patients reported to be very or fairly satisfied with the 111 experience, this compares to 88% with the neighbouring area of Derbyshire County.
**Level 2 - NHS 111 Performance**

**System Impact Performance Comparison**

The above table looks at the system impact of the 111 service. As can be seen 10% of calls ended with an Ambulance being dispatched. 7% of patients were recommended to attend A&E, this is a similar level of performance to that seen across the Midlands and East. The recommendations to attend as well as not to attend other services vary between Nottinghamshire and other Midlands and East areas. Only 2% of Nottinghamshire patients were recommended to attend other services, this includes specialist practitioners including midwives, child protection, social services and opticians, this compares to 7% of Derbyshire patients.

### System Impact

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Latest Month = Jul-16</th>
<th>Notts Rank (out of 17)</th>
<th>1 = Best</th>
<th>17 = Worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>111 dispositions: % Ambulance dispatches</td>
<td>13</td>
<td>11%</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>111 dispositions: % Recommended to attend A&amp;E</td>
<td>-</td>
<td>7%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>111 dispositions: % Recommended to attend primary and community care</td>
<td>-</td>
<td>50%</td>
<td>45%</td>
<td>90%</td>
</tr>
<tr>
<td>Of which: % Recommended to contact primary and community care</td>
<td>-</td>
<td>37%</td>
<td>32%</td>
<td>34%</td>
</tr>
<tr>
<td>% Recommended to speak to primary and community care</td>
<td>-</td>
<td>11%</td>
<td>9%</td>
<td>11%</td>
</tr>
<tr>
<td>% Recommended to dental/pharmacy</td>
<td>-</td>
<td>3%</td>
<td>4%</td>
<td>5%</td>
</tr>
<tr>
<td>111 dispositions: % Recommended to attend other service</td>
<td>-</td>
<td>2%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Of which: % Recommended to contact primary and community care</td>
<td>-</td>
<td>29%</td>
<td>38%</td>
<td>31%</td>
</tr>
<tr>
<td>% Recommended to speak to primary and community care</td>
<td>-</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>% Recommended to dental/pharmacy</td>
<td>-</td>
<td>6%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>% Recommended home care</td>
<td>-</td>
<td>5%</td>
<td>2%</td>
<td>11%</td>
</tr>
<tr>
<td>Of which: % Given health information</td>
<td>-</td>
<td>1%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>% Recommended non clinical</td>
<td>-</td>
<td>5%</td>
<td>2%</td>
<td>11%</td>
</tr>
<tr>
<td>% of calls not triaged</td>
<td>-</td>
<td>18%</td>
<td>31%</td>
<td>13%</td>
</tr>
</tbody>
</table>

NCA = Not currently available
### Quality Premium

The Quality Premium is £5 per head of running cost population and will be payable to CCGs in 2016/17 based on the quality of health services commissioned during 2015/16. This will be based on several measures that cover a combination of national and local priorities.

This initial value will be reduced if providers, from which the CCG commissions services, are unable to meet the 4 key areas of the NHS Constitution and pledges for its population.

As well as achieving the above there are 3 prerequisites for the Quality Premium to be payable. A CCG will not achieve a quality premium if it:

a. is not considered in a manner that is consistent with Managing Public Money during 2015/16; or
b. Incurs an unplanned deficit during 2015/16, or requires unplanned financial support to avoid being in this position; or
c. Incurs a qualified audit in respect of 2015/16.

The table below provides an overview of the Quality Premium for the CCG.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Percentage of Quality Premium</th>
<th>Potential Reduction</th>
<th>Performance Needed</th>
<th>Achieve by</th>
<th>Latest Performance</th>
<th>Latest Period Available</th>
<th>Trend</th>
<th>Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premature Mortality</td>
<td>Reducing Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare over time</td>
<td>10%</td>
<td>£45,492</td>
<td>less than or equal to 101.6</td>
<td>2015 Calendar Year</td>
<td>2014</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td>Composite Urgent &amp; Emergency Care Menu</td>
<td>Unplanned hospitalisation for chronic ambulatory care sensitive conditions</td>
<td>N/A</td>
<td>N/A</td>
<td>1000</td>
<td>2015/16</td>
<td>2014/15</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unplanned hospitalisation for asthma, diabetes and epilepsy in children</td>
<td>N/A</td>
<td>N/A</td>
<td>1000</td>
<td>2015/16</td>
<td>2014/15</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency admissions for acute conditions that should not usually require hospital admission</td>
<td>N/A</td>
<td>N/A</td>
<td>1000</td>
<td>2015/16</td>
<td>2014/15</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency admissions for children with lower respiratory tract infection</td>
<td>N/A</td>
<td>N/A</td>
<td>1000</td>
<td>2015/16</td>
<td>2014/15</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoidable Emergency Admissions Composite</td>
<td>10%</td>
<td>£45,492</td>
<td>more than or equal to 1000</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£45,492</td>
<td></td>
</tr>
<tr>
<td></td>
<td>An increase in the level of discharges at weekends and bank holidays</td>
<td>10%</td>
<td>£45,492</td>
<td>more than or equal to 23.5%</td>
<td>2015/16</td>
<td>2014/16</td>
<td>£45,492</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reducing NHS-responsible delayed transfers of care (days delayed per 100,000 population)</td>
<td>10%</td>
<td>£45,492</td>
<td>more than or equal to 2709</td>
<td>2015/16</td>
<td>2014/16</td>
<td>£45,492</td>
<td></td>
</tr>
<tr>
<td>A&amp;E Mental Health Menu</td>
<td>Improvement in coding of patients attending A&amp;E</td>
<td>5%</td>
<td>£22,746</td>
<td>more than or equal to 90%</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduction in the number of patients with A&amp;E 4 hour breaches who have attended with a mental health need</td>
<td>5%</td>
<td>£22,746</td>
<td>more than or equal to 88.96%</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improvement in the health-related quality of life for people with a long-term mental health condition</td>
<td>10%</td>
<td>£45,492</td>
<td>more than or equal to 0.1761</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduction in the number of people with severe mental illness who are smokers</td>
<td>10%</td>
<td>£45,492</td>
<td>more than or equal to 30.6%</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase the proportion of adults with secondary mental health conditions who are in paid employment</td>
<td>5%</td>
<td>£22,746</td>
<td>more than or equal to 6.5</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td>Improving Antibiotic Prescribing</td>
<td>Reduction in the number of antibiotics prescribed in primary care</td>
<td>5%</td>
<td>£22,746</td>
<td>more than or equal to 0.99</td>
<td>2015/16</td>
<td>2013/14</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reduction in the proportion of broad spectrum antibiotics prescribed in primary care</td>
<td>3%</td>
<td>£13,647</td>
<td>more than or equal to 12.17%</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Secondary care providers validating their total antibiotic prescription data</td>
<td>2%</td>
<td>£9,098</td>
<td>Validated</td>
<td>Yes</td>
<td>2015/16</td>
<td>£22,746</td>
<td></td>
</tr>
<tr>
<td>Local Measure 1</td>
<td>C3.6 People who have had a stroke who receive thrombolysis following an acute stroke</td>
<td>10%</td>
<td>£45,492</td>
<td>more than or equal to 8.5%</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£45,492</td>
<td></td>
</tr>
<tr>
<td>Local Measure 2</td>
<td>C3.9 Patients who have had an acute stroke who spend 90% or more of their stay on a stroke unit</td>
<td>10%</td>
<td>£45,492</td>
<td>more than or equal to 90.7%</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£250,203</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>RTT Patients on incomplete pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral</td>
<td>-30%</td>
<td>-£75,061</td>
<td>more than or equal to 92%</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£75,061</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E Patients should be admitted, transferred or discharged within four hours of their arrival at an A&amp;E department</td>
<td>-30%</td>
<td>-£75,061</td>
<td>more than or equal to 95%</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£75,061</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Maximum two week (14 day) wait from urgent GP referral to first outpatient appointment for suspected cancer</td>
<td>-20%</td>
<td>-£50,041</td>
<td>more than or equal to 93%</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£50,041</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Red 1 ambulance calls resulting in an emergency response arriving within 8 minutes (Total EMAS not CCG)</td>
<td>-20%</td>
<td>-£50,041</td>
<td>more than or equal to 75%</td>
<td>2015/16</td>
<td>2014/15</td>
<td>£50,041</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>-100%</td>
<td>-£250,203</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£125,102</td>
<td></td>
</tr>
</tbody>
</table>

34
The Better Care Fund creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

The BCF is a critical part of the NHS 2 year operational plans and the 5 year strategic plans as well as local government planning. Within the BCF there are six indicators as shown below, which are supported by a range of schemes that contribute towards delivery of the required standards.

Please note, the data is monitored and reported at Nottinghamshire County Local Authority level in line with the requirements of the BCF. Therefore commentary may relate to organisations other than the CCG to which this report relates.

<table>
<thead>
<tr>
<th>REF</th>
<th>Indicator</th>
<th>2016/17 Target</th>
<th>2016/17 (to date)</th>
<th>RAG rating and trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCF1</td>
<td>Total non-elective admissions in to hospital (general &amp; acute), all-age, per 100,000 population</td>
<td>19,743</td>
<td>21,457 Q1 proxy</td>
<td>R ▼</td>
</tr>
<tr>
<td>BCF2</td>
<td>Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population</td>
<td>578.9</td>
<td>131 YTD</td>
<td>G ▼</td>
</tr>
<tr>
<td>BCF3</td>
<td>Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services</td>
<td>91.2%</td>
<td>81.88% Q1</td>
<td>R ▼</td>
</tr>
<tr>
<td>BCF4</td>
<td>Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)</td>
<td>1,115.8 Q1</td>
<td>1,032 Q1</td>
<td>G ▼</td>
</tr>
<tr>
<td>BCF5</td>
<td>Percentage of users satisfied that the adaptations met their identified needs</td>
<td>75%</td>
<td>100% Q1</td>
<td>G ▼</td>
</tr>
<tr>
<td>BCF5</td>
<td>BCF5: Question 32 from the GP Patient Survey: In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)</td>
<td>65.4%</td>
<td>64.4% YTD</td>
<td>R ▼</td>
</tr>
<tr>
<td>BCF6</td>
<td>Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of older people (aged 65 and over) to residential and nursing care homes</td>
<td>34%</td>
<td>29.6% Q1</td>
<td>G ▼</td>
</tr>
</tbody>
</table>
### BCF 1 - Total non-elective admissions into hospitals (general and acute), all ages

<table>
<thead>
<tr>
<th></th>
<th>Planned</th>
<th>Actual</th>
<th>Current RAG rating and trend</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline rate (Jan-14 to Dec-14)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan 14 - Mar 14</td>
<td>2,444</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr 14 - Jun 14</td>
<td>2,546</td>
<td>2,577</td>
<td></td>
</tr>
<tr>
<td>Jul 14 - Sep 14</td>
<td>2,538</td>
<td>2,586</td>
<td></td>
</tr>
<tr>
<td>Oct 14 - Dec 14</td>
<td>2,547</td>
<td>2,643</td>
<td></td>
</tr>
<tr>
<td><strong>Baseline rate (Jan-15 to Dec-15)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan 15 - Mar 15</td>
<td>2,596</td>
<td>2,607</td>
<td></td>
</tr>
<tr>
<td>Apr 15 - Jun 15</td>
<td>2,680</td>
<td>2,608</td>
<td></td>
</tr>
<tr>
<td>Jul 15 - Sep 15</td>
<td>2,689</td>
<td>2,578</td>
<td></td>
</tr>
<tr>
<td>Oct 15 - Dec 15</td>
<td>2,733</td>
<td>2,615</td>
<td></td>
</tr>
<tr>
<td><strong>Q4 2015/16</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan 16 - Mar 16</td>
<td>-</td>
<td>2,619</td>
<td></td>
</tr>
<tr>
<td><strong>2016/17</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr 16 - Jun 16</td>
<td>19,743</td>
<td>21,457 (proxy)</td>
<td></td>
</tr>
<tr>
<td>Jul 16 - Sep 16</td>
<td>20,038</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct 16 - Dec 16</td>
<td>19,866</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan 17 - Mar 17</td>
<td>19,707</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments**
- Monitored by CCG boards and System Resilience Groups
- This data is provisional from SUS (national data published monthly by NHS England)
- SUS data is not currently available for CCGs outside of Nottinghamshire, MAR data presented as a proxy
- Change of definition in 16/17, no longer expressed as a rate per 100,000 population

**Key issues**

**Mitigating actions**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>All non-elective admissions into hospital (all ages)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Nottinghamshire resident population</td>
</tr>
<tr>
<td>Reporting</td>
<td>Monthly, two months in arrears (targets quarterly). Low values are good.</td>
</tr>
</tbody>
</table>
BCF 3 - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

<table>
<thead>
<tr>
<th></th>
<th>Planned</th>
<th>Actual</th>
<th>Current RAG rating and trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline rate</td>
<td>88.8%</td>
<td>81.88%</td>
<td>Q1 R↓</td>
</tr>
<tr>
<td>April – March 2013/14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014/15 Target</td>
<td>89.8%</td>
<td>89.7%</td>
<td></td>
</tr>
<tr>
<td>2015/16 Target</td>
<td>90.7%</td>
<td>91.93%</td>
<td></td>
</tr>
<tr>
<td>2016/17 Target</td>
<td>91.2%</td>
<td>81.88%</td>
<td></td>
</tr>
</tbody>
</table>

**Comments**
- Data reported three months in arrears due to indicator definition
- Monitored by Nottinghamshire County Council ASCH&PP
- This data is provisional (national data published annually).

**Key issues**
- Overall performance is below target. New data collection methodology in place for 16/17 and discrepancies are being addressed with individual service areas.
- Small numbers and data validation means that variation against target on a monthly basis can impact significantly on RAG rating.
- The target requires the denominator i.e. people receiving reablement/rehabilitation services to be maintained.

**Mitigating actions**

**Numerator**
Number of people at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. People who are in hospital or in a registered care home at the three month date and those who have died within the three months are not included in the numerator.

**Denominator**
Older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home. Rehabilitation includes START reablement and intermediate care in both community and residential settings.

**Reporting**
Reported monthly, three months in arrears.

**Source**
Nottinghamshire County Council, Framework internal report.
**Better Care Fund**

**BCF 5 - Question 32 from the Patient GP Survey: In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)**

<table>
<thead>
<tr>
<th>Question 32 from the GP Patient Survey:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)</td>
<td></td>
</tr>
<tr>
<td>2013/14 Baseline</td>
<td>65.8%</td>
</tr>
<tr>
<td>2014/15 target</td>
<td>67.1%</td>
</tr>
<tr>
<td>2015/16 target</td>
<td>68.5%</td>
</tr>
<tr>
<td>2015/16 actual</td>
<td>64.4%</td>
</tr>
<tr>
<td>2016/17 target</td>
<td>65.4%</td>
</tr>
<tr>
<td>Latest performance (July 2016 weighted)</td>
<td>64.4%</td>
</tr>
</tbody>
</table>

**Reporting** | Data is reported six monthly, four months in arrears. High values are good

**Source** | NHS England six monthly reporting
**Meeting Title**  
NHS Nottingham West CCG  
**Governing Body**

**Date:**  
29 September 2016

**Paper Title**  
2016/17 Quarter 1 Contract Update

**Agenda Item:**  
NW/GB/16/367

**Lead Director**  
Maxine Bunn, Director of Contracting & Deputy Chief Officer, NWCCG

**Report Author**  
Maxine Bunn, Director of Contracting & Deputy Chief Officer, NWCCG

**Purpose (tick one only)**  
☐ Approval  
☒ Acknowledge/ Note  
☐ Review  
☐ For Information

**Executive Summary**  
This report shows the most recent position for all main contracts managed by the South Contract Team and shows the position for the 3 south county CCGs in relation to the performance of those contracts.

**Implications: (please tick where relevant)**

- Integration
- Patient Choice
- Reducing inequality
- Patient & Public Involvement
- Constitution
- Quality of Services
- Governance
- QIPP
- Innovation
- Research
- Learning and Development
- Sustainability

**Finance checked by:** (initials)

**Appendices**

**Report History**

**Recommendation**  
The Governing Body is asked to:  

NOTE the 2016/17 Quarter 1 Contract Update
2016/17 Quarter 1 Contract Update

1) NUH

a) Activity and Finance (month 3 data)

<table>
<thead>
<tr>
<th>CCG</th>
<th>Activity Plan</th>
<th>Activity Actuals</th>
<th>Activity Variance</th>
<th>% Variance</th>
<th>£ Plan</th>
<th>£ Actuals</th>
<th>£ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NW</td>
<td>198,620</td>
<td>222,280</td>
<td>23,659</td>
<td>12%</td>
<td>£11,355,648</td>
<td>£11,271,799</td>
<td>-£83,849</td>
<td>-1%</td>
</tr>
<tr>
<td>NNE</td>
<td>335,773</td>
<td>345,388</td>
<td>9,615</td>
<td>3%</td>
<td>£18,614,087</td>
<td>£19,662,441</td>
<td>£1,048,354</td>
<td>6%</td>
</tr>
<tr>
<td>Rushcliffe</td>
<td>251,450</td>
<td>252,974</td>
<td>1,524</td>
<td>1%</td>
<td>£13,315,909</td>
<td>£14,078,976</td>
<td>£763,067</td>
<td>6%</td>
</tr>
<tr>
<td>Nottm City</td>
<td>715,553</td>
<td>724,722</td>
<td>9,169</td>
<td>1%</td>
<td>£40,306,642</td>
<td>£40,537,060</td>
<td>£230,418</td>
<td>1%</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>1,501,397</td>
<td>1,545,364</td>
<td>43,967</td>
<td>3%</td>
<td>£83,592,286</td>
<td>£85,550,275</td>
<td>£1,957,990</td>
<td>2%</td>
</tr>
<tr>
<td>Total Contract</td>
<td>1,746,977</td>
<td>1,792,363</td>
<td>45,386</td>
<td>3%</td>
<td>£106,223,986</td>
<td>£107,944,181</td>
<td>£1,720,195</td>
<td>2%</td>
</tr>
</tbody>
</table>

b) Quality and Performance

i) ED

Performance (to 6 September 2016) stands at 73.24% year to date against the 95% standard:

- Q1: 74.66%
- Q2 YTD: 71.29%

The current performance has triggered an additional Contract Query Notice, covering the requirement to meet both the STP trajectory to deliver performance of 89% by the end of March as well as the required 95% national standard. A revised Remediaal Action Plan (RAP) is required which includes clear actions and a trajectory for improvement/delivery. This was signed off by commissioners on 21 July 2016.

ii) Cancer

Year to date performance at the end of quarter 1 was as follows:

- 2ww: April 92.5% against 93% standard, May 93.2% against 93% standard, June 92.5% against 93% standard
- 2ww breast symptoms: April 87% against 93% standard, May 94.7% against 93% standard, June 93.2% against 93% standard
- 62 day urgent RTT: April 82.3% against the 85% standard, May 78.8% against the 85% standard, June 76% (unvalidated) against the 85% standard
The current performance has triggered the contractual requirement for a revised RAP which includes clear actions and a trajectory for improvement/delivery. The previous RAP delivered the actions stated without the corresponding delivery of the standard. A revised RAP has now been agreed by commissioners.

iii) RTT

NUH continues to achieve the national standard of 96.43% in June 2016 against the national standard of 92%. NUH has consistently met this standard over the last 12 month period.

iv) Never Events

There have been 3 never events YTD reported by NUH, details are shown below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Never Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2016</td>
<td>Wrong size implant used in surgery</td>
</tr>
<tr>
<td>May 2016</td>
<td>Misplaced nasogastric tube</td>
</tr>
<tr>
<td>July 2016</td>
<td>Incorrect administering of insulin</td>
</tr>
</tbody>
</table>

c) Contract Performance Notices and Penalties

Commissioners have served additional Contract Performance Notices (CPNs) to Nottingham University Hospitals NHS Trust (NUH) in line with National Standard NHS Contract General Conditions 9 as performance is below national standards for the following indicators, A&E, Cancer 2 week wait, 2 week wait Breast and Cancer 62 days.

Commissioners and NUH representatives have met to develop Remedial Action Plans (RAPs) to ensure required performance is achieved. With the new national requirements around System Transformation Fund, no contractual financial sanctions can be levied.

Contractual fines for other standards to the value of £5,538 have been applied in quarter 1 2016/17.

2) Circle

a) Activity and Finance (month 3 data)

<table>
<thead>
<tr>
<th>CCG</th>
<th>Activity Plan</th>
<th>Activity Actuals</th>
<th>Activity Variance</th>
<th>% Variance</th>
<th>£ Plan</th>
<th>£ Actuals</th>
<th>£ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NW</td>
<td>7,708</td>
<td>7,499</td>
<td>-222</td>
<td>-3%</td>
<td>£1,950,290</td>
<td>£2,049,993</td>
<td>£99,698</td>
<td>5%</td>
</tr>
<tr>
<td>NNE</td>
<td>7,904</td>
<td>8,265</td>
<td>343</td>
<td>4%</td>
<td>£1,870,907</td>
<td>£2,111,194</td>
<td>£240,280</td>
<td>13%</td>
</tr>
<tr>
<td>Rushcliffe</td>
<td>10,755</td>
<td>10,837</td>
<td>65</td>
<td>1%</td>
<td>£2,575,987</td>
<td>£2,850,049</td>
<td>£274,062</td>
<td>11%</td>
</tr>
<tr>
<td>Nottm City</td>
<td>21,793</td>
<td>22,317</td>
<td>644</td>
<td>3%</td>
<td>£5,579,610</td>
<td>£5,900,014</td>
<td>£320,385</td>
<td>6%</td>
</tr>
<tr>
<td>Sub-Total</td>
<td>48,160</td>
<td>48,918</td>
<td>660</td>
<td>1%</td>
<td>£11,976,794</td>
<td>£12,911,250</td>
<td>£934,418</td>
<td>8%</td>
</tr>
<tr>
<td>Total Contract</td>
<td>60,973</td>
<td>62,080</td>
<td>970</td>
<td>2%</td>
<td>£15,858,241</td>
<td>£16,917,560</td>
<td>£1,059,264</td>
<td>7%</td>
</tr>
</tbody>
</table>

b) Quality and Performance

i) Cancer

31 day DTT 99.3% against the 96% standard
ii) **RTT**

Circle continues to meet the RTT standard with performance in July 2016 at 93.86% against the 92% standard. Circle has consistently met this standard over the last 12 month period.

**c) Contract Performance Notices and Penalties**

No contract performance notices have been triggered in Q1.

Contract penalties to the end of July 2016 total £47,948 across all commissioners. These are in relation to the RTT incomplete pathway and 28 day readmissions.

3) **CHP**

a) **Activity and Finance**

These contracts are block contracts in 2016/17; therefore activity levels are not necessarily reflective of funding levels.

There are still data quality issues around the new reporting requirements for activity and KPIs. These are being worked through via the Outcomes and Performance Groups, as well as each individual Contract Monitoring Meeting.

Reporting is slowly starting to improve, and CHP are giving greater assurances that they are working with services and applied informatics to resolve, which will mean improved reporting from September.

b) **Quality and Performance**

i) **Pressure ulcers**

April: 18 stage 3/4 pressure ulcers against a target of zero (in April the numbers were counted by those 'reviewed post root cause analysis').

May: 7 stage 3/4 pressure ulcers against a target of zero (from May onwards, the numbers are by 'reported in month')

June: 5 stage 3/4 pressure ulcers against a target of zero

These numbers may increase following the 80 day ratification process.

ii) **Lings Bar (LBH) and the Short Stay Rehabilitation Unit (SSRU)**

In June 2016:

LBH the average length of stay was 33 days, occupancy was 94.2%.

SSRU the average length of stay was 18.1, occupancy was 86%.

Length of stay is slightly above what is expected, and this is due to a more complex cohort of patients being referred into the service. CHP are working with the acute provider to improve referral information, and this is starting to improve. Despite an increase in length of stay, there is capacity within the system, and very little patients waiting for beds at any one time.
iii) 13 Week RTT

The Trust is meeting the expected RTT standard. Some patients are seen post 13 weeks in AHP services due to patient choice.

iv) Workforce

At month 3:

Turnover: 15%
Sickness: 4.6%
Vacancy rate: 5.7%

This information is not currently available at a locality level, thought this will be discussed at a locality level in future at the individual CCG meetings.

v) Outcomes Framework

Q1 outcomes are currently under review, and will be presented at the next relevant contract monitoring meetings for formal agreements.

vi) Patient Experience

In Q1:

The friends and family score was 99%
The service quality rating was 96%.

c) Current Issues

i) A Contract Query Notice has been raised for Dietetics during Q1 as there were concerns around capacity of the team, and if demand was being met. Concerns remain but agreement to review end of Q2 as activity monitoring improves.

ii) Generally there are concerns around data quality which does make performance management difficult. However it is worth acknowledging that the data received is much greater than it has been in the past, and is an improvement. Data quality is a priority for the Outcomes and Performance Group, and feeding into each individual Contract Monitoring Meeting.

4) BMI The Park

a) Activity and Finance (Month 3 data)

<table>
<thead>
<tr>
<th>CCG</th>
<th>Activity Plan</th>
<th>Activity Actuals</th>
<th>Activity Variance</th>
<th>% Variance</th>
<th>£ Plan</th>
<th>£ Actuals</th>
<th>£ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NW</td>
<td>114</td>
<td>141</td>
<td>27</td>
<td>23%</td>
<td>£58,686</td>
<td>£58,685</td>
<td>-£1</td>
<td>0%</td>
</tr>
<tr>
<td>NNE</td>
<td>228</td>
<td>399</td>
<td>171</td>
<td>75%</td>
<td>£88,585</td>
<td>£128,191</td>
<td>£39,606</td>
<td>45%</td>
</tr>
<tr>
<td>Rushcliffe</td>
<td>79</td>
<td>51</td>
<td>-28</td>
<td>-35%</td>
<td>£31,048</td>
<td>£22,276</td>
<td>-£8,771</td>
<td>-28%</td>
</tr>
<tr>
<td>Total Contract</td>
<td>421</td>
<td>591</td>
<td>170</td>
<td>40%</td>
<td>£178,319</td>
<td>£209,153</td>
<td>£30,834</td>
<td>17%</td>
</tr>
</tbody>
</table>
b) Quality and Performance

i) Performance

All key performance requirements are on target – no penalties have been levied.

5) Ramsay Woodthorpe Hospital

a) Activity and Finance (Month 3 data)

<table>
<thead>
<tr>
<th>CCG</th>
<th>Activity Plan</th>
<th>Activity Actuals</th>
<th>Activity Variance</th>
<th>% Variance</th>
<th>£ Plan</th>
<th>£ Actuals</th>
<th>£ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NW</td>
<td>369</td>
<td>330</td>
<td>-39</td>
<td>-10%</td>
<td>£173,315</td>
<td>£164,970</td>
<td>-£8,345</td>
<td>-5%</td>
</tr>
<tr>
<td>NNE</td>
<td>1,852</td>
<td>2,016</td>
<td>164</td>
<td>9%</td>
<td>£706,468</td>
<td>£745,808</td>
<td>£39,340</td>
<td>6%</td>
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<tr>
<td>Rushcliffe</td>
<td>1,000</td>
<td>1,024</td>
<td>24</td>
<td>2%</td>
<td>£357,607</td>
<td>£373,894</td>
<td>£16,287</td>
<td>5%</td>
</tr>
<tr>
<td>Total Contract</td>
<td>3,221</td>
<td>3,370</td>
<td>149</td>
<td>5%</td>
<td>£1,237,391</td>
<td>£1,284,672</td>
<td>£47,281</td>
<td>4%</td>
</tr>
</tbody>
</table>

b) Quality and Performance

i) Performance

All key performance requirements are on target – no penalties have been levied.
<table>
<thead>
<tr>
<th>Meeting Title</th>
<th>NHS Nottingham West CCG Governing Body</th>
<th>Date: 29 September 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper Title</td>
<td>Master Contracts List</td>
<td>Agenda Item: NW/GB/16/368</td>
</tr>
<tr>
<td>Lead Director Report Author</td>
<td>Maxine Bunn, Director of Contracting &amp; Deputy Chief Officer, NWCCG</td>
<td></td>
</tr>
</tbody>
</table>

**Executive Summary**
The Nottingham West Master Contracts List for all contracts with Providers for 2016/17

If paper is for approval, have the following impact assessments been completed?

<table>
<thead>
<tr>
<th>Quality Impact Assessment</th>
<th>Yes</th>
<th>☐</th>
<th>☒</th>
<th>N/A</th>
<th>☐</th>
<th>☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality Impact Assessment</td>
<td>Yes</td>
<td>☐</td>
<td>☒</td>
<td>N/A</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Privacy Impact Assessment</td>
<td>Yes</td>
<td>☐</td>
<td>☒</td>
<td>N/A</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

**Implications:** (please tick where relevant)

| Integration | ☐ | Patient Choice | ☐ |
| Reducing inequality | ☐ | Patient & Public Involvement | ☐ |
| Constitution | ☐ | Quality of Services | ☐ |
| Governance | ☐ | QIPP | ☐ |
| Innovation | ☐ | Research | ☐ |
| Learning and Development | ☐ | Sustainability | ☐ |

**Finance checked by:** (initials)

**Appendices**

**Report History**

**Recommendation**
The Governing Body is asked to:

NOTE the Nottingham West Master Contracts list
<table>
<thead>
<tr>
<th>Provider_Name</th>
<th>Contract_Title</th>
<th>Service_Description</th>
<th>Start_Date</th>
<th>End_Date</th>
<th>Contract_Value</th>
<th>Responsible CCG in County</th>
<th>Contract Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Derbyshire Healthcare NHS Foundation Trust</td>
<td>Neonatal Postnatal Support Service</td>
<td>Psych and post-natal support for people with memory problems or dementia</td>
<td>01/04/2017</td>
<td>31/03/2017</td>
<td>£2,427,764</td>
<td>Mental Health (Derby)</td>
<td>Ellen Kinsley</td>
</tr>
<tr>
<td>Derbyshire Healthcare NHS Foundation Trust</td>
<td>Mental Health and Learning Disability Services in Derbyshire</td>
<td>Mental Health and Learning Disability Services in Derbyshire</td>
<td>01/04/2017</td>
<td>31/03/2017</td>
<td>£286,019,810</td>
<td>Mental Health (Derby)</td>
<td>Ellen Kinsley</td>
</tr>
<tr>
<td>Nottinghamshire Healthcare Nhs Foundation Trust</td>
<td>Mental Health and Learning Disability Services in Nottinghamshire</td>
<td>Mental Health and Learning Disability Services in Nottinghamshire</td>
<td>01/04/2017</td>
<td>31/03/2019</td>
<td>£115,626,192</td>
<td>Mental Health (Nottingham)</td>
<td>Sci Ede</td>
</tr>
<tr>
<td>Nottinghamshire Healthcare Nhs Foundation Trust</td>
<td>AQP</td>
<td>Psychological Therapies</td>
<td>01/04/2017</td>
<td>31/03/2019</td>
<td>£2,472,892</td>
<td>Mental Health (Nottingham)</td>
<td>Marie Crowley</td>
</tr>
<tr>
<td>Nottinghamshire Healthcare Nhs Foundation Trust</td>
<td>AQP MPT</td>
<td>Psychological Therapies</td>
<td>01/04/2017</td>
<td>31/03/2019</td>
<td>£2,472,892</td>
<td>Mental Health (Nottingham)</td>
<td>Marie Crowley</td>
</tr>
<tr>
<td>Tree ITS Ltd</td>
<td>AQP MPT</td>
<td>Psychological Therapies</td>
<td>01/04/2017</td>
<td>31/03/2019</td>
<td>£2,472,892</td>
<td>Mental Health (Nottingham)</td>
<td>Marie Crowley</td>
</tr>
<tr>
<td>Turning Point</td>
<td>AQP MPT</td>
<td>Psychological Therapies</td>
<td>01/04/2017</td>
<td>31/03/2019</td>
<td>£2,472,892</td>
<td>Mental Health (Nottingham)</td>
<td>Marie Crowley</td>
</tr>
<tr>
<td>Nottinghamshire Healthcare Nhs Foundation Trust</td>
<td>Mental Health and Learning Disability Services in Lincolnshire</td>
<td>Mental Health and Learning Disability Services in Lincolnshire</td>
<td>01/04/2017</td>
<td>30/09/2017</td>
<td>£31,529,925</td>
<td>Mental Health (Lincoln)</td>
<td>Ellen Kinsley</td>
</tr>
<tr>
<td>Nottingham Community Housing Association</td>
<td>Mental Health</td>
<td>Core Residential Homes (34 beds) for city and county</td>
<td>01/04/2017</td>
<td>30/09/2017</td>
<td>£291,780</td>
<td>Mental Health (Nottingham)</td>
<td>Ellen Kinsley</td>
</tr>
<tr>
<td>Mustard Seed Advocacy CIC</td>
<td>CAMHS CVS 5 Mustard Seed</td>
<td>Mental Health Services for Children &amp; Young People (Bereavement 0-18 years)</td>
<td>01/04/2016</td>
<td>31/03/2017</td>
<td>£17,000</td>
<td>Mental Health (Nottingham)</td>
<td>Ellen Kinsley</td>
</tr>
<tr>
<td>Mustard Seed Advocacy CIC</td>
<td>CAMHS CVS 5 Mustard Seed</td>
<td>Mental Health Services for Children &amp; Young People (Grief 0-18 years)</td>
<td>01/04/2016</td>
<td>31/03/2017</td>
<td>£17,000</td>
<td>Mental Health (Nottingham)</td>
<td>Ellen Kinsley</td>
</tr>
<tr>
<td>Family Care</td>
<td>CAMHS CVS 7 Family Care</td>
<td>Treatment of emotional health and well-being for children (Aged 0-18 years)</td>
<td>01/04/2016</td>
<td>31/03/2017</td>
<td>£17,000</td>
<td>Mental Health (Nottingham)</td>
<td>Ellen Kinsley</td>
</tr>
<tr>
<td>POCAEN</td>
<td>Non-Statutory Advocacy</td>
<td>Advocacy for people admitted to Mental Health or Learning Disability Units who are not under a section of the Mental Health Act</td>
<td>01/04/2016</td>
<td>30/03/2018</td>
<td>£25,212</td>
<td>Mental Health (Nottingham)</td>
<td>Ellen Kinsley</td>
</tr>
<tr>
<td>Emmanuel House</td>
<td>Mental Health Support Team</td>
<td>Mentally ill in the community</td>
<td>01/04/2016</td>
<td>31/03/2017</td>
<td>£25,000</td>
<td>Mental Health (Nottingham)</td>
<td>Ellen Kinsley</td>
</tr>
<tr>
<td>Hope's Haven</td>
<td>Mental Health Support Team</td>
<td>Mentally ill in the community</td>
<td>01/04/2016</td>
<td>31/03/2017</td>
<td>£25,000</td>
<td>Mental Health (Nottingham)</td>
<td>Ellen Kinsley</td>
</tr>
<tr>
<td>Framework</td>
<td>The Star Project</td>
<td>Homelessness accommodation and mental health support</td>
<td>01/04/2016</td>
<td>31/03/2017</td>
<td>£31,853</td>
<td>Mental Health (Nottingham)</td>
<td>Ellen Kinsley</td>
</tr>
</tbody>
</table>
Sherwood Forest Hospitals NHS AQP
Foundation Trust

AQP Non-Obstetric Ultrasound

01/04/2016

31/03/2019

AQP

AQP

North contract team
Richard Moles
(Mansfield and Ashfield)

Mansfield and Ashfield

Sherwood Forest Hospitals NHS AQP
Foundation Trust

Driect Access MRI

01/04/2016

31/03/2017

AQP

AQP

North contract team
Richard Moles
(Mansfield and Ashfield)

Mansfield and Ashfield

TICCS (The Integrated Care
Clinics)

AQP Non-Obstetric Ultrasound

01/04/2016

31/03/2019

AQP

AQP

North contract team
Richard Moles
(Mansfield and Ashfield)

Mansfield and Ashfield

Acute Services

01/04/2016

31/03/2017

£5,708,530

£55,847

North contract team
Dale Johnson
(Mansfield and Ashfield)

Lincolnshire PCT

Self Help Nottingham

Supports a wide range of self help groups within 01/04/2014
Nottinghamshire

31/03/2017

£80,987

£11,039

North contract team
Helen Shrives
(Mansfield and Ashfield)

Mansfield and Ashfield

Age UK

LBH Patient Representative
Service

Advocacy Services Lings Bar

01/04/2016

31/03/2019

£9,620

£1,689

South contract team
(Nottingham north and
east)

Sharon Geggie

Barnardos and NUH

Butterfly Project

Service for Children and Young People with Life 01/04/2007
limiting conditions

31/06/2016

£149,592

£18,347

South contract team
(Nottingham north and
east)

Sharon Geggie

Barnardos

Support Services for Children & Service for Children and Young People with Life 01/07/2016
Young People with Palliative
limiting conditions
Care Needs

31/03/2019

£149,592

£18,347

South contract team
(Nottingham north and
east)

Sharon Geggie

Base 51

Base 51 - Core Services

Contribution to post

01/04/2016

31/03/2019

£9,351

£1,275

South contract team
(Nottingham north and
east)

Sharon Geggie

Bassetlaw Health Partnership

Community Services

Community Services

01/04/2016

31/03/2017

N/A

South contract team
(Nottingham north and
east)

Tracey Duggan

British Pregnancy Advisory
Service [BPAS]

TOP Service - Pre-Assessment Central booking and pre-assessment service for 01/04/2015
and Early TOPs (up to 14
termination of pregnancy. Early terminations of
weeks)
pregnancy up to 14 weeks' gestation.

31/03/2018

£47,702

£47,702

South contract team
(Nottingham north and
east)

Leon Blackwell

British Pregnancy Advisory
Service [BPAS]

AQP: Later TOPs (14 to 24
weeks)

AQP: Provision of late terminations of
pregnancy 14 to 24 weeks' gestation.

01/04/2015

31/03/2018

£0

£0

South contract team
(Nottingham north and
east)

Leon Blackwell

British Red Cross

Crisis Intervention Community
Support Service (CICSS)

Crisis Response Support Service to prevent
admissions to hospital

01/04/2013

31/03/2018

£303,752

£130,953

South contract team
(Nottingham north and
east)

Sharon Geggie

Communication Aids for
Children

Section 75

Communication aids

01/04/2016

31/03/2019

£28,318

£3,860

South contract team
(Nottingham north and
east)

Sharon Geggie

Connect

CMATS

MSK Assessment & Treatment

01/04/2016

31/03/2021

£1,469,348

£527,901

South contract team
(Nottingham north and
east)

Tracey Duggan

Community Services

01/04/2016

31/03/2017

£87,226,156

£939,848

South contract team
(Nottingham north and
east)

Tracey Duggan

AQP

United Lincolnshire Hospitals
NHS Trust
Self Help Nottingham

SOUTH CONTRACTS TEAM

Derbyshire Community Services
NHS Trust

Bassetlaw CCG

North Derbyshire CCG

ERS Medical

CAS Referral Gateway

CAS Referral Gateway

01/04/2015

31/03/2018

#REF!

£9,868

South contract team
(Nottingham north and
east)

Sharon Geggie

Home Start

Home Start

Offers one to one support to families with
children under 5 years old

01/04/2016

31/03/2017

£126,576

£8,621

South contract team
(Nottingham north and
east)

Sharon Geggie

Leicestershire Partnership NHS Leicestershire Alliance
Trust

Community Services (Outpatients)

01/04/2015

31/03/2017

£23,715,004

N/A

South contract team
(Nottingham north and
east)

Tracey Duggan

Lesbian and Gay Switchboard

Telephone Helpline

Provision of a switchboard that gives
information, help and advice on all matters
concerning lesbian and gay sexuality,
bisexuality, transvestism and transsexualism

01/04/2016

31/03/2019

£1,550

£61

South contract team
(Nottingham north and
east)

Sharon Geggie

Marie Stopes International

AQP: Later TOPs (14 to 24
weeks)

AQP: Provision of late terminations of
pregnancy 14 to 24 weeks' gestation.

01/04/2015

31/03/2018

£0

£0

South contract team
(Nottingham north and
east)

Leon Blackwell

Nottingham CityCare
Partnership (from 1.7.15)

Continuing Health Care Service - Provision of administrative and service support
Service Support
for continuing care and free nursing care

01/07/2015

30/06/2018

£1,199,273.00

£167,179

South contract team
(Nottingham north and
east)

Vicky Bailey

Rushcliffe CCG

Nottingham CityCare
Partnership

STOC

Supported Transfer of Care

01/04/2016

31/03/2017

£394,676

£65,161

South contract team
(Nottingham north and
east)

Tracey Duggan

Nottingham City

Nottingham CityCare
Partnership

CityCare Contract

Weekend Treatment Room Service (cv'd into
main CityCare Contract)

01/10/2015

30/09/2016

£30,000

£1,800

South contract team
(Nottingham north and
east)

Tracey Duggan

Nottingham City

Nottingham CityCare
Partnership

Urgent Care Centre

Urgent Care Walk-in Centre, Seaton House

01/10/2015

30/09/2018

£2,464,467

£86,402

South contract team
(Nottingham north and
east)

Tracey Duggan

Nottingham City

Nottingham Community Minor
Surgery Services (Nottingham
Road Clinic)

Community Vasectomy Service

Community Vasectomy Service

01/04/2014

31/03/2017

£0

South contract team
(Nottingham north and
east)

Sharon Geggie

Nottinghamshire County Council Action for Children/Future Minds

£15,463

£2,108

South contract team
(Nottingham north and
east)

Sharon Geggie

Nottinghamshire Healthcare
NHS Foundation Trust

Rushcliffe Integrated Care Team Adult Integrated Care & CHD Diagnostics

01/04/2016

31/03/2021

£4,421,338

N/A

South contract team
(Nottingham north and
east)

Tracey Duggan/Helen
Griffiths

Nottinghamshire Healthcare
NHS Foundation Trust

NNE Integrated Care Team

Adult Integrated Care & Phlebotomy

01/04/2016

31/03/2021

£5,989,509

N/A

South contract team
(Nottingham north and
east)

Tracey Duggan/Stewart
Newman

Nottinghamshire Healthcare
NHS Foundation Trust

NW Integrated Care Team

Adult Integrated Care & Phlebotomy

01/04/2016

31/03/2021

£5,275,274

£5,275,274

South contract team
(Nottingham north and
east)

Tracey Duggan/Kelly
Wallace

Nottinghamshire Healthcare
NHS Foundation Trust

Evening & Night Service

01/04/2016

31/03/2021

£404,845

£89,541

South contract team
(Nottingham north and
east)

Tracey Duggan

Nottinghamshire Healthcare
NHS Foundation Trust

ICCYPH

01/04/2016

31/03/2021

£9,825,213

£662,699

South contract team
(Nottingham north and
east)

Tracey Duggan

Nottinghamshire Healthcare
NHS Foundation Trust

Children in Care

Community Nursing

01/04/2016

31/03/2021

£434,946

£18,832

South contract team
(Nottingham north and
east)

Tracey Duggan

Nottinghamshire Healthcare
NHS Foundation Trust

AHP

Adult Speech & Language Therapy. Community 01/04/2016
Dietetics & Podiatry

31/03/2021

£1,989,025

£458,296

South contract team
(Nottingham north and
east)

Tracey Duggan

Nottinghamshire Healthcare
NHS Foundation Trust

Short Term Rehab

Community Beds Provision

01/04/2016

31/03/2021

£7,386,489

£1,337,749

South contract team
(Nottingham north and
east)

Tracey Duggan

Nottinghamshire Healthcare
NHS Foundation Trust

Stroke

Community Stroke Team

01/04/2016

31/03/2017

£372,053

£75,953

South contract team
(Nottingham north and
east)

Tracey Duggan

Nottinghamshire Healthcare
NHS Foundation Trust

Mid Nottinghamshire Community Community Services
Services

01/04/2016

31/03/2017

£24,957,244

N/A

South contract team
(Nottingham north and
east)

Tracey Duggan

Nottinghamshire Hospice

End of Life & Bereavement
Services

01/04/2016

31/03/2021

#REF!

£183,244

South contract team
(Nottingham north and
east)

Sharon Geggie

Palliative Care Services

East Leicestershire &
Rutland

Mansfield & Ashfield
CCG


The service aims to provide care for children and young people (aged 0-25 years) who are the victims or have potential care needs and support for their families/local communities or schools.

Management of chronic pain in the community - adults, children and young people (aged 0-25 years) who are the victims or have potential care needs and support for their families/local communities or schools.

Management of chronic pain in the community.

Management of chronic pain in the community.

Management of chronic pain in the community.

Management of chronic pain in the community.

Management of chronic pain in the community.

Management of chronic pain in the community.

Management of children, young people, and families with complex and chronic conditions.

Management of children, young people, and families with complex and chronic conditions.

Management of chronic pain in the community.

Community Behaviour Support - Embedded into the Community.

Management of chronic pain in the community.

Management of chronic pain in the community.

Management of chronic pain in the community.
<table>
<thead>
<tr>
<th>Carers Federation</th>
<th>Carer Support Worker</th>
<th>Support member practices to embed the carers' agenda into their GP practice</th>
<th>01/02/2016</th>
<th>31/03/2018</th>
<th>£64,911</th>
<th>£64,911</th>
<th>Nottingham West</th>
<th>Rachael Harrold</th>
</tr>
</thead>
</table>

Contract List last updated 10/08/2016
<table>
<thead>
<tr>
<th>Purpose (tick one only)</th>
<th>Approval</th>
<th>☒</th>
<th>Acknowledge/ Note</th>
<th>☐</th>
<th>Review</th>
<th>☐</th>
<th>For Information</th>
<th>☐</th>
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</thead>
</table>

### Executive Summary

At the August 2016 meeting of the CCG Governing Body a number of changes were agreed to the CCG Committee structure which required transacting into specific changes to terms of reference and the CCG Corporate Governance Framework (Constitution, Standing Orders and Scheme of Reservation Delegation).

These have now been completed and are presented to the Governing Body for approval. In addition to the governance framework revisions, there are a number of further good governance housekeeping items for the attention of the Governing Body, specifically:

- CCG Indemnity Arrangements
- Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England

If paper is for approval, have the following impact assessments been completed?

<table>
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<tr>
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<th>No</th>
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<tbody>
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<td>Equality Impact Assessment</td>
<td>Yes</td>
<td>☒</td>
<td>No</td>
<td>☐</td>
<td>N/A</td>
<td>☒</td>
</tr>
<tr>
<td>Privacy Impact Assessment</td>
<td>Yes</td>
<td>☒</td>
<td>No</td>
<td>☒</td>
<td>N/A</td>
<td>☒</td>
</tr>
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</table>

**Implications:** (please tick where relevant)

- Integration ☐
- Patient Choice ☐
- Reducing inequality ☐
- Patient & Public Involvement ☒
- Constitution ☒
- Quality of Services ☐
- Governance ☒
- QIPP ☐
- Innovation ☐
- Research ☐
- Learning and Development ☐
- Sustainability ☐

Finance checked by:  

(initials)

### Appendices

- Appendix A – Committee Handbook
- Appendix B - Impact Assessment of Proposed Variations to NWCCG Constitution
- Appendix C - Revised draft Constitution including tracked changes
<table>
<thead>
<tr>
<th>Report History</th>
<th>Appendix D - Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation</strong></td>
<td>The Governing Body is asked to:</td>
</tr>
<tr>
<td></td>
<td>• Approve the terms of reference and membership of the revised committee structure</td>
</tr>
<tr>
<td></td>
<td>• Approve the changes to the CCG Constitution and Standing Orders</td>
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<td></td>
<td>• Resolve that “A Chairman, Lay Member, any other Governing Body member or Clinical Lead who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution or his or her CCG function, save where the person has acted recklessly”.</td>
</tr>
<tr>
<td></td>
<td>• Confirm commitment to upholding the Standards for members of CCG Governing Bodies, and</td>
</tr>
<tr>
<td></td>
<td>• Provide feedback in terms of any training and development requirements to enable compliance with the Standards.</td>
</tr>
</tbody>
</table>
Revisions to the CCG Committee structure and Corporate Governance Framework

1. Purpose and Context

At the last meeting of the CCG Governing Body a number of changes were agreed to the CCG Committee structure which required transacting into specific changes to terms of reference and the CCG Corporate Governance Framework (Constitution, Standing Orders and Scheme of Reservation Delegation).

These have now been completed and are presented to the Governing Body for approval. This report also presents some items of good governance housekeeping for the attention of the Governing Body.

2. Background

This report builds on the recent governance review which looked at all aspects of governance within the CCG and proposed changes in relation to the composition of the Governing Body and the CCG committee structure. The outcomes of the CCG Governance Review presented and approved at the August 2016 Governing Body meeting.

In summary, the outcomes which were approved by the Governing Body following the review were:

- Revisions to the CCG committee structure; establishing the Clinical Development Committee and Finance and Performance Committee in place of the Clinical Innovation Group and the Finance and Information Group respectively
- Revisions to the membership of the Governing Body to ensure parity with CCGs across the East Midlands and to meet the requirements of revised conflicts of interest statutory guidance
- Changes to terms of office for non-officer members to ensure consistency across roles.

The revised committee structure is described in more detail in the Committee Handbook at Appendix A which describes the terms of reference and proposed membership for each committee. In addition to the development of the Clinical Development Committee and Finance and Performance Committee terms of reference, the terms of reference for the Governing Body, Remuneration Committee and the Primary Care Commissioning Committee have been revised and are presented for approval.

Recommendation 1. The Governing Body is asked to approve the terms of reference and membership of the revised committee structure.

As part of the implementation of the revised committee structure, it is suggested that:

- Each committee prepares and regularly reviews its rolling plan covering a 6-12 month period, these plans will be shared with the Governing Body
• Papers for each committee be made electronically available to all Governing Body members at the same time that they are distributed to committee members, enabling Governing Body members to have a wider view of business flowing across the organisation and to seek more information on specific items required.

3. Revisions to the Corporate Governance Framework

To support the introduction of the revised committee arrangements, a number of enabling revisions are proposed to the CCG Constitution and Standing Orders. The detail of the material changes to the constitution is presented in table 1 below.

A completed impact assessment of the changes, which covers as a minimum the factors to be considered by NHS England has been completed and is appended (Appendix B) to this report to provide assurance to the Governing Body. The revised draft Constitution including the tracked changes is appended (Appendix C).

<table>
<thead>
<tr>
<th>Clause</th>
<th>Section</th>
<th>Amendment</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.1</td>
<td>Membership of the Clinical</td>
<td>Removal of Doctors Corner Branch Surgery of Linden Medical Practice</td>
<td>The branch surgery was closed in July 2016.</td>
</tr>
<tr>
<td></td>
<td>Commissioning Group</td>
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<tr>
<td>Throughout</td>
<td>Throughout</td>
<td>References to the Clinical Innovation Group amended to Clinical Development Committee</td>
<td>The committee terms of reference and title were reviewed as part of CCG review of corporate governance</td>
</tr>
<tr>
<td>Throughout</td>
<td>Throughout</td>
<td>References to the Finance and Information Group amended to Finance and Performance Committee</td>
<td>The committee terms of reference and title were reviewed as part of CCG review of corporate governance</td>
</tr>
<tr>
<td>5.3.1 (d)</td>
<td>Budgetary Control and Reporting</td>
<td>Removal of reference to provision of financial services from the commissioning support unit.</td>
<td>Technical and financial accounting services that were provided by the commissioning support unit are now provided in house by the shared CCG finance team</td>
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<tr>
<td>6.7.5</td>
<td>Joint Arrangements</td>
<td>The addition of a new joint committee – East Midlands Affiliated Commissioning Committee (EMACC)</td>
<td>EMACC has been established across 19 East Midlands CCGs as a joint committee to enable collaborative working on the development and maintenance of commissioning policies on a regional scale</td>
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<tr>
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<tr>
<td>6.8.2</td>
<td>Composition of the Governing Body</td>
<td>The composition of the Governing Body has been updated to reflect the changes to the leadership arrangements for the CCG. Specifically, the changes are: - Removal of the Chief Operating Officer - Removal of the Clinical Lead and Accountable Officer - Addition of the Accountable Officer - Addition of the GP Chair (the designated Clinical Leader as required by NHSE) - Revision of the CCG Chairman role to become Lay Member lead for PPI - Addition of a new Lay Member role</td>
<td>NHS England requires that one of the two key leadership roles in the CCG (either Accountable Officer of Chair) be undertaken by a practicing GP. Due to the recent leadership changes the Accountable Officer role will be a management lead, the CCG is required to review the Chair arrangements. The GP Chair is now the Chair of the CCG and the Governing Body. The Chairman role has now been revised to focus on Lay Member of PPI, and will also act as deputy chair should conflicts of interest preclude the GP Chair from chairing the Governing Body meeting. The additional Lay Member role has been added to comply with NHS England recommendations relating to conflicts of interest management.</td>
</tr>
<tr>
<td>6.8.4</td>
<td>Remuneration Committee</td>
<td>Amended to reflect the decision making authority delegated to the Remuneration Committee.</td>
<td>This change has been made to ensure consistency with the scheme of reservation and delegation and the terms of reference of the committee.</td>
</tr>
<tr>
<td>6.8.4</td>
<td>Medicines Management Group</td>
<td>The reference to this group has been removed from the constitution</td>
<td>Following a review of CCG governance, it was determined that the Medicines Management Group would become a sub-group of the Clinical Development Committee rather than the Governing Body.</td>
</tr>
<tr>
<td>Clause</td>
<td>Section</td>
<td>Amendment</td>
<td>Rationale</td>
</tr>
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</tr>
<tr>
<td>6.8.4</td>
<td>East Midlands Affiliated Commissioning Committee</td>
<td>The addition of a new joint committee – East Midlands Affiliated Commissioning Committee (EMACC)</td>
<td>EMACC has been established across 19 East Midlands CCGs as a joint committee to enable collaborative working on the development and maintenance of commissioning policies on a regional scale.</td>
</tr>
<tr>
<td>7.3</td>
<td>Role of the Chair of the Governing Body</td>
<td>This section has been revised and is now headed “The GP Chair of the Governing Body”.</td>
<td>NHS England requires that one of the two key leadership roles in the CCG (either Accountable Officer of Chair) be undertaken by a practicing GP. Due to the recent leadership changes the Accountable Officer role will be a management lead, the CCG is required to review the Chair arrangements. The GP Chair is now the Chair of the CCG and the Governing Body. The Chairman role has now been revised to focus on Lay Member of PPI, and will also act as deputy chair should conflicts of interest preclude the GP Chair from chairing the Governing Body meeting.</td>
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<tr>
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<td>Amendment</td>
<td>Rationale</td>
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<tr>
<td>Standing Orders 2.3 (pg 58)</td>
<td>The Chair of the Governing Body</td>
<td>This section has been revised and is now headed “The GP Chair of the Governing Body”. As this position is now to be undertaken by a practicing clinician, the Nominations process, eligibility criteria, appointments process, term of office, eligibility for re-appointment, grounds for removal of office and notice period have all been revised and aligned to NHS England guidance for the appointment of Governing Body members.</td>
<td>To reflect the change in leadership arrangements for the CCG</td>
</tr>
<tr>
<td>Standing Orders 2.4 (pg 59)</td>
<td>Clinical Lead and Accountable Officer</td>
<td>This section has now been removed from the constitution.</td>
<td>To reflect the changes in leadership arrangements for the CCG</td>
</tr>
<tr>
<td>Standing Orders 2.6 (pg 67)</td>
<td>Lay Member Elected by the Patient Reference Group</td>
<td>This title of this role has been amended from Lay Member to “Elected Patient Representative of the Patient Reference Group”</td>
<td>This amendment is to reflect the fact that the role was not a formal Lay Member subject to the recruitment processes required, but an elected member of the Governing Body, elected from the CCG Patient Reference Group</td>
</tr>
<tr>
<td>Standing Orders 2.7 (pg 67)</td>
<td>Lay Member, Audit and Remuneration</td>
<td>The term of office for this position has been amended from two years to three years.</td>
<td>This is to bring this into line with the terms of office of other lay members of the CCG – as agreed at the June Governing Body Development Session.</td>
</tr>
<tr>
<td>Standing Orders 2.8 (pg 72)</td>
<td>Lay Member Patient and Public Involvement (and Deputy Chair)</td>
<td>This is a new section which has been inserted to reflect the change in leadership arrangements.</td>
<td>The Chairman role has now been revised to focus on Lay Member of PPI, and will also act as deputy chair should conflicts of interest preclude the GP Chair from chairing the Governing Body meeting.</td>
</tr>
<tr>
<td>Clause</td>
<td>Section</td>
<td>Amendment</td>
<td>Rationale</td>
</tr>
<tr>
<td>-------------</td>
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<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Standing</td>
<td>Lay Member</td>
<td>Additional Governing Body Role of Lay Member</td>
<td>NHS England guidance on Conflicts of interest strongly recommends that CCGs have a minimum of three Lay Member roles. This role has been added to the constitution to ensure compliance with the guidance.</td>
</tr>
<tr>
<td>Orders 2.9</td>
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<tr>
<td>Standing</td>
<td>Accountable Officer</td>
<td>This section has been added to reflect the new leadership role for the CCG. It outlines the Nominations process, eligibility criteria, appointments process, term of office, eligibility for re-appointment; grounds for removal of office and notice period have all been revised and aligned to NHS England guidance for the appointment of Governing Body members.</td>
<td>To reflect the forthcoming changes in leadership arrangements for the CCG</td>
</tr>
<tr>
<td>Orders 2.10</td>
<td></td>
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</tr>
<tr>
<td>Scheme of Reservation and Delegation</td>
<td>Annual Reports and Accounts</td>
<td>The review and approval of the CCG’s Annual Report and Accounts will be delegated to the Audit and Governance Committee</td>
<td>To ensure that the Annual Report and Accounts can be approved in a timely manner, in line with national timeframes.</td>
</tr>
<tr>
<td>(Pg 88)</td>
<td></td>
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</tr>
<tr>
<td>Appendix G</td>
<td>NHS Constitution</td>
<td>This section has been updated to reflect the recently published changes made to the NHS Constitution (July 2015)</td>
<td>To ensure the CCG Constitution remains contemporaneous with national guidance.</td>
</tr>
<tr>
<td>(pg 107)</td>
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</tbody>
</table>

**Recommendation 2.** The Governing Body is asked to approve the changes to the CCG Constitution and Standing Orders.

### 3.1 Governance Framework Timescales

Subject to Governing Body agreement, moves to the new structure will be made from October 2016.

### 4. CCG Indemnity Arrangements

The CCG must use reasonable skill in carrying out its functions and is liable for the acts or omissions of its staff in the course of their employment and of its members and officers in carrying out CCG duties. Any claim for damages in relation to these executive decisions (for example, agreement of contracts) would need to be brought against the CCG as a body corporate rather than individual members or employees of the CCG. A right of action does not attach to the individual member, officer, employee or other person concerned. As the
CCG is responsible for the risks arising from its executive decisions, it is necessary to make arrangements to manage those risks. The CCG is a member of the NHSLA Liabilities to Third Parties Scheme (LTPS) and the Property Expenses Scheme (PES). LTPS typically covers employers’ and public liability but also extends to cover the personal liabilities of the members of NHS boards, including non-executive directors.

Claims for damages for clinical negligence are likely to be made against providers so it would be very unusual for a clinical negligence case to be brought against a commissioner. In the unlikely event of a claim for damages for clinical negligence against a CCG, this would need to be brought against the CCG as a body corporate. A right of action would not attach to an individual member, officer, employee or other person concerned. The CCG is not a member of the NHSLA Clinical Negligence Scheme for Trusts.

Section 69 of the NHS Act 2006 makes provision for protection from personal liability; all officers and members whether employed by the CCG or otherwise, are indemnified by the Department of Health as being the holder of a public office when acting in their CCG capacity. However, this existing blanket cover does not necessarily extend to legal action being taken personally against an individual instead of, or as well as in the role as a member of the Governing Body. Since it would be unreasonable for members to be personally at risk when acting on behalf of the CCG it is proposed they be indemnified by the CCG using its power to do things incidental to its functions (Section 2 NHS 2006 Act). This achieved by the Governing Body resolving that:

“A Chairman, Lay Member, any other Governing Body member or Clinical Lead who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution or his or her CCG function, save where the person has acted recklessly”.

It is important to note that the proposed indemnity would only cover Governing Body members and Clinical Leads whilst acting in this capacity for the CCG. The indemnity would not in any way extend to other capacities in which they operate, for example, as practicing clinicians, for which members remain responsible for making their own arrangements.

**Recommendation 3. The Governing Body is asked to RESOLVE that “A Chairman, Lay Member, any other Governing Body member or Clinical Lead who has acted honestly and in good faith will not have to meet out of his or her own personal resources any personal civil liability which is incurred in the execution or purported execution or his or her CCG function, save where the person has acted recklessly”**.

**5. Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England**

All members of CCG Governing Bodies should understand and be committee do the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and the limitations of their personal responsibilities. To this end, the Professional Standards authority published the “Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England”.
The Standards bring together the essential skills that are expected of all executive and non-executive leaders in terms of personal behaviour, technical competence and business practices and are based on seven core values: responsibility, honesty, openness, respect, professionalism, leadership, and integrity. The Standards challenge people to take responsibility for their own behaviour, to challenge the behaviour of others, and to recognise and resolve conflicts of interest.

The standards are appended to this report (Appendix D).

**Recommendation 4. All members of the Governing Body are:**

- Requested to confirm their commitment to upholding the Standards, and
- Provide feedback in terms of any training and development requirements to enable compliance with the Standards.
Purpose

This handbook sets out the Governing Body’s revised committee structure following the recent review; it includes terms of reference, decision making powers, membership and dates of future meetings. The handbook will be updated annually by the Governance team and will be available on the Nottingham West CCG website.

The Governing Body

The Governing Body has the overall function and duty of establishing and maintaining the strategic direction of the CCG. It agrees the vision, strategy and policy, and agrees a forward plan with clear objectives to deliver the CCG’s purpose. The Governing Body must be risk aware and receive assurance about progress against aims and targets.

The Governing Body provides leadership in developing a healthy culture for the organisation and ensuring this is modelled in Governing Body behaviour and decision making. It ensures that decisions are made in the best interest of patients and the public. It receives and assures itself on the integrity of accurate, timely and clear financial, performance and quality intelligence.

Committee Summary

The following table briefly describes the roles of each of the committees reporting to the Governing Body:

<table>
<thead>
<tr>
<th>Committee</th>
<th>Role Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Development Committee</td>
<td>Drive forward Nottingham West CCGs clinical and service development agenda to support the delivery of NHS West CCGs objectives and plans.</td>
</tr>
<tr>
<td>Remuneration Committee</td>
<td>Makes determinations about remuneration, fees and allowances for employees of the CCG and people who provide services to the CCG; and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.</td>
</tr>
<tr>
<td>Finance &amp; Performance Committee</td>
<td>Provide assurance to the Governance Body on the workings of the CCGs financial strategy, planning and delivery cycles.</td>
</tr>
<tr>
<td>Patient Reference Group</td>
<td>Represent the patients, public and carers of Nottingham West in the business of the CCG through active participation and provide a two-way communication channel between patients, the public of Nottingham West, and NHS Nottingham West CCG.</td>
</tr>
<tr>
<td>Audit &amp; Governance Committee</td>
<td>Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s</td>
</tr>
<tr>
<td>Committee</td>
<td>Activities</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>East Midlands Affiliated Commissioning Committee (EMACC)</td>
<td>Enables the CCGs to work collaboratively on the development and maintenance of policies for services which CCGs have responsibility for commissioning; and new policies identified as being appropriate for identical implementation on a regional scale.</td>
</tr>
<tr>
<td>Quality &amp; Risk Committee</td>
<td>Monitor, review and provide assurance that services commissioned by the CCGs are being delivered in a high quality and safe manner, and to promote a culture of continuous improvement and innovation by focussing on the three quality domains; Patient Safety, Patient Experience and Clinical Effectiveness.</td>
</tr>
<tr>
<td>Primary Care Co-Commissioning Committee</td>
<td>Make decisions on the review, planning and procurement of primary care services in Nottingham West, under delegated authority from NHS England.</td>
</tr>
<tr>
<td>Individual funding Request Panel</td>
<td>Consider funding requests for individuals who seek NHS commissioned services outside established commissioning policies.</td>
</tr>
<tr>
<td>Information Governance, Management &amp; Technology Committee</td>
<td>Support and drive the broader information governance and information management and technology agendas.</td>
</tr>
<tr>
<td>Safeguarding Committee</td>
<td>Ensure that systems and processes are in place to safeguard vulnerable adults and children as a core component of the services provided and commissioned by the six Nottinghamshire CCGs.</td>
</tr>
</tbody>
</table>
The Committee Structure

- **Remuneration Committee**
  - Make decisions on the remuneration and terms of service of the Chief Officer, Chief Finance Officer and other senior staff.
  - Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities.
  - Consider relevant financial, activity and information issues affecting the CCG and its member practices.
  - Ensure that there is an effective Internal Audit function.

- **Audit & Governance Committee**
  - Monitor and evaluate the performance of the Chief Officer, Chief Finance Officer and other senior staff.
  - Monitor the integrity of the financial statements of the CCG, ensuring that the systems for financial reporting to the Governing Body are subject to review.
  - Assess financial risk and recommend mitigating actions to members and the Governing Body.
  - Identify and develop new opportunities for service change and integration.

- **Finance & Performance Committee**
  - Advise the Governing Body on matters relating to pensions, allowances or gratuities.
  - Identify risks of non-delivery of the QIPP plan and recommend mitigating actions.
  - Agree financial plan principles and assumptions.

- **Clinical Development Committee**
  - Provide clinical leadership across all service redesign and change programmes.
  - Identify and develop new opportunities for service change and integration.
  - Advise the Governing Body on priority areas for service redesign, taking account of local health needs.

- **Primary Care Co-Commissioning Committee**
  - Making decisions relating to the commissioning, procurement and management of Primary Medical Services contracts.
  - Approval of practice mergers.
  - Making decisions in relation to the management of poorly performing GP practices.
  - Undertaking reviews of Primary Medical Services in the area.

- **Patient Reference Group**
  - Represent the patients, public and carers of Nottingham West in the business of the CCG through active participation and provide a two-way communication channel between patients, the public of Nottingham West, and NHS Nottingham West CCG.
Monitor, review and provide assurance that services commissioned by the CCGs are being delivered in a high quality and safe manner.

Encourage a culture of quality improvement within the CCGs provider and partner organisations.

Consider funding requests for individuals who seek NHS commissioned services outside of established commissioning policies.

Provide assurance to the CCGs that the national and local IG and IM&T strategies are appropriate, supporting the delivery of associated improvements in health whilst facilitating the realisation of clinical and non-clinical benefits.

Recommend the annual work programme which will set out the policies to be developed by EMACC for approval by the Governing Bodies of the participating CCGs.

Ensure that systems and processes are in place to safeguard vulnerable adults and children as a core component of the services provided and commissioned by Nottinghamshire CCGs.
Appendix 1 - Terms of Reference

The following pages set out the terms of reference for each of the Governing Body’s committees, covering purposes of the committee, duties and membership.

Some general principles which apply to all committees are:

- Chairs will agree and set agendas, and approve papers in consultation with the Lead Director and secretary, who will provide support, manage logistics, and arrange for appropriate attendees to be invited for relevant parts of the meeting.

- Minutes and/or Highlight Reports will go to the Governing Body, together with an annual report of performance against objectives. The minutes of all committees should be made accessible on the Nottingham West CCG website.

<table>
<thead>
<tr>
<th>Committee</th>
<th>Page No.</th>
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<tbody>
<tr>
<td>Governing Body</td>
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<tr>
<td>Remuneration Committee</td>
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<tr>
<td>Finance &amp; Performance Committee</td>
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</tr>
<tr>
<td>Primary Care Co-Commissioning Committee</td>
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<td>Quality and Risk Committee</td>
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<tr>
<td>Information Governance, Management &amp; Technology Committee</td>
<td></td>
</tr>
<tr>
<td>East Midlands Affiliated Commissioning Committee</td>
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</tr>
</tbody>
</table>
NHS Nottingham West Clinical Commissioning Group  
Governing Body  
Terms of Reference

<table>
<thead>
<tr>
<th>Role and Purpose</th>
</tr>
</thead>
</table>
| The Governing Body will lead on the delivery of the organisation’s strategic and business objectives, supporting GP practices to work together with local people and other stakeholders to develop and deliver services to improve health and wellbeing to the population served.  

<table>
<thead>
<tr>
<th>Duties</th>
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<tbody>
<tr>
<td><strong>Commissioning</strong></td>
</tr>
<tr>
<td>• Set the commissioning priorities for the CCG and ensure that local provision of quality healthcare is equitably available to patients within Nottingham West, and co-operate in this endeavour with all interested bodies.</td>
</tr>
<tr>
<td>• Develop and oversee the implementation of the strategic aims and objectives of the CCG.</td>
</tr>
<tr>
<td>• Develop business plans, complete service proposals and direct resources to carry out its managerial and commissioning functions on behalf of member practices.</td>
</tr>
<tr>
<td>• Review contractual and other performance information including activity and finance and direct actions as required enabling the CCG to manage its budget within available resources.</td>
</tr>
<tr>
<td>• Lead on reducing health inequalities and matters in relation to Equality Diversity Systems.</td>
</tr>
<tr>
<td>• Seek continuous improvements to quality of care from all commissioned providers and ensure that all services satisfy the highest standards of clinical governance and patient safety.</td>
</tr>
<tr>
<td>• Identify and address any significant risks that may impact on the delivery of strategic objectives.</td>
</tr>
<tr>
<td><strong>Engagement</strong></td>
</tr>
<tr>
<td>• Ensure that local patients and their representatives are fully involved and informed at all stages of the commissioning process, paying due regard to equality considerations and duties.</td>
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<tr>
<td>• Ensure that views of professionals (who work across the wider health economy) are taken into account when making decisions on service issues.</td>
</tr>
<tr>
<td>• Lead and participate in service redesign and the integration of care pathways, in collaboration with other commissioners and providers.</td>
</tr>
<tr>
<td>• Provide leadership on the development of shared partnership, commissioning plans, policies</td>
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### Working with member practices
- Represent all member practices who have signed an agreement to join the CCG.
- Approve payment for work performed by individuals, or practices on behalf of the CCG, including through work streams or a specific incentive scheme.
- The PMG will ensure clinical leadership and representation of member practices in all relevant matters discussed by the Governing Body. The arrangements for urgent decisions are set out in the CCG constitution.

### Governance
- Ensure the highest standards of governance and transparency throughout the organisation.

### Membership
The membership of the NW CCG Governing Body will comprise:
- Lay representative, PPI Lead and E&D Lead*
- Chief Clinical Officer*
- GP (with lead for Finance and Information)*
- Secondary Care Consultant*
- Registered Nurse*
- Lay Representative (with responsibility for Audit & Governance)*
- Elected PRG representative*
- Accountable Officer*
- Chief Finance Officer*
- Lay Member*

*Indicates voting members

Other stakeholder and members of staff will be invited to attend meetings as might be appropriate to the agenda.

### Attendance
Attendance at 75% of meetings per year is required by all members. The Chair will decide on and take appropriate action should Members fail to attend the required number of Governing Body meetings.

A quorum will be one GP/clinical member, two Lay Members, one non-clinical member and one officer member. NW CCG Governing Body will seek agreement and decisions by consensus after debate wherever possible, but otherwise a two-thirds majority in a quorate meeting is required for a motion to be passed.

### Frequency of Meetings
The Governing Body will meet at least six times per year.
Minutes and Reporting

Minutes and papers of each meeting of NW CCG Governing Body will be published on the CCG website seven days in advance of the meeting. The Governing Body is accountable to its member practices via the Practice Members Group.

The Governing Body will hold meetings in public and will provide the opportunity for questions from public attendees. Confidential matters (in accordance with Freedom of Information and Data Protection Act and other relevant legislation and guidance) will be discussed in confidence.

The Governing Body will receive reports monthly from all its committees, including hosted committees for Safeguarding, Quality and Risk, Individual Funding Request Panel, East Midlands Affiliated Commissioning Committee and Information Governance Management and Technology.

Secretary

Secretarial support is provided by the Governance Officer who will be responsible for supporting the Chair in the management of Governing Body business.

Declaration of Interest

All members of the Governing Body will be required to complete a declaration of interest form and report issues as they arise in accordance with the CCG’s Conflicts of Interest Policy.

At the beginning of each meeting members will be required to declare a personal interest if it relates to a particular issue under consideration. Any such declaration will be formally recorded in the minutes of the meeting. The Chair will then make a decision about the member’s participation in the discussion in accordance with the CCG’s Conflict of Interest Policy.

Review

The terms of reference will be reviewed as a minimum annually, or more frequently in response to national policy and local changes.

Date approved by Governing Body:

Review date:
Role and Purpose
The Remuneration Committee will determinations about remuneration, fees and allowances for employees of the CCG and people who provide services to the CCG; and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.

Duties
The principal duties of the Committee are:

- Make decisions on the remuneration and terms of service of the Chief Officer, Chief Finance Officer and other senior staff on pay and conditions of service, ensuring that they are fairly rewarded for their individual contribution, having due regard to the CCG’s circumstances and to any provisions prescribed by the NHS Commissioning Board

- To monitor and evaluate the performance of the Chief Officer, Chief Finance Officer and other senior staff in respect of any bonus or supplementary pay

- To advise on and oversee appropriate contractual arrangements for senior staff including the proper calculation and scrutiny of termination payments, taking account of national guidance as appropriate

- To make decisions and advise the Governing Body on any proposed remuneration for the Chair, Lay members, GP Governing Body members and Clinical Lead/Accountable Officer in connection with their leadership roles within the CCG, and resolve remuneration issues taking into account national guidance and with due regard for the CCG’s circumstances

- To advise the Governing Body on arrangements for establishing and administering one or more pension schemes as appropriate

- To advise the Governing Body on arrangements for providing pensions, allowances or gratuities for its employees

- To consider and advise on any other remuneration or compensation issue referred to it by either the Chair or Chief Officer

Authority
The Remuneration Committee is authorised by the Governing Body to consider any matter within its terms of reference. It is authorised to seek any information it requires from any source, and all employees are directed to co-operate with any request made by it.

The Committee will apply best practice in its decision making processes. When considering individual remuneration the Committee will:

- Comply with current disclosure requirements for remuneration
- Seek independent advice about remuneration for individuals when required
- Ensure that decisions are based on clear and transparent criteria

The Committee may commission any report or survey it deems necessary to fulfil its obligations.

### Membership

The Remuneration Committee shall be appointed by the CCG as set out in its Constitution from amongst its Governing Body members. The membership of the Remuneration Committee is as follows:

- Lay Member leading on PPI (Chair)
- Governing Body Lay Member leading on audit and governance
- Lay Member

Rules governing Members’ qualification, disqualification, appointment, tenure and eligibility for reappointment are detailed in the Group’s Standing Orders (section 2), and in *Clinical commissioning group governing body members – Role outlines, attributes and skills* (NHS Commissioning Board Authority, July 2012)

### Attendance

The Accountable Officer (Chief Officer) shall normally attend meetings. The HR lead and external advisors may be invited to attend for all or part of any meeting as required.

A quorum will be two members.

### Frequency of Meetings

The Remuneration Committee will meet at least once a year and at other times as deemed necessary, occasioned by the needs of the Group. Meetings will be called at the request of the Chair. Where possible, meetings will be arranged to follow a Governing Body meeting.

Where possible, notice of each meeting, including an agenda and supporting papers, will be forwarded to Members not less than five days before the date of the meeting.

### Minutes and Reporting

The Remuneration Committee will report to the Governing Body at the next available meeting (in confidential session), submitting minutes and any other reports.

### Secretary

The Head of Quality, Governance and Engagement will attend meetings to provide appropriate secretarial support to the Chair and the Committee, arranging for minutes of the meeting to be taken, and providing procedural and other guidance as necessary.

### Declaration of Interest

All members of the Remuneration Committee will be required to complete a declaration of interest form and report issues as they arise in accordance with the CCG’s Conflicts of Interest Policy.

At the beginning of each meeting members will be required to declare a personal interest if it relates to a particular issue under consideration. Any such declaration will be formally recorded.
in the minutes of the meeting. The Chair will then make a decision about the member’s participation in the discussion in accordance with the CCG’s Conflict of Interest Policy.

Review

The terms of reference will be reviewed on an annual basis from the date that they were approved by the Governing Body, unless it proves necessary to do so sooner. Any resulting changes to these terms of reference or membership of the Remuneration Committee must be approved by the Governing Body before they shall be deemed to take effect.

Date approved by Governing Body:

Review date:
## Role and Purpose

The purpose of the Finance and Performance Committee is to provide assurance to the Governing Body on the workings of the CCG’s financial strategy, planning and delivery cycles. This will include:

- Oversight of the financial planning process and agreement of the financial plan assumptions and principles.
- Monitoring budgets and patient activity and ensure their delivery against plan.
- Monitoring delivery against the QIPP and financial recovery plans.
- Monitoring of the main services commissioned by the CCG and delivery against performance targets.
- Provide assurance about delivery and sustained performance in these areas to the Governing Body, by reviewing and approving performance reports and recovery action plans in detail prior to Governing Body meetings.

## Duties

The Committee has delegated authority form the Governing Body to monitor budgets and activity and ensure their delivery against plan, reporting all deviations and respective corrective action to the Governing Body. The Committee will be responsible for monitoring delivery against QIPP and financial recovery plans. The Committee will also oversee the financial plan assumptions and principles.

Specifically the Committee will:

- Agree long-term and annual financial plan principles and assumptions
- Receive regular updates on the long-term financial plan and key milestones, together with funding gaps/QIPP requirements
- Assure that the long-term financial plan is consistent with the annual budget
- Agree GP practice budget setting methodology
- Receive and discuss the monthly financial performance report
- Receive and discuss reports on the patient activity and performance targets of the main services commissioned by the CCG
- Consider relevant financial, activity and information issues affecting the CCG and its member practices
- Receive updates on QIPP initiatives and monitor returns against priorities and schedule of delivery
- Identify risks of non-delivery in the QIPP plan and recommend mitigating actions in relation to realignment of the plan against initiatives that are delivering and schedule of delivery
- Review service development and medicines management plans for future QIPP initiatives to address financial challenges
- Review achievement against the CCG incentive schemes and receive reports of the actual and forecast performance to inform the success of incentive schemes
- Assess financial risk and recommend mitigating actions to members and the Governing Body
- Consider topic specific issues as required (catch all?)
The Committee will review on an annual basis the financial limits in the Scheme of Delegation and make recommendations to the Governing Body accordingly.

The Committee will also review the CCGs Assurance Framework and Finance and Performance? Risk Registers at each meeting of the Committee.

**Authority**

The Finance and Performance Committee will act as a formal committee of the NHS Nottingham West CCG Governing Body. The primary purpose of the Committee is to provide the Governing Body with independent and objective assurance and oversight of finance and performance issues to ensure that the CCG meets its obligations.

**Membership**

The membership of the Finance and Performance Committee will be:

- Lay Member (Chair)
- Lay Member – Governance (Deputy Chair)
- Chief Officer
- Chief Clinical Officer
- Chief Finance Officer
- Director of Outcomes and Information /Head of Outcomes and Information
- Director of Contracting/Deputy Chief Officer
- Head of Strategy and Development
- QIPP Lead
- GP Lead for Finance and Information

Membership will be reviewed and adjusted as necessary to ensure the Committee meets its responsibilities, and it can co-opt expert members as necessary to support its function.

A minimum of six members will constitute a quorum, including one Lay Member, one Officer and one GP representative.

Members should nominate another committee member or designated deputy to represent them in their absence.

**Frequency of Meetings**

The Finance and Performance Committee will meet at least ten times a year in a published schedule of meetings. Extraordinary meetings may be held as required.

Agenda and supporting papers will be distributed 7 days in advance of the meeting.

**Minutes and Reporting**

The minutes of the Finance and Performance Committee shall be formally recorded and submitted to the Governing Body alongside a highlight report.

The Chair of the Finance and Performance Committee will once a year report on the effectiveness of the committee in discharging its duties to the Audit and Governance Committee.

An Annual Report of the Finance and Performance Committee will be produced and submitted to
the Governing Body.

**Secretary**
The Executive Assistant will attend meetings to provide appropriate secretarial support to the Chair and the Committee, arranging for minutes of the meeting to be taken, and providing procedural and other guidance as necessary.

**Declaration of Interest**
All members of the Finance and Performance Committee will be required to complete a declaration of interest form and report issues as they arise in accordance with the CCG’s Conflicts of Interest Policy.

At the beginning of each meeting members will be required to declare a personal interest if it relates to a particular issue under consideration. Any such declaration will be formally recorded in the minutes of the meeting. The Chair will then make a decision about the member’s participation in the discussion in accordance with the CCG’s Conflict of Interest Policy.

**Review**
The terms of reference will be reviewed on an annual basis from the date that they were approved by the Governing Body, unless it proves necessary to do so sooner. Any resulting changes to these terms of reference or membership of the Finance and Performance Committee must be approved by the Governing Body before they shall be deemed to take effect.

**Date approved by Governing Body:**

**Review date:**
NHS Nottingham West Clinical Commissioning Group  
Primary Care Co-Commissioning Committee  
Terms of Reference

### Introduction

NHS England has invited CCGs to expand their role in primary care commissioning. NHS Nottingham West CCG (the “CCG”) has agreed with NHS England delegated commissioning arrangements for certain primary care commissioning functions.

In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended) (“NHS Act”), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to the CCG. The delegation is set out in Schedule 1.

The Governing Body of the CCG has resolved to establish a committee to be known as the Primary Care Commissioning Committee in accordance with Schedule 1A of the NHS Act. The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

### Role

The Committee has been established in accordance with the statutory provisions to enable the members to make decisions on the review, planning and procurement of primary care services in Nottingham West, under delegated authority from NHS England.

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

The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

The role of the Committee is to oversee the delivery of the delegated functions. The Delegated Functions are the functions set out in paragraph 12 of the Delegation and being:

- decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:
  - decisions in relation to Enhanced Services;
  - decisions in relation to Local Incentive Schemes (including the design of such schemes);
  - decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
  - decisions about ‘discretionary’ payments;
  - decisions about commissioning urgent care (including home visits as required) for out of area registered patients;
- the approval of practice mergers;
• planning primary medical care services in the Area, including carrying out needs assessments;
• undertaking reviews of primary medical care services in the Area;
• decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
• management of the Delegated Funds in the Area;
• Premises Costs Directions Functions;
• co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
• such other ancillary activities that are necessary in order to exercise the Delegated Functions.

Duties

Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act including:

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P);
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
d) Duty as to improvement in quality of services (section 14R);
e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T);
g) Duty to promote the involvement of each patient (section 14U);
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:

a) Duty to have regard to impact on services in certain areas (section 13O);
b) Duty as respects variation in provision of health services (section 13P).

The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Authority

In accordance with its statutory powers under section 13Z of the NHS Act, NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference, to the CCG.

Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

The decision-making responsibilities of the Committee are set out in the delegation set out in Schedule 1 and the functions set out in Schedule 2.
The Committee is established as a committee of the Governing Body of the CCG in accordance with Schedule 1A of the NHS Act. The Committee will make decisions within the bounds of its remit and will be accountable to the Governing Body of the CCG. The decisions of the Committee shall be binding on NHS England and the CCG.

Membership

Voting members of the Committee are:

- Lay representative, PPI Lead (Chair)
- Governing Body Secondary Care Consultant
- Director of Nursing and Quality (Registered Nurse)
- Governing Body Lay representative (with responsibility for Audit and Governance)
- Elected PRG Governing Body representative
- Chief Operating Officer
- Chief Finance Officer
- Lay Member

There will be standing invitations to Healthwatch and the Health and Wellbeing Board, and the Primary Care Contracting Team of NHS England to offer representation in a non-voting capacity on the Committee and attend meetings of the Committee.

There are a further six non-voting members of the Committee:

- Director of Outcomes and Information
- Director of Contracting
- Officer representative of Nottinghamshire County Council
- Officer representative of Broxtowe Borough Council
- Clinical Lead/Accountable Officer
- Governing Body GP representative (with lead for Finance and Information)

The names of the members of the Committee are set out in Schedule 3.

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

Frequency of Meetings

Ordinary meetings of the Committee shall be held at regular intervals at such times and places as the group may determine, but at least quarterly.

Meetings of the Committee shall:

a) be held in public, subject to the application of 5(b)

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

The Committee will operate in accordance with the CCGs’ Constitution and Standing Orders. The Secretary to the Committee will be responsible for giving notice of meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than 7 days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as he shall specify.

Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present at a quorate meeting, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

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

The Committee may delegate non decision-making tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties’ relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

Members of the Committee shall respect confidentiality requirements as set out in the CCG’s Constitution.

Minutes and Reporting

The Committee will present its minutes to NHS England and the Governing Body of the CCG for information. The Committee will produce an executive summary report which will be presented to NHS England and the CCG’s Governing Body after each meeting for information.

The Committee will also comply with any reporting requirements set out in the CCG’s Constitution including any information required for the register or procurement decisions.

Declaration of Interest

All members of the Primary Care Co-Commissioning Committee will be required to complete a declaration of interest form and report issues as they arise in accordance with the CCG’s Conflicts of Interest Policy.

At the beginning of each meeting members will be required to declare a personal interest if it relates to a particular issue under consideration. Any such declaration will be formally recorded in the minutes of the meeting. The Chair will then make a decision about the member’s participation in the discussion in accordance with the CCG’s Conflict of Interest Policy.

Review

The Terms of Reference will be reviewed annually from the date they are approved by the Committee and the Governing Body. NHS England may also issue revised model terms of reference.
from time to time.

Any resulting changes to these terms of reference or membership of the Primary Care Commissioning Committee must be approved by the Governing Body before they shall be deemed to take effect.

Date approved by Governing Body:

Review date:
## Role and Purpose

Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities that supports the achievement and expertise if it considers this necessary.

## Duties

The Committee’s duties/responsibilities can be categorised as follows:

### Integrated governance, risk management and internal control

The Audit & Governance Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities that supports the achievement and expertise if it considers this necessary.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the governance statement), together with any accompanying Head of Internal Audit Opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Governing Body
- The underlying assurance processes that indicate the degree of achievement of the organisation’s objectives, the effectiveness of the management of principle risks and the appropriateness of the above disclosure statements
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting self-certifications
- All work related to fraud, bribery and corruption, to ensure compliance with NHS Protect’s ‘Standards for Commissioners: Fraud, Bribery & Corruption’.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from CCG officers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee’s use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees so that it understands processes and linkages. However, these other committees must not usurp the Committee’s role.

### Financial reporting

The Audit and Governance Committee will monitor the integrity of the financial statements of the CCG and any formal announcements relating to the CCGs’ financial performance. It will ensure that
the systems for financial reporting to the CCG Governing Body, including those of budgetary control
are subject to review as to completeness and accuracy of the information provided to the CCG
Governing Body.

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

- The wording in the Governance Statement and other disclosures relevant to the terms of
  reference of the Audit and Governance Committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the financial statements;
- Significant judgements in preparing the financial statements
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Explanations of significant variances.

Internal Audit
The Audit and Governance Committee shall ensure that there is an effective internal audit function
that meets the Public Sector Internal Audit Standards and provides appropriate independent
assurance to the Audit and Governance Committee, Accountable Officer and CCG. This will be
achieved by:

- Consideration of the provision of the internal audit service and the costs involved
- Review and approval of the internal audit plan and more detailed programme of work, ensuring
  that this is consistent with the audit needs of the organisation, as identified in the assurance
  framework.
- Considering the major findings of internal audit work (and management’s response) and
  ensuring co-ordination between the internal and external auditors to optimise audit resources.
- Ensuring that the internal audit function is adequately resourced and has appropriate standing
  within the CCG.
- An annual review of the effectiveness of internal audit and carrying out an annual review.

External Audit
The Audit and Governance Committee shall review and monitor the external auditors’ independence
and objectivity and the effectiveness of the audit process. In particular, the Committee will review
the work and findings of the external auditors and consider the implications and management’s
responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules
  governing the appointment permit (and make recommendations to the Governing Body when
  appropriate)
- Discussion and agreement with the external auditors, before the audit commences, the nature
  and scope of the audit as set out in the annual plan.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of
  the CCG and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance,
  (before its submission to the Governing Body) any work undertaken outside the annual audit
  plan, together with the appropriateness of management responses
- Ensuring there is in place a clear policy for the engagement of external auditors to supply non
  audit services.
Other Assurance Functions
The Audit and Governance Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

These will include, but not limited to, any reviews by Department of Health arm’s length bodies or regulators/inspectors (for example the Care Quality Commission) and professional bodies with responsibility for performance of staff or functions (for example, Royal Colleges, accreditation bodies, etc.)

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Committee’s own areas of responsibility. In particular, this will include any clinical governance, risk management or quality committees that are established.

In reviewing the work of a clinical governance committee, and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

Counter Fraud, Bribery and Corruption
The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud, bribery and corruption and shall review the outcomes of counter fraud, bribery and corruption work. The Committee shall seek assurance regarding the organisation’s compliance with NHS Protect’s ‘Standards for Commissioners: Fraud, Bribery & Corruption’, by means including: reports from the Counter Fraud Specialist, the CCG’s annual Self-Assessment Review Toolkit (SRT) submissions to NHS Protect, and from NHS Protect inspection reports.

Management
The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit).

Whistleblowing
The Committee shall review the effectiveness of the arrangement in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

Membership
The Audit and Governance Committee shall be appointed by the Governing Body as set out in NW CCG Constitution from the Lay Membership of the CCG, and will consist of not less than three members.

The Chair of the CCG will not be a member of the Audit and Governance Committee.

The membership of the Audit and Governance Committee is as follows:
- Governing Body Lay Member with lead responsibility for governance (Chair)
- Governing Body Lay Member with lead responsibility for patient and public involvement
- Lay Member elected from the Patient Reference Group

Members’ qualification, disqualification, appointment, and tenure on the Audit and Governance Committee, and eligibility for reappointment is detailed in Section 2, Appendix C – Standing Orders, of the CCG’s Constitution.

If a member of the Audit and Governance Committee is not a member of the Governing Body, the above will still apply.

**Attendance**

At least once a year the Audit and Governance Committee will meet privately with the external and internal auditors.

The CCG Chief Finance Officer, internal audit representative, and external audit representative shall normally attend meetings. The Head of Quality, Governance and Engagement will attend meetings to provide appropriate support to the Chair, and Audit and Governance Committee members, and will arrange for minutes of the meeting to be taken.

NHS Protect (the counter fraud and security management) will have full and unrestricted rights of access to the Audit and Governance Committee and will normally attend at least two committee meetings per annum.

Other members of the CCG senior management team will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that manager.

The Accountable (or accounting) officer should be invited to attend meetings and should discuss at least annually with the Audit and Governance Committee the process for assurance that supports the governance statement. They should also attend when the Committee considered the draft annual governance statement and the annual report and accounts.

The Chair of the CCG will be invited to attend at least annually to form a view on and understanding of the Audit and Governance Committee’s operations.

The Chair will be the Lay Member on the Governing Body, with a lead role for Audit and Governance.

In the event of the Chair of the Audit and Governance Committee being unable to attend all or part of the meeting, he or she will nominate a replacement from within the membership to deputise for that meeting.

A quorum will be two members.

**Frequency of Meetings**

A minimum of five meetings per annum will be held at appropriate times in the reporting and audit cycle. The dates of the meeting during a financial year will be agreed in advance of the start of that financial year. In addition the external auditors or head of internal audit may request a meeting if they consider that one is necessary.

Agenda and supporting papers will be circulated at least seven days in advice of the meetings. The Chair will agree the agenda prior to the papers being circulated.
Minutes will be taken at all meetings and circulated to members of the Group within 10 days of the meeting. The Audit and Governance Committee will agree the minutes at the following meeting.

Minutes and Reporting

The Committee shall report to the Governing Body on how it discharges its responsibilities.

The minutes of the Audit and Governance Committee meetings shall be submitted to the CCG Governing Body. The Chair of the Audit and Governance Committee shall draw to the attention of the Governing Body any issues that require disclosure to the Governing Body, or require action.

In the event of urgent reporting of any issues to the Governing Body, the Chair of the Audit and Governance Committee will agree with the Chair of the Governing Body to include the item on the next agenda of the Governing Body meeting.

The Committee will report to the Governing Body at least annually on its work in support of the annual governance statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness and ‘embeddedness’ of risk management in the organisation
- The integration of governance arrangements
- The appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business.

This annual report should also describe how that Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

Secretary

The Committee shall be supported administratively by the Governance Officer. Their duties will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking the minutes and helping the Chair prepare reports to the Governing Body
- Keeping a record of matters arising and issues carried forward
- Arranging meetings for the Chair – for example, with the internal/external auditors or the Counter Fraud Specialists
- Maintaining records of members’ appointments and renewal dates etc.
- Advising the committee on pertinent issues/areas of interest/policy developments
- Ensuring that action points are taken forward between meetings
- Ensuring committee members receive the development and training they need.

Declaration of Interest

All members of the Audit and Governance Committee will be required to complete a declaration of interest form and report issues as they arise in accordance with the CCG’s Conflicts of Interest Policy.

At the beginning of each meeting members will be required to declare a personal interest if it relates to a particular issue under consideration. Any such declaration will be formally recorded.
in the minutes of the meeting. The Chair will then make a decision about the member’s participation in the discussion in accordance with the CCG’s Conflict of Interest Policy.

**Review**

The Audit and Governance Committee Terms of Reference will be reviewed on an annual basis from the date that they were approved by NW CCG Governing Body, unless it is deemed necessary for them to be reviewed earlier than one year.

Any resulting changes to these terms of reference or membership of the Audit and Governance Committee must be approved by the CCG Governing Body before they shall be deemed to take effect.

**Date approved by Governing Body:**

**Review date:**
NHS Nottingham West Clinical Commissioning Group
Clinical Development Committee
Terms of Reference

<table>
<thead>
<tr>
<th>Role and Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Clinical Development Committee will drive forward NHS Nottingham West's CCG's clinical and service development agenda to support the delivery of NHS Nottingham West CCG's objectives and plans. To ensure effective involvement of all practices and other representatives.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Clinical Development Committee will:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>▪ Provide clinical leadership across all relevant service redesign and change programmes.</td>
</tr>
<tr>
<td>▪ Advise NHS Nottingham West CCG Governing Body on priority areas for service redesign and innovation, taking account of local health needs.</td>
</tr>
<tr>
<td>▪ Identify new and emerging opportunities for service change and service integration.</td>
</tr>
<tr>
<td>▪ Develop innovative proposals for service change which meet the opportunities identified.</td>
</tr>
<tr>
<td>▪ Suggest means of resolving problems associated with the implementation of agreed service changes, proposing the deployment of management resources as necessary.</td>
</tr>
<tr>
<td>▪ Identify key stakeholders associated with service changes, and secure the necessary representation as required.</td>
</tr>
<tr>
<td>▪ Develop methodologies which ensure the effective evaluation and review of agreed service changes ensuring quality measures are included.</td>
</tr>
<tr>
<td>▪ Ensure the consideration of member practices and patient and carers' views in all aspects.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Clinical Development Committee is authorised by the Governing Body of NHS Nottingham West Clinical Commissioning Group to:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>▪ Contribute to the construction of the annual CCG Operational Plan.</td>
</tr>
<tr>
<td>▪ Lead on the delivery of service redesign priorities as identified in NHS Nottingham West CCG's Operational Plan or from other sources.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Membership</th>
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</thead>
<tbody>
<tr>
<td>Standing members of the CDC will include:</td>
</tr>
<tr>
<td>▪ Chief Clinical Officer</td>
</tr>
<tr>
<td>▪ Clinical Lead representative from each member practice</td>
</tr>
<tr>
<td>▪ Practice Manager representatives/s</td>
</tr>
</tbody>
</table>
- Two patient representatives
- Accountable Officer
- Head of Strategy & Development
- Finance representative
- A representative from the Local Authority
- A nominated Public Health representative

In addition to these individuals, the CDC will invite other stakeholders to be involved for specific issues if required.

A Chair and Deputy Chair will be elected for a period of one year from the membership of the CDC. If the Chair and Deputy Chair are unable to attend a meeting then the Chair will be elected from the quorate meeting.

A quorum will be ten members to include:

- 8 GPs
- 1 patient or council representative
- 1 other members

All members shall be voting members. Any questions where it is deemed necessary by the Chair to require a vote at a meeting shall be determined by a majority of the votes of members present at the meeting. If necessary the Chair will have the casting vote.

**Frequency of Meetings**

The CDC will meet on a monthly basis for two hours for clinical discussions. The agenda will focus on clinical service redesign.

**Minutes and Reporting**

Reports will be provided to NHS Nottingham West CCG Governing Body. Action points arising from the meeting will be minuted and shared with the Governing Body and Patient Reference Group.

**Declaration of Interest**

All members of the Clinical Development Committee will be required to complete a declaration of interest form and report issues as they arise in accordance with the CCG’s Conflicts of Interest Policy.

At the beginning of each meeting members will be required to declare a personal interest if it relates to a particular issue under consideration. Any such declaration will be formally recorded in the minutes of the meeting. The Chair will then make a decision about the member’s participation in the discussion in accordance with the CCG’s Conflict of Interest Policy.

**Review**

The CDC Terms of Reference will be reviewed on an annual basis from the date that they were approved by NHS Nottingham West CCG Governing Body unless it is deemed necessary for them to be reviewed earlier than one year.
## Role and Purpose

The purpose of the IFR panel is to consider funding requests for individuals who seek NHS commissioned services outside established commissioning policies. This may either be a request for funding treatment where there is no commissioning policy or where the medical condition is not included in a current policy or does not meet the criteria set out in the policy.

Each individual funding request will be handled by following the Nottinghamshire County CCGs* IFR process (see the Nottinghamshire County CCGs* IFR Policy) which will ensure the request is considered in a fair and transparent way, with decisions based on the best available evidence and the CCGs* commissioning principles.

The IFR Panel is hosted by NHS Nottingham West CCG on behalf of NHS Mansfield & Ashfield CCG, NHS Newark & Sherwood CCG, NHS Rushcliffe CCG and NHS Nottingham North & East CCG.

## Members Responsibilities

All core members are expected to have a named deputy who will attend on their behalf as necessary. It is their responsibility to ensure that the deputy is included in any training sessions as appropriate to maintain competency.

All core members/deputies are expected to attend a minimum of 75% of all IFR meetings that are held on an annual basis.

## Membership

The Individual Funding Request (IFR) panel will have a core membership of:

- Director of Public Health or nominated deputy
- Clinical Commissioning Group (CCG) Chief Officer or nominated deputy
- Clinical Member (Medical)
- Lay representative (Chair)

In attendance:

- IFR Manager to record the decision of the IFR Panel against each of the questions in the Decision Framework Document
- Senior Medicines Management Representative
- Health Economist

Other individuals with specific expertise and skills may also be included on the panel e.g. pharmacist, commissioning manager in order to ensure effective and robust decision making.

The panel members will determine who the chair and deputy chair for the panel is and they will each serve for a period of 3 years.
Clinical members who have had any clinical involvement with an individual case cannot be part of the panel hearing for that request. This also applies to cases where the patient is registered at the clinical member’s practice(s).

The panel will only be quorate if four (different) core members are present, including the Director of Public Health (or nominated deputy) and the Clinical Member (Medical).

### Frequency of Meetings

The IFR Panel will normally be held monthly. If there are no cases to consider the meeting will be cancelled 5-10 working days ahead of the scheduled meeting. Quarterly meetings will be held regardless whether there are any cases to consider.

### Extraordinary Meetings

A case may need to be considered urgently between meetings on the advice of the Director of Public Health, or nominated deputy, after consultation with the patient’s clinicians.

An ‘extraordinary’ IFR meeting can be convened by the Director of Public Health or nominated deputy where quoracy of the extraordinary meeting will be four (different) core members, including the Director of Public Health (or nominated deputy) and the Clinical Member (Medical). Other panel members may attend if available.

Ideally, all urgent cases will be considered by a face-to-face meeting, but, exceptionally, where the clinical urgency makes this impossible, communication by phone or e-mail will be deemed appropriate.

### Voting Rights

IFR Panel members will seek to reach decisions by consensus where possible, but if a consensus cannot be achieved, decisions will be taken by a majority vote with each panel member present having an equal vote. If the panel is equally split then the chair of the panel will have the casting vote.

### Minutes and Reporting

The IFR Manager will record the decision of the IFR Panel against each of the questions in the Decision Framework Document. The completed Decision Making Document, together with the record of attendance, will form the minutes of an individual case. Decisions that are made urgently outside a formal IFR Panel meeting will be taken to the next routine meeting of the IFR Panel.

The IFR Panel will agree monitoring parameters for each of the individual cases that are approved where the IFR Manager will ensure that progress reports are obtained from the requesting clinician to update the IFR Panel as to the patient’s response.

The IFR Panel will meet on a quarterly basis to review the IFR database with the IFR Manager in order to evaluate the process, including the consistency of panel decision making, and to consider any improvements that could be made.

The IFR Manager will produce an annual report which will be considered by Governing Bodies of NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG and NHS Rushcliffe CCG

The minutes of the IFR Panel will be approved by the Chair of the Panel. The IFR Panel is accountable
to NHS Nottingham West CCG Governing Body who is also responsible for the performance management of the Panel.

**Documentation**

Individual Funding Requests will be date stamped and logged onto the Nottinghamshire County CCGs* IFR database by the IFR Manager. It is the responsibility of the IFR Manager to manage all requests received and correspondence relating to each case.

All cases will be anonymised before consideration by the IFR panel. The IFR Manager will produce a summary of the key information using the Decision Framework Document which will be considered by the IFR Panel. All other documentation that has been received regarding the case will also be available to the panel.

Patients will be encouraged to set out their views in writing to the Panel. Save to the extent that is required to ensure anonymity is preserved, the IFR Manager shall not be entitled to redact any written material provided by the patient. However the IFR Manager shall be entitled to put any observations in writing before the IFR Panel that the IFR Manager may have concerning material submitted by a patient including:

- Observations on any areas where issues are raised which do not appear to be supported by the clinical evidence
- Advice to the panel concerning any social, caring or other personal factors raised by the patient which the IFR Panel are not entitled to consider under the terms of the Nottinghamshire County CCGs* Policy.

The patient shall be entitled on request to a copy of any observations by the IFR Manager. Patients will not be permitted to attend panel meetings in person or be represented by any person at the meeting.

**Training**

All members of the IFR Panel must undergo mandatory induction training organised by the Shared Medicines Management team on behalf of the Nottinghamshire County CCGs*. This will cover both the legal and ethical framework for IFR decision making, the CCGs commissioning processes and structures, and the technical aspects of interpretation of clinical evidence and research. This training will be regularly refreshed to ensure that all panel members maintain the appropriate skills and expertise to function effectively.

**Review**

The Terms of Reference of the IFR Panel will be reviewed annually by NHS Nottingham West CCG Governing Body.

**Date approved by Governing Body:**

**Review date:**
<table>
<thead>
<tr>
<th><strong>Director of Public Health or nominated deputy</strong></th>
<th><strong>CCG Chief Officer or nominated deputy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Mary Corcoran, Consultant in Public Health, Public Health Nottinghamshire County</td>
<td>Vicky Bailey, Accountable Officer, NHS Nottingham West CCG</td>
</tr>
<tr>
<td>Dr Kate Allen, Consultant in Public Health (1st deputy), Public Health Nottinghamshire County</td>
<td>Sharon Pickett, Deputy Chief Officer (deputy), NHS Nottingham North &amp; East CCG</td>
</tr>
<tr>
<td>Cathy Quinn, Associate Director of Public Health (2nd deputy), Public Health Nottinghamshire County</td>
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<table>
<thead>
<tr>
<th><strong>Clinical Member (Medical)</strong></th>
<th><strong>Lay Representative</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Simon Brenchley, GP, NHS Newark &amp; Sherwood CCG</td>
<td>Peter Robinson (Chair)</td>
</tr>
<tr>
<td>Dr James Read, GP, NHS Nottingham West CCG</td>
<td>Usha Gadhia (deputy Chair)</td>
</tr>
<tr>
<td>Dr Sean Ottey, GP, NHS Rushcliffe CCG</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>In Attendance - Individuals with specialist expertise</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicky Bird, Senior Prescribing Advisor, Shared Medicines Management Team, NHS Mansfield &amp; Ashfield CCG</td>
</tr>
<tr>
<td>Amanda Rawlings, Prescribing Interface Advisor (deputy), Shared Medicines Management Team, NHS Mansfield &amp; Ashfield CCG</td>
</tr>
<tr>
<td>Jane Urquhart, IFR Manager, Shared Medicines Management Team, NHS Mansfield &amp; Ashfield CCG</td>
</tr>
<tr>
<td>Marilyn James, Health Economist, Nottingham University</td>
</tr>
</tbody>
</table>
# Safeguarding Committee
## Terms of Reference

### Aim
To ensure that systems and process are in place to safeguard vulnerable adults and children as a core component of the services provided and commissioned by the following Nottinghamshire Clinical Commissioning Groups (CCGs):
- NHS Newark and Sherwood (N&S) CCG
- NHS Mansfield and Ashfield (M&A) CCG
- NHS Nottingham North & East (NNE) CCG
- NHS Nottingham West (NW) CCG
- NHS Rushcliffe CCG
- NHS Bassetlaw CCG

### Constitution
Nottinghamshire and Bassetlaw CCGs hereby resolve to constitute a committee of the Newark & Sherwood Clinical Commissioning Governing Body to be known as the Nottinghamshire County Safeguarding Adult Committee as outlined in the “Memorandum of Understanding in Relation to Collaborative Governance Arrangements 2012”.

### Duties
The duties of the committee are:
- To ensure Nottinghamshire CCGs fulfill statutory responsibilities as outlined in the Care Act 2014 and promote the safety and welfare of adults with care and support needs within the CCGs and across all commissioned and contracted services.
- To monitor CCG and contracted and commissioned services compliance with statutory guidance relating to safeguarding adults including the Mental Capacity Act (2005).
- To promote the safety and welfare of children within the Nottinghamshire CCGs and across all commissioned and contracted services.
- To maintain clear lines of accountability and reporting for safeguarding vulnerable adults to the Nottinghamshire CCGs and the Member Governing bodies.
- To maintain links to Nottinghamshire Safeguarding Children Board (NSCB), Nottinghamshire Safeguarding Adults Board (NSAB), the Local Area Teams of the NHS Commissioning Board (LAT) and other relevant committees
- To monitor resulting actions following serious case reviews, independent management reviews and other relevant safeguarding incidents and to promote the dissemination of learning.
To develop, review and approve policies and procedures relating to safeguarding practice.

To approve annual reports for the CCGs relating to safeguarding.

To monitor key performance indicators relating to safeguarding adults and children as required by the Care Quality Commission, the LSAB/LSCB or any other statutory regulating authority.

To produce regular reports to the Nottinghamshire CCGs via Chief Nurses on any significant developments, exceptions and risks, relating to safeguarding adults and the public in general to inform the risk register.

To act as a monitoring, dissemination and advisory group for new national or local guidance (including feedback from NSAB/NSCB) and to promote effective communication of key messages across provider organisations.

Review audit, evaluation and quality assurance of safeguarding processes and practice across the CCGs and provider organisations.

To oversee a process for implementing, monitoring, and embedding safeguarding principles in all service level agreements.

The identification of challenges and risks to the safeguarding aims and objectives, so that actions to mitigate them can be planned and implemented.

Authority
The Committee will receive its powers from the following CCGs:
- NHS Newark and Sherwood CCG
- NHS Mansfield and Ashfield CCG
- NHS Nottingham North & East CCG
- NHS Nottingham West CCG
- NHS Rushcliffe CCG
- NHS Bassetlaw CCG

The Committee will be directly accountable to the N&S CCG Governing Body and the Chief Operating Officer N&S CCG.

The Committee will respond to matters referred to it by the Nottinghamshire and Bassetlaw CCG Governing Bodies, Nottinghamshire Safeguarding Children and Adult Boards. It will seek independent advice as it considers necessary. Wider clinical consultation will take place as necessary with the Nottingham Health Community, the Care Quality Commission, Local Authority Police and other statutory agencies as appropriate.

Membership
- Chief Nurse and Director of Quality for Newark and Sherwood and Ashfield and Mansfield CCGs (Chair)
- Director of Nursing and quality for Nottingham North and East, Nottingham West and Rushcliffe CCGs (Vice Chair)
- Assistant Director of Quality and Patient Safety for Nottingham North and East, Nottingham West and Rushcliffe CCGs
### Nottingham West Clinical Commissioning Group

- Deputy Chief Nurse, for Newark and Sherwood and Ashfield and Mansfield CCGs
- Nurse Consultant Safeguarding for Bassetlaw CCG
- Deputy Chief Nurse, Bassetlaw CCG
- Consultant in Public Health nominated by the Director of Public Health, Nottinghamshire County Council
- General Practitioner
- Practice Nurse
- Adult Safeguarding Leads from member CCGs
- Designated Professionals Safeguarding Children CCGs
- Designated Professionals Children in Care
- Public Health Manager (children lead) nominated by the Director of Public Health, Nottinghamshire County Council
- Head of Quality and Patient Safety for Newark and Sherwood and Ashfield and Mansfield CCGs

It is an expectation that if any member is unable to attend the meeting a representative is nominated to act on their behalf.

The Committee, or its Chair on its behalf, may co-opt such other Directors and officers of the CCGs as may be required.

<table>
<thead>
<tr>
<th>Attendance</th>
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</thead>
<tbody>
<tr>
<td>Regular attendance is required by all members. On the occasions when nominated members cannot attend they will submit a brief written report on all actions. This will be presented by their named deputy. The forum may also request the attendance of other members of staff as required.</td>
</tr>
</tbody>
</table>

Either the Chair or Deputy Chair and a minimum of two clinical members and two executive safeguarding leads from two CCGs.

Chair – Chief Nurse and Director of Quality for N&S, M&A CCG
Vice Chair – Director of Nursing and Quality for NNE, NW and Rushcliffe CCGs

<table>
<thead>
<tr>
<th>Frequency of Meetings</th>
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<tbody>
<tr>
<td>The sub-committee shall meet bi-monthly. Extraordinary meetings may be convened as necessary.</td>
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<thead>
<tr>
<th>Reporting</th>
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<tbody>
<tr>
<td>Reporting and individual accountability arrangements are outlined in Appendices 1 &amp; 2</td>
</tr>
</tbody>
</table>

The committee shall report to the CCG Governing Bodies of:
- Newark and Sherwood (N&S) CCG
- Mansfield and Ashfield (M&A) CCG
- Nottingham North and East (NNE) CCG
- Nottingham West (NW) CCG
- Rushcliffe CCG
- Bassetlaw CCG

It shall also report through the Chief Nurse and Director of Quality to the Nottinghamshire
Safeguarding Adult and Children Boards.

Copies of the minutes of the meeting will be submitted to each of the Nottinghamshire CCG Governance Leads to inform their Governing Bodies.

Confidential Session

The meeting will include a confidential section which will consider cases subject to serious case reviews which are patient identifiable and by their nature are exempt from the Freedom of Information Act.

Review

Terms of reference to be reviewed annually, one year following approval by the CCG Governing Bodies and Local Adult and Children Safeguarding Boards.  
**Date of Approval**: September 2015

Review date: September 2016
INDIVIDUAL SAFEGUARDING REPORTING & ACCOUNTABILITY NOTTINGHAMSHIRE CLINICAL COMMISSIONING GROUPS

Directors of Quality, Governance, and Patient Safety (North South and Bassetlaw)

Executive Leads for:-
- Safeguarding
- MAPPA (North Exec Lead takes responsibility for all Notts CCGs excl. Bassetlaw)
- PREVENT (South Exec Lead takes responsibility for all Notts CCGs excl. Bassetlaw)
- Senior Officer for Allegations Against Staff
- Mental Capacity Act

Members of Nottinghamshire Safeguarding Children and Adults Boards

Designated Nurse/Doctors
Safeguarding Children and Children in Care
Clinical Advisors

Designated Safeguarding Adult Managers x 3
(North, South & Bassetlaw)
Delegated responsibility for MCA and Clinical Advisors
ORGANISATIONAL EXTERNAL SAFEGUARDING REPORTING ARRANGEMENTS
NOTTINGHAMSHIRE CLINICAL COMMISSIONING GROUPS

Nottinghamshire Safeguarding Boards (Adults and Children)

CCG Safeguarding Executive Leads (Provide assurance and link with their CCG Governing Bodies)

Nottinghamshire Safeguarding Committee
(Hosted by Newark & Sherwood CCG)

Nottinghamshire CCGs
Governing Bodies
- Mansfield & Ashfield
- Newark & Sherwood
- Nottingham North & East
- Nottingham West
- Rushcliffe
- Bassetlaw

Functions:
- Policy Development
- Assurance and links with Local Safeguarding Children and Adults Boards
- Oversee SCR progress and monitor impact
- Overview of provider performance around safeguarding (each CCG responsible for their co-ordinating commissioner contract)
- To identify risks and mitigation actions relating to safeguarding
**Quality and Risk Committee**

**Terms of Reference**

<table>
<thead>
<tr>
<th>Introduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Committee is established as a joint committee of NHS Nottingham North and East (NNE), NHS Nottingham West (NW) and NHS Rushcliffe (RCCG) CCGs to support collaborative arrangements and assist in the exercise of CCG functions.</td>
</tr>
</tbody>
</table>

These terms of reference set out the membership, responsibilities, and reporting arrangements of the Quality and Risk Committee and are incorporated into the individual CCG Constitutions.

<table>
<thead>
<tr>
<th>Responsibilities</th>
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<tbody>
<tr>
<td>The role of the Quality and Risk Committee is to monitor, review and provide assurance that services commissioned by the CCGs are being delivered in a high quality and safe manner, and to promote a culture of continuous improvement and innovation by focusing on the three quality domains:</td>
</tr>
</tbody>
</table>

- Patient Safety – the safety of treatment and care provided to patients
- Patient Experience – the experience patients and their carers have of treatment and care they receive
- Clinical Effectiveness – measured by both clinical outcomes and patient-related outcomes

The Committee will act on behalf of the CCGs to fulfil their obligations in respect of the following functions:

- Clinical Governance
- Risk Management
- Infection Prevention and Control
- Equality and Diversity and EDS
- Patient Feedback including Complaints and PALS
- Health and Safety

From 1 April 2015 the three South Nottinghamshire CCGs have a statutory responsibility for commissioning primary care services having taken on delegated authority from the Area Team. During the first year transitional arrangements are in place with the Primary Care Hub based within the Area Team to monitor quality of primary care services with a view to securing continuous improvement in the quality of primary medical services. The Primary Care Commissioning Committees of each of the three CCGs and their associated sub-groups will co-ordinate activities required to ensure that each CCG is able to fulfil this duty once the transitional year concludes.

The Committee will have specific responsibility for:

- Assuring the quality performance of its providers
- Overseeing and being assured that effective management of risk is in place to manage and address clinical governance issues
- Oversight of the process and compliance issues concerning serious incidents requiring investigation (SIRIs); being informed of all Never Events and near misses; monitoring complaints and patient, carer and public feedback and informing the Governing Body of any escalation or
sensitive issues in a timely way

- Seeking assurance on the performance of provider organisations in terms of the Care Quality Commission and Monitor (and any other relevant regulatory bodies)
- Receiving any investigation reports relating to patient safety issues to seek assurance that appropriate mitigating actions have been taken in response
- Developing, approving and reviewing relevant policies and procedures as per the scheme of delegation
- Encouraging a culture of quality improvement within the CCGs’ provider and partner organisations, including reporting any lack of assurance to CCG Governing Bodies
- Identifying opportunities for improvement through promotion of education and training and quality initiatives and through encouraging innovation
- Receiving and reviewing individual CCGs training and development reports
- Reviewing Quality Impact Assessments (QIAs) which have high risks (8 or above) identified
- Equality Impact Assessments will be reviewed by the Equality and Diversity forum and reported to the Committee via the meeting minutes
- Adults and Children’s Safeguarding is considered at a separate Nottinghamshire County wide Safeguarding Committee which reports directly to the Governing Bodies

**Quality Scrutiny Panels and Sub-Groups**

**Quality Scrutiny Panels**

Three Quality Scrutiny Panels have been established to review and routinely monitor performance against the Clinical Quality Performance Indicators stated in the quality section of the contract and quality schedules for lead contracts. The panels will provide assurance that patient safety and the quality of clinical services are acceptable for all users of those services. The panels will report to the Committee through the Director of Nursing and Quality’s Quality Report and through the minutes of individual panel meetings. The three panels established by the Committee are for the following contracts:

- Nottingham University Hospitals NHS Trust – acute hospital services
- Community Health Partnership – community services
- Circle Nottingham – treatment centre services

Quality monitoring arrangements are also in place for the following smaller contracts:

- Ramsay (Woodthorpe Hospital)
- BMI (The Park Hospital)

The Committee also receives quality monitoring information for services where the three CCGs are Associate Commissioners to the contract via the Lead Commissioners e.g. EMAS, Arriva, Nottinghamshire Healthcare NHS FT, out of hours providers.
Sub Groups

Health and Safety Group
The Health and Safety Working Group has been established as a subgroup of the Committee to co-ordinate activities required for each CCG to comply with the Health and Safety Act 1974 and other statutory provisions; and provide a healthy and safe environment for all people who work in, use or visit their premises.

Care Homes Group
The Care Homes Sub-Group has been established as a sub-group of the Committee to co-ordinate activities required to provide assurance on the quality of care provided to residents; and to act as a central information sharing point for concerns identified by stakeholders, areas of good practice and review of audits.

Equality and Diversity Forum
The Equality and Diversity Forum has been established as a sub-group of the Committee to co-ordinate the delivery of the Equality Delivery System across the south CCGs and thereby provide assurance that the CCGs are compliant with the Equality Act 2010.

Each sub-group will provide a brief written update to the Committee highlighting progress and any areas of concern.

Each sub-group will review its terms of reference annually. Any changes to must be approved by the Committee.

The Committee may also establish its own task and finish or working groups for finite periods of time and for specific purpose. Each sub-group will produce an annual prospective work programme which must be approved by the Committee.

Authority
The Quality and Risk Committee is authorised by the respective Governing Bodies to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any group or employee, who are directed to co-operate with any request.

Membership
Each CCG will be represented on the Committee by the Director of Nursing and Quality (a shared post between the three CCGs) and their respective governance or quality leads.

Patients will be represented by CCG governing body lay members and other representatives nominated by the three CCGs party to this agreement.

The membership of the Quality and Risk Committee is as follows:

- Director of Nursing and Quality
- Deputy Director of Nursing and Quality
- Head of Quality, Patient Safety and Experience
- Head of Quality and Adult Safeguarding
- Director of Operations (NNE)
- Head of Quality, Governance and Engagement (NW)
- Head of Governance and Integration (RCCG)
- Consultant in Public Health
- Governing Body Lay Member/Lay Representative x 3 (one from each CCG)
- Secondary Care Consultant
- GP
- Chairs or Vice-Chairs of all sub-groups

Non-lay members are responsible for identifying appropriate deputies to represent their CCG.

Other attendees will be invited to attend as appropriate.

**Attendance**

Attendance at meetings is mandatory by a member or nominated deputy. A minimum attendance of 75% of meetings per year is required.

The Chair will be a Lay Member, nominated by the Chief Officers and endorsed by the Committee. When required, the Deputy Chair will be nominated from within the membership.

A quorum will be six members of which one should be a practising doctor, one a lay member plus the Director of Nursing and Quality (or nominated deputy)

**Frequency of Meetings**

The committee will meet quarterly. The agenda will be developed by the Director of Nursing and Quality in conjunction with the Chair.

Agenda and supporting papers will be circulated at least five working days in advance of meetings.

Minutes of meetings will be taken by the Quality Team Secretary and circulated, unratified, to members of the Quality and Risk Committee within 10 days of the meeting. Minutes will be ratified by the Committee at its next meeting.

All actions from the previous meeting(s) will be reviewed. Members will send a written update if they are not able to attend the next meeting. The Director of Nursing and Quality will produce a Quality and Risk Committee Annual Report for approval by the Committee.

**Reporting**

The minutes of Quality and Risk Committee meetings will be submitted to each CCG Governing Body.

The Director of Nursing and Quality will draw to the attention of the Governing Bodies any issue that requires disclosure or action via a highlight report and the minutes.

Six monthly provider focus reports will be submitted to the Quality and Risk Committee operated by NHS Newark and Sherwood CCG and NHS Mansfield and Ashfield CCG and vice versa to ensure that any common issues or concerns are shared appropriately.

**Secretary**

Secretarial support is provided by the Quality Team Secretary who will be responsible for:
- Providing support to the Chair
- Agreeing the agenda with the Chair
- Collating and circulating all necessary papers for the Committee
- Ensuring that all reports to CCG Governing Bodies are provided in line with the CCGs paper
Declaration of Interest

All members of the Quality and Risk Committee will be required to complete a declaration of interest form in accordance with the CCG Conflict of Interest Policy.

At the beginning of each meeting members will be required to declare a personal interest if it relates to a particular issue under consideration. Any such declaration will be formally recorded in the minutes of the meeting. The Chair will then make a decision about the member’s participation in the discussion in accordance with the host CCG Conflict of Interest Policy.

Conduct

The Quality and Risk Committee will conduct its business in accordance with the codes of conduct set out for all Governing Body members and good governance practice, and any other guidance or statute.

Review

The Quality and Risk Committee Terms of Reference will be reviewed annually.

Any resulting changes to these terms of reference or membership of the Quality and Risk Committee must be approved by the Governing Body of participating CCGs before they shall be deemed to take effect.

**Date of Approval:** November 2015

**Review date:** November 2016
Introduction
The Information Governance, Management and Technology (IGM&T) Committee is established on behalf of NHS Rushcliffe (RCCG), NHS Nottingham North and East (NNE), NHS Nottingham West (NW), NHS Mansfield and Ashfield (M&A) and NHS Newark and Sherwood (N&S) CCGs in accordance with the joint arrangements detailed in their respective Constitutions and referred to in these terms of reference as ‘the CCGs’.

The purpose of the Committee is to support and drive the broader information governance (IG) and information management & technology (IM&T) agendas, including:

- Ensuring risks relating to information governance and health informatics are identified and managed
- Leading the development of community-wide IG and IM&T strategies
- Developing IM&T to improve communication between services for the benefit of patients

These terms of reference set out the membership, responsibilities, and reporting arrangements of the Information Governance, Management and Technology Committee and shall have effect as if incorporated into the individual CCG Constitutions.

Responsibilities
The Information Governance, Management & Technology Committee will provide assurance to the five Clinical Commissioning Groups (CCGs) that the national and local IG and IM&T strategies are appropriate, supporting the delivery of associated improvements in health whilst facilitating the realisation of clinical and non-clinical benefits.

Information Governance

1) Ensure that an appropriate comprehensive information governance framework and systems are in place throughout the constituent organisations in line with national standards.

2) Receive regular action plans with regard to the organisations’ progress on the annual Information Governance Toolkit submission.

3) Ensure that information is effectively managed, and that appropriate policies, procedures and management accountability are provided and approved in relation to confidentiality, security and records management.

4) Ensure that information risks are identified, assessed and managed in line with the Information Governance Assurance Framework and recommend actions to the Senior Information Risk Owner (SIRO) to ensure risks are mitigated.

5) Ensure that information risks for commissioned services, including GP practices are identified and managed in line with National Serious Incident Framework, NHS England, March 2015. This will include incidents that result in a serious breach in confidentiality or data loss.

6) Assure the CCGs’ Governing Bodies that all person identifiable information is processed in
accordance with the Data Protection Act and that all staff are aware and comply with the NHS Code of Confidentiality and other professional codes of conduct.

7) Ensure that new or proposed changes to organisational processes or information assets are identified and risk assessed, considering any impact on information quality and identifying any new security measures that may be required.

8) Provide oversight and monitoring of provider IG Toolkit compliance on behalf of the CCGs, advising the relevant Quality Scrutiny Panels regarding any areas of concern.

9) Ensure that all locally-developed clinical information systems are accredited and signed off by the IM&T Clinical Safety Officer as laid out by statute and the relevant Information Standard Notices.

10) Receive regular compliance reports on the processing of Freedom of Information requests; determining exemptions as appropriate.

11) Develop an information governance training programme and monitor the progress of the staff training and awareness in line with the National Department of Health requirements.

12) Support the Caldicott function, working with the Caldicott Guardian to ensure work related to confidentiality and data protection is appropriately carried out and any risks reported appropriately.

13) Work with independent contractors and commissioned services to ensure their compliance with the Information Governance Toolkit.

**Information Management and Technology**

1) Promote new technologies across the CCGs to ensure quality of patient services.

2) Develop and approve the CCG’s IM&T Strategy ensuring it is congruent with both national and local strategy, and complements the business plans of individual Clinical Commissioning Groups; providing Governing Body assurance on the plan.

3) Ensure that the individual CCGs’ components of the programme are delivered in accordance with the timescales and milestones laid out in a project plan.

4) Act as the Project Assurance mechanism for any significant IM&T investment within the CCGs ensuring that the appropriate rigour has been applied to the case for change, specification, procurement, implementation and mobilisation of such investment plans.

5) Ensure that the CCGs have mechanisms and plans in place to raise the basic competencies and skills of the commissioning organisation in order to base decisions on knowledge and information.

6) Agree the relative priority of IM&T investment projects where flexibility exists outside of any national programmes.

7) Provide assurance to the Governing Bodies that sufficient attention is being placed on data
quality of both mandated and local datasets generated by the CCGs and their providers.

8) Ensure the CCGs are able to maximise all clinical and non-clinical benefits from planned and existing information systems and IT infrastructure.

9) Facilitate development and local implementation of health informatics policies ensuring they are consistent with national and local strategy.

10) Receive reports relating to the Nottinghamshire Health Informatics Service (NHIS), its services, the performance of the SLA between the NHIS and CCGs and progress against specific projects.

11) Monitor and review data and hardware security arrangements.

12) Ensure appropriate business continuity arrangements are in place relating to information technology.

Membership

Membership of the Committee will reflect the CCGs’ acknowledgement of the importance of IG and IM&T, the emphasis it places on its contribution to the commissioning process and the successful implementation of projects of work.

Each CCG will be represented on the Committee by their respective leads for IGM&T.

Patients will be represented by governing body lay members and lay representatives nominated by the CCGs party to this joint committee.

The membership of the Information, Governance, Management and Technology Committee is as follows:

- Director of Outcomes and Information (Chair and Representative for South CCGs)
- Each CCG’s SIRO
- Each CCG’s Caldicott Guardian
- Information Governance Lead at the Greater East Midlands Commissioning Support Service
- Information Governance Lead at NHS Nottingham City CCG
- Freedom of Information Lead at the Greater East Midlands Commissioning Support Service
- Director of Health Informatics, NHIS
- Customer Services Manager, NHIS
- GP representative
- Governing Body Lay Member

Current nominated officers at Appendix 1

Members’ qualification, disqualification, appointment, tenure on the Information Governance, Management and Technology Committee and eligibility for reappointment as per Governing Body members is detailed in Section 2 of Appendix C of each CCG’s constitution.

If a member of the Information Governance, Management and Technology Committee is not a member of the Governing Body, the above will apply as per the Lay Member for Patient and Public Involvement.

Members are expected to attend at a minimum of three meetings a year and are responsible for identifying appropriate deputies to represent their position if unable to attend.
Attendance
The Chair will be the Director of Outcomes and Information.

The General Practitioner and Senior Information Risk Owner for NHS Nottingham West CCG will be the Deputy Chair of the committee. In the event of the Chair of the Information Governance, Management and Technology Committee being unable to attend all or part of the meeting, the Deputy Chair will deputise for that meeting.

Other attendees will be invited to attend meetings as appropriate.

To be deemed quorate, the meeting must include the Chair or Deputy Chair, a representative for each CCG and at least one SIRO and one Caldicott Guardian from across the CCGs.

Voting and Decisions
Decisions will normally be reached by consensus, but where this is not possible, then a vote of member CCGs will be required. The process is:
- One vote per CCG
- The presiding Chair will have the casting vote
- Members voting against a decision but in the minority may request the minutes to reflect their dissent

Frequency and conduct of business
Meetings will be held quarterly or more frequently should an identified need arise.

The agenda, papers and minutes of the previous meeting will be circulated at least five working days prior to the next meeting.

Minutes will be taken at all meetings by Rushcliffe CCG and circulated within 10 days of the meeting, unratified, to members of the Information Governance, Management and Technology Committee for approval at the following meeting. A highlight report will also be produced within 10 days of the meeting for each CCG’s Governing Body.

All actions from the previous meeting(s) will be reviewed. Members will send a written update if they are not able to attend the next meeting.

Reporting
The IGMT Committee will report to each CCG’s Governing Body via a highlight report that will be available no later than 10 working days after each meeting and via minutes for each meeting that will be available after approval at the following Committee meeting.

The Chair of the Information Governance, Management and Technology Committee will draw to the attention of the Governing Bodies any issues that require disclosure to the Governing Body, or require action.

Specific issues of concern or matters requiring escalation to the Governing Bodies will be the subject of reports by the Committee Chair to each Governing Body.

The Director of Outcomes and Information will produce an Information Governance, Management and Technology Committee Annual Report for approval by the Committee.
Secretary

Secretarial support is provided by Rushcliffe CCG who will be responsible for:

- Providing support to the Chair
- Agreeing the agenda with the Chair
- Collating and circulating all necessary papers for the Committee
- Ensuring that all reports to CCG Governing Bodies are provided in line with the CCGs paper format and deadlines

<table>
<thead>
<tr>
<th>Declarators of Interest</th>
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<tbody>
<tr>
<td>All members of the Information Governance, Management and Technology Committee will be required to complete a declaration of interest form in accordance with the CCG’s Conflict of Interest Policy.</td>
</tr>
</tbody>
</table>

At the beginning of each meeting members will be required to declare a personal interest if it relates to a particular issue under consideration. Any such declaration will be formally recorded in the minutes of the meeting. The Chair will then make a decision about the member’s participation in the discussion in accordance with the CCGs’ Conflict of Interest Policies.

<table>
<thead>
<tr>
<th>Review</th>
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<tbody>
<tr>
<td>The Information Governance, Management and Technology Committee Terms of Reference will be reviewed on an annual basis from the date that they were approved by the CCGs, unless it is deemed necessary for them to be reviewed earlier.</td>
</tr>
</tbody>
</table>

Any resulting changes to these terms of reference or membership of the Information Governance, Management and Technology Committee must be approved by the CCGs before they shall be deemed to take effect.

| Date of Approval: May 2017 |
| Review date: May 2016 |
# Appendix 1

Membership list as of May 2016

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Permanent Membership</strong></td>
<td></td>
</tr>
<tr>
<td>(Chair) Director of Outcomes and Information and Senior Information Risk Owner (SIRO) Rushcliffe CCG</td>
<td>Andy Hall</td>
</tr>
<tr>
<td>Head of Information Governance, Mansfield and Ashfield CCG and Newark and Sherwood CCG</td>
<td>Alexis Farrow</td>
</tr>
<tr>
<td>Head of Information Governance, Nottingham City CCG</td>
<td>Paul Gardner</td>
</tr>
<tr>
<td>Caldicott Guardian South CCGs</td>
<td>Nichola Bramhall</td>
</tr>
<tr>
<td>General Practitioner Mid Nottinghamshire CCGs</td>
<td>Vacant</td>
</tr>
<tr>
<td>(Deputy Chair) General Practitioner Nottingham West CCG and Senior Information Risk Owner (SIRO) Nottingham West</td>
<td>Mike O’Neil</td>
</tr>
<tr>
<td>Senior Information Risk Owner (SIRO) Nottingham North and East</td>
<td>Hazel Buchanan</td>
</tr>
<tr>
<td>Caldicott Guardian Mansfield and Ashfield CCG and Newark and Sherwood CCG</td>
<td>Elaine Moss</td>
</tr>
<tr>
<td>Senior Information Risk Owner (SIRO) for Mansfield and Ashfield CCG and Newark and Sherwood CCG</td>
<td>Sarah Bray</td>
</tr>
<tr>
<td>Governing Body Lay Members of Newark &amp; Sherwood CCG</td>
<td>Paul Morris</td>
</tr>
<tr>
<td>General Practitioner Rushcliffe CCG</td>
<td>Dr Sean Ottey</td>
</tr>
<tr>
<td>Director of Health Informatics at NHIS</td>
<td>Eddie Olla</td>
</tr>
<tr>
<td><strong>Nominated deputies</strong></td>
<td></td>
</tr>
<tr>
<td>Head of Transformation, NHIS</td>
<td>Jaki Taylor</td>
</tr>
<tr>
<td>Representative Mansfield and Ashfield CCG and Newark and Sherwood CCG</td>
<td>Di Butcher</td>
</tr>
<tr>
<td>Representative Mansfield and Ashfield CCG and Newark and Sherwood CCG</td>
<td>Marcus Pratt</td>
</tr>
<tr>
<td>Representative Mansfield and Ashfield CCG and Newark and Sherwood CCG</td>
<td>Gina Holmes</td>
</tr>
<tr>
<td>Representative Rushcliffe CCG</td>
<td>Caroline Stevens</td>
</tr>
<tr>
<td>Representative Nottingham West CCG</td>
<td>Craig Sharples</td>
</tr>
<tr>
<td>Representative Nottingham North and East CCG</td>
<td>Sergio Pappalettera</td>
</tr>
</tbody>
</table>
NOTTINGHAMSHIRE CLINICAL COMMISSIONING GROUP (CCG) INFORMATION GOVERNANCE REPORTING FRAMEWORK

CCG GOVERNING BODY
Receives minutes and highlight report

CONNECTED NOTTINGHAMSHIRE IM&T SRO PROGRAMME BOARD

INFORMATION GOVERNANCE, MANAGEMENT AND TECHNOLOGY COMMITTEE

EAST MIDLANDS STRATEGIC INFORMATION GOVERNANCE NETWORK (EMSIGN)
Health and Social care IG Leads across East Midlands

RECORDS AND INFORMATION GROUP (RIG)
Local Health Community IG Leads

IG LEADS MEETING
Nottinghamshire CCG Operational IG CCG Leads and GEM and Nottingham City CCG IG Lead

DATA MANAGEMENT GROUP (DMG)
DMG CCG Leads and Head of Data Management

DATA ADVISORY GROUP (DAG)
NHIS and community wide group

PROJECT BOARDS for specific projects
NHS Nottingham West Clinical Commissioning Group
East Midlands Affiliated Commissioning Committee
Terms of Reference

Introduction

Nineteen East Midlands Clinical Commissioning Groups (CCG) have established a joint committee which enables the CCGs to work collaboratively on the development and maintenance of:

- Policies for services which CCGs have responsibility for commissioning; and
- New policies identified as being appropriate for identical implementation on a regional scale.

Accordingly the East Midlands Affiliated Commissioning Committee (EMACC) has been established as a joint committee of the 20 East Midlands CCGs in accordance with section 14Z3 of the NHS Act 2006 and the constitutions of each of the CCGs listed in Annex 1 (the Participating CCGs).

The terms of reference set out the membership, remit, responsibilities and reporting arrangements of EMACC.

The vision for EMACC is to:
Maximise resources, reduce duplication and ensure the development of clinical and cost effective policies that improve the quality of care for patients.

Principles

The EMACC decisions will be based on the following principles:

- **Optimise Health Outcomes**: To agree policies that aim to achieve the greatest possible improvement in health outcomes for the East Midlands population within the resources that are available;
- **Clinical Effectiveness**: Ensure that the decisions are based on sound evidence of clinical effectiveness;
- **Cost Effectiveness**: Take into account cost-effectiveness analyses of healthcare interventions (where available) to assess which interventions yield the greatest benefits relative to the cost of providing them as part of agreeing policies;
- **Equity**: Operate within the context of each individual within the East Midlands population being of equal value;
- **Access**: Ensure that policy decisions reflect the need for care to be delivered as close to where patients live as possible;
- **Patient Choice**: Respect the right of individuals to determine the course of their own lives, including the right to be fully involved in decisions concerning their health care. However, this has to be balanced against the responsibility to ensure equitable and consistent access to appropriate quality healthcare for all the population;
- **Affordability**: Ensure policies that are approved are evidence based to deliver clinical and cost effective delivery of care within the resources available to the CCGs. Where policies exceed the available resources of the CCGs, EMACC will consider prioritisation of the policies based on national and local policies and strategies, including local assessments of the health needs of the population;
- **Disinvestment**: As well as agreeing new policies on the basis of the criteria above, EMACC will...
keep policies under constant review to ensure that they continue to deliver clinical and cost-effective services at affordable cost;

- **Quality**: EMACC will aim to agree policies that offer high quality services as evidenced against national and international best practice.

**Responsibilities**

The principal duties of the EMACC are to:

- Recommend the Annual Work Programme (Appendix 4) which will set out the policies to be developed by EMACC for approval by the governing bodies of the Participating CCGs by 31st March every year;
- Make binding decisions on clinical policies delegated by the Participating CCGs in the Annual Work Programme listed in Appendix 4;
- Make binding decisions on clinical policies that are outside the Annual Work Programme in year where the EM CCGs determine that they fall within EMACC’s remit;
- Consider recommendations from the CPSG;
- Agree decisions using a recognised and validated process for assessment based on evidence, quality, value for money, equality and inequality with due regard to the need to act transparently and ensure a robust decision making process;
- Take or arrange for all necessary steps to be taken to enable CCGs to comply with their statutory duties including (but not limited to) the quality and choice of health care provision, working to the NHS Constitution;
- Manage and update risk and conflict of interest registers;
- Ensure a shared commitment to improving quality, reducing inequalities and ensuring that collective resources secure a sustainable NHS that does not disadvantage or destabilise the functions;
- Promote the contribution of partner organisations contribution to the production of robust policies;
- Ensure full engagement with the relevant clinical and non-clinical experts from all the CCGs across the region to ensure they have opportunity to shape the policy;
- Engage patients and the public in the development and maintenance of the policies;
- Provide opportunity for shared learning and development across the local system that result in improved practice and better outcomes for the population;
- Provide the mechanism through which consensus can be built between the CCGs;
- Agree communications and ways of working as part the implementation of the decisions made;
- Establish and annually review the terms of reference for the CPSG;
- Publish meetings and minutes and an annual overview for inclusion in the Host CCG’s public annual report; and
- Deliver the Annual Work Programme on time and within the annual budget set by the Participating CCG’s as part of the Annual Work Programme.

**Hosting Arrangements and Funding**

The Participating CCGs have agreed that **NHS Nottingham West CCG** will be the Host of EMACC and that it will employ the chair and supply any other staff required to provide managerial and administrative support for EMACC (**the Host CCG**). Hosting arrangements will be agreed annually as part of the Annual Work Programme (as defined in Appendix 4).

The costs of the above employees, administrative support and audit and governance arrangements are funded by all of the Participating CCGs.

The budget is agreed annually by the Participating CCGs as part of the Annual Work Programme and the agreed budget is then apportioned amongst the participating CCGs on a capitated basis.
### Decision Making

Decisions will be made by consensus of the CCG Representatives. Where this is not possible CCG Representative’s opting out of a decision or abstaining or in the minority may request the minutes reflect their position.

### Authority

The EMACC has delegated authority from each of the Participating CCGs in accordance with section 14Z3 of the NHS Act 2006 to:

- Undertake the responsibilities listed in section 11;
- Seek any information it requires in order to discharge its duties from any source;
- Seek information from any of the CCG’s employees;
- Secure support from each Participating CCG to ensure they commit officers who are competent, available, authorised to represent and negotiate the CCG’s position to input fully to the delivery of the Annual Work Programme;
- Call on the obligation of Local Authority Public Health to support delivery of the Annual Work Programme under the CCG Memorandum of Understanding with Public Health in Local Authorities;
- Establish and oversee a Clinical Priorities Steering Group (CPSG) which will support delivery of any EMACC’s duties and responsibilities;
- Direct CPSG to adopt task and finish processes to deliver the Annual Work Programme calling on subject matter experts to develop, review and amend policies.

### Sub-Groups

EMACC has a delivery group to assist EMACC’s delivery of the responsibilities listed in section 11:

The Clinical Priorities Steering Group (**CPSG**) will not have any delegated powers and is an advisory and delivery group. CPSG will operate under Terms of Reference agreed by EMACC.

### Membership

The members of EMACC shall be as follows:

**Standing members:**

- Independent Chair.
- Two Representatives in total from each participating CCG, one clinical and one non-clinical, nominated by their respective Governing Bodies (**both called CCG Representative**) or nominated to represent the CCGs in their geographical area (see below* and footnote);
- Public and Patient Representative with population perspective;
- Senior Officer of the Clinical Priorities Steering Group.

The CCG Representatives may appoint a deputy to attend on their behalf (**Nominated deputy**).

*The CCG Representatives may also agree to appoint one clinical and one non-clinical regional representative for each geographical area¹ to attend and represent all of the Participating CCGs provided that any such appointing CCG Representative is entitled to revoke this appointment and attend meetings themselves at any time should he or she wish to do so.

**Co-optees**

The Chair may co-opt such other individuals as may be required from time to time including, for example, but not limited to:

- EMACC Commissioning Manager.

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¹ Derbyshire, Nottinghamshire, Lincolnshire, Northamptonshire and Leicestershire
- Topic experts, clinical and non-clinical.
- Director of Commissioning.
- Director of Finance.
- Directors of Nursing/Quality.

## Attendance

The Chair of EMACC will be an independent lay member and the Vice Chair will be a CCG Representative. The Vice Chair will be nominated from the membership of the committee. In the event of the Chair being unable to attend all or part of the meeting the Vice Chair will deputise.

No business shall be transacted at any meeting unless a quorum is present.

A quorum will be the Chair or Vice Chair and one clinical or non-clinical CCG Representative from each of the five geographical regions of Nottinghamshire, Derbyshire, Leicestershire, Lincolnshire and Northamptonshire.

## Frequency and Conduct of Business

EMACC will meet at least three times a year and meetings will be held in April, September and January. Meetings (including extraordinary meetings) shall be convened at the discretion of the Chair.

Meetings will be organised and supported by the Host CCG. An agenda and supporting papers will be issued to Members not less than five working days before the meeting dates.

## Reporting

The EMACC will report to each CCG Governing Body following each meeting. Such reports will be prepared and circulated to all Participating CCGs by the Host CCG (following approval by the Chair) and will compromise the minutes of the meeting, summary of action taken since the last report, up to date risk register and an up to date conflicts of interest register.

Minutes of the meeting will be available as requested and published publically on the Host CCG website.

The work of EMACC will be subject to regular monitoring by the Host CCG Audit Committee, which will undertake at least one formal review in the first year as part of its assurance function.

## Declaration of Interest & Register of Procurement Decisions

The Host CCG will maintain and keep up to date a conflicts of interest register on behalf of EMACC.

Members are required to declare any interests which relate to a particular issue under consideration as soon as they become aware of it and at the start of each meeting. Any such declaration will be formally recorded in the minutes (along with details of the action taken to address the conflict) and declaration of interest forms completed for the Register of Interests. The Chair’s decision regarding a Member’s participation, or that of any attendee, in any meeting will be final. The Chair’s decision regarding a Member’s participation in a meeting (or part of a meeting) will be final.

If the Chair has a conflict of interest the Vice Chair shall make a decision regarding their participation and that decision shall be final.
### Conduct

Members and attendees will act in accordance with all applicable laws and guidance and relevant codes of conduct/good governance practice, and shall comply with the Host CCG’s Conflict of Interest Policy.

### Review

The EMACC Terms of Reference will be reviewed annually by the EM CCG Congress.

Any changes to these Terms of Reference which are proposed by the East Midlands CCG Congress must be approved by the Governing Bodies of the Participating CCGs before they are deemed to take effect.

**Date of Approval:**

**Review date:**
Appendix 1

East Midlands Affiliated Commissioning Committee (EMACC)

Final Terms of Reference: Summary of changes following Governing Body reviews

Introduction

Table 1 below details the changes to the EMACC draft terms of reference; document reference EMACC Draft Proposal v1.5 dated 25-11-15.

The original paper and tracked changed document are available on request.

Column 1 includes the place in the document and change in *italics*. Column 2 shows the original section and page and column 3 where the changes are in the final version.

Table 1

<table>
<thead>
<tr>
<th>Section and change – <em>italics</em> denotes wording change/amend/addition</th>
<th>Section and Page Number Original draft document</th>
<th>Section and Page Number Final Terms of Reference</th>
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<tbody>
<tr>
<td><strong>Executive summary cover page</strong></td>
<td>Page 1 of 27</td>
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<tr>
<td><strong>April 2016 Executive cover paper</strong></td>
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<tr>
<td>Changed ‘proposes’ to ‘confirms’</td>
<td>Page 3 of 27</td>
<td>New Cover separate paper</td>
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<td><strong>Terms of Reference</strong></td>
<td>Appendix 1 Page 8 of 27</td>
<td>Title Page 2 of 13</td>
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<td>Removed ‘draft’ from the title</td>
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<td><strong>Introduction</strong></td>
<td>Appendix 1 Page 8 of 27</td>
<td>Section 1 Page 2 of 13</td>
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<tr>
<td>Amended from ‘wish to establish’ to ‘have established’</td>
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<tr>
<td><strong>Vision</strong></td>
<td>Appendix 1 Page 8 of 27</td>
<td>Section 2 Page 2 of 13</td>
</tr>
<tr>
<td>Added ensure ‘the development of’ clinical and cost effective policies</td>
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<tr>
<td><strong>Principles</strong></td>
<td>Appendix 1 Page 8 of 27</td>
<td>Section 3 Page 2 of 13</td>
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<tr>
<td>Bullet 7: Affordability amended from...</td>
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<td>Will not agree policies that may not be able to afford all</td>
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<td>interventions supported by evidence of clinical and cost-effective</td>
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<td>effectiveness within the available resources. Where this is the</td>
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<td>case, advise CCGs to undertake further prioritisation based on</td>
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<td>criteria including national and local policies and strategies,</td>
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<td>local assessment of the health needs of the population, to</td>
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<td>ensure that the CCGs do not exceed their available resources;</td>
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<td>Ensure policies that are approved are evidence based to deliver</td>
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<td>clinical and cost effective delivery of care within the resources</td>
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<td>available to the CCGs. Where policies exceed the available</td>
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<td>resources of the CCGs, EMACC will consider prioritisation of the</td>
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<td>including local assessments of the health needs of the population</td>
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<td><strong>Hosting arrangements</strong>&lt;br&gt;Removed ‘INSERT NAME’&lt;br&gt;Inserted ‘NHS Nottingham West CCG’</td>
<td>Section 4 Page 9 of 27</td>
<td>Section 4 Page 3 of 13</td>
</tr>
<tr>
<td><strong>Membership</strong>&lt;br&gt;Changed ‘voting’ to ‘standing members’&lt;br&gt;Added two additional standing members ‘public and patient representative with a population perspective’ and ‘senior officer from the Clinical Priorities Steering Group’</td>
<td>Section 5 Bullets Page 9 of 27</td>
<td>Section 5 Page 3 of 13</td>
</tr>
<tr>
<td><strong>Membership</strong>&lt;br&gt;Amended ...One clinical and one non-clinical CCG Representatives may also agree to appoint one clinical and one non-clinical regional representative for each geographical area to attend and ‘represent’...&lt;br&gt;Geographical areas added to a footnote</td>
<td>Section 5 Paragraph 3 Page 9 of 27</td>
<td>Section 5 Page 3 of 13</td>
</tr>
<tr>
<td><strong>Membership</strong>&lt;br&gt;Amended ...CCG Representatives may also agree to appoint 1 regional representative for each geographical area to attend and ‘represent’...&lt;br&gt;Removed ‘non-voting members’</td>
<td>Section 5 Paragraph 3 Page 9 of 27</td>
<td>Section 5 Page 3 of 13</td>
</tr>
<tr>
<td><strong>Chair and Vice Chair</strong>&lt;br&gt;Amended ...They will be appointed by the Host CCG to The Vice Chair will be nominated from the membership of the committee.</td>
<td>Section 6 Page 10 of 27</td>
<td>Section 6 Page 4 of 13</td>
</tr>
<tr>
<td><strong>Attendees</strong>&lt;br&gt;Removed the section as duplicates section 5</td>
<td>Section 8 Page 10 of 27</td>
<td>Removed</td>
</tr>
<tr>
<td><strong>Authority</strong>&lt;br&gt;Removed bullet 3 as repeat of bullet 2</td>
<td>Section 10 Bullet 3</td>
<td>Removed</td>
</tr>
<tr>
<td><strong>Responsibility</strong>&lt;br&gt;Bullet 2: Removed reference to annexes and replaced with...‘Make binding decisions on clinical policies delegated by the Participating CCGs in the Annual Work Programme listed in Appendix 4 which were in place prior to the 2012 NHS reforms’&lt;br&gt;Bullet 4 removed receive&lt;br&gt;Added bulletin 14 ‘ensure full engagement with the relevant clinical and non-clinical experts from all CCGs across the region to ensure they shape policy’</td>
<td>Section 11 Page 11 and 12 of 27</td>
<td>Section 11 Page 4 of 13</td>
</tr>
<tr>
<td><strong>Voting</strong>&lt;br&gt;Removed ‘voting’ and replaced with ‘decision making’&lt;br&gt;Amended - Decisions will be made by consensus of the CCG Representatives. Where this is not possible CCG Representative’s ‘opting out’ of a decision or abstaining but in the minority may request the minutes reflect their position</td>
<td>Section 12 Page 12 of 27</td>
<td>Section 12 Page 5 of 13</td>
</tr>
</tbody>
</table>
### Section and change – ‘italics’ denotes wording change/amend/addition

<table>
<thead>
<tr>
<th>Section and Page Number Original draft document</th>
<th>Section and Page Number Final Terms of Reference</th>
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</table>
| **Sub groups**  
Removed the list of the Clinical Priorities Steering Group (CPSG) duties and added a general statement. CPSG terms of reference will be set by EMACC so EMACC can discharge it’s duties. | Section 13  
Page 12 of 27 | Section 12  
Page 6 |
| **Declaration of Interest and Register of Procurement Decisions**  
Removed ‘Procurement Decisions’  
Removed ‘...and in the case of a CCG representative their entitlement to vote’ | Section 15  
Page 13 of 27 | Section 14  
Page 6 of 13 |
| **Date of document**  
Amended to ‘final’ and ‘dated’ | Page 13  
Page 7 of 14 |
| **Participating CCGs**  
Removed ‘NHS Milton Keynes’ | Annex 1  
Page 14 | Appendix 2  
Page 8 of 13 |
| **Job Description - Chair**  
Inserted ‘NHS Nottingham West CCG’ as host. Amended salary to ‘rates linked to lay members rates for CCGs’ | Appendix 2  
Removed |
| **Budget**  
Approximate budget for 16/17  
Chair salary not confirmed until appointed but to be in line with current, average, CCG lay member rates. | Appendix 3  
Page 22 of 27 | Appendix 3  
Page 9 of 13 |
| **Potential Areas for the Annual Work Programme**  
Amended to ‘Annual Work Programme 2016-2017’ | Annex 2  
Page 15 of 27 | Appendix 4  
Page 13 of 13 |
| **Model wording**  
For amendments to Clinical Commissioning Groups’ constitutions | Appendix 4  
Page 22 | Removed |
Participating CCGs

1. NHS Southern Derbyshire CCG
2. NHS North Derbyshire CCG
3. NHS Erewash CCG
4. NHS Hardwick CCG
5. NHS Nottingham City CCG
6. NHS Nottingham West CCG
7. NHS Nottingham North & East CCG
8. NHS Rushcliffe CCG
9. NHS Newark & Sherwood CCG
10. NHS Mansfield & Ashfield CCG
11. NHS Corby CCG
12. NHS Nene CCG
13. NHS West Leicestershire CCG
14. NHS Leicester City CCG
15. NHS East Leicestershire & Rutland CCG
16. NHS Lincolnshire West CCG
17. NHS South West Lincolnshire CCG
18. NHS South Lincolnshire CCG
## Approximate Budget – 2016/17

### Staff Category

<table>
<thead>
<tr>
<th>Name</th>
<th>Pay Scale</th>
<th>Current Inc.</th>
<th>Next Inc.</th>
<th>Date of next Increment</th>
<th>Days at current Inc.</th>
<th>Months at current Inc.</th>
<th>Total Net of Oos Costs</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
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</table>

#### Band 7
- **Approx. Chair Lead EMISCA**
  - Approximate annual cost until appointed - to be paid in line with current lay member CCG
  - Approx. Non-Pay and overheads
  - Approx. Contingency pay and non-pay
  - Approximate CCGs contribution

#### Band 8
- **Approx. Total Cost**
  - 10,000

### Approximate Budget for 2016/17

<table>
<thead>
<tr>
<th>2015-16</th>
<th>31/03/16</th>
<th></th>
</tr>
</thead>
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### CCGs Contribution

- **Total CCGs Contribution**
  - 4,242

### Notes

- 26,760
- 5,206
- 26,760
- 0.60 Band 7 working on EMISCA
- 12,840
- 0.60 Band 8 working on EMISCA
- 10,000
- 10,000
- 10,000
- 10,000
- 3,000
- 18,000
- Approx. Total Cost

---

**NHS Nottingham West Clinical Commissioning Group Appendix 3**

---

60
The 2016-17 Annual Work Programme will focus on a number of policies that are in need to urgent review and updating. Table 2, below, provides the detail.

Table 2: Annual Work Programme 16/17

<table>
<thead>
<tr>
<th>Clinical Policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthotic functional electrical stimulation for foot drop of neurological origin</td>
</tr>
<tr>
<td>Hip Arthroscopy all pathologies</td>
</tr>
<tr>
<td>Surrogacy</td>
</tr>
<tr>
<td>Gastric Electrical Stimulation</td>
</tr>
<tr>
<td>Gamete Cryopreservation</td>
</tr>
<tr>
<td>Use of Bone Morphogenetic proteins</td>
</tr>
</tbody>
</table>
Introduction

The Terms of Reference (ToR) for East Midlands Affiliated Commissioning Committee (EMACC) has been agreed by eighteen East Midlands Clinical Commissioning Groups.

NHS Lincolnshire East CCG is expected to agree the ToR on 28 April 2016 which will total nineteen participating CCGs.

A number of actions are required to take forward the work of EMACC and to drive the annual work programme. These are described in Tables 1 and 2 below.

Table 1: Next Steps

<table>
<thead>
<tr>
<th>What</th>
<th>By when</th>
<th>By whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG Governing Bodies/Executive Teams to receive the final Terms of</td>
<td>April 2016</td>
<td>CCG Chief Officers</td>
</tr>
<tr>
<td>Reference and note the proposed 2016-2017 annual work plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appointment of the Chair of EMACC</td>
<td>28 April 2016</td>
<td>Vicky Bailey, panel will include Falu Bharmal, Deputy Chief Officer, NHS</td>
</tr>
<tr>
<td>Appointment of the manager and associated support arrangements</td>
<td>20 April 2016</td>
<td>Erewash CCG and Ben Milton, Clinical Chair, NHS North Derbyshire CCG</td>
</tr>
<tr>
<td>Hold a workshop with all CCG members to agree the membership and</td>
<td>May 2016</td>
<td>Tracy Madge and Jonathan Gribbin</td>
</tr>
<tr>
<td>responsibilities of the Clinical Priorities Steering Group (CPSG)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Invite CCGs to nominate their EMACC members</td>
<td>May 2016</td>
<td>Tracy Madge</td>
</tr>
<tr>
<td>Issue the agenda and papers for the inaugural meeting of EMACC</td>
<td>August 2016</td>
<td>EMACC Manager</td>
</tr>
<tr>
<td>Hold the inaugural meeting of EMACC</td>
<td>September 2016</td>
<td>EMACC Manager</td>
</tr>
<tr>
<td>Agree the time frame for internal audit to review EMACC in 2017-18</td>
<td>October 2016</td>
<td>EMACC Manager</td>
</tr>
</tbody>
</table>
## Appendix B - Meeting Schedule

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Date</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing Body</td>
<td>3rd Thursday of the month, 1pm</td>
<td>Monthly</td>
</tr>
<tr>
<td>Clinical Development Committee</td>
<td>2nd Thursday of the month, 1:30pm</td>
<td>Monthly</td>
</tr>
<tr>
<td>Remuneration Committee</td>
<td>As and when required</td>
<td>At least once a year. As deemed necessary.</td>
</tr>
<tr>
<td>Finance &amp; Performance Committee</td>
<td>3rd Tuesday of the month, 9am</td>
<td>Monthly</td>
</tr>
<tr>
<td>Patient Reference Group</td>
<td>1st Thursday of the month, alternate between 1pm and 6pm</td>
<td>Monthly</td>
</tr>
<tr>
<td>Audit &amp; Governance Committee</td>
<td>Various, in line with financial reporting and audit cycle</td>
<td>Quarterly</td>
</tr>
<tr>
<td>East Midlands Affiliated Commissioning Committee (EMACC)</td>
<td>Meetings will be held in April, September and January</td>
<td>At least three times a year</td>
</tr>
<tr>
<td>Quality &amp; Risk Committee</td>
<td>Various, in line with members’ availability</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Primary Care Co-Commissioning Committee</td>
<td>Following Governing Body meetings, 3rd Thursday of the month</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Individual funding Request Panel</td>
<td>2nd Thursday of the month, 9am</td>
<td>Monthly</td>
</tr>
<tr>
<td>Information Governance, Management &amp; Technology Committee</td>
<td>4th Friday of the month, 1:30pm</td>
<td>Bi-monthly</td>
</tr>
<tr>
<td>Safeguarding Committee</td>
<td>Various, in line with members’ availability</td>
<td>Bi-monthly</td>
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</tbody>
</table>
### Appendix C - Summary of Committee Membership

<table>
<thead>
<tr>
<th>Member</th>
<th>Governing Body</th>
<th>Clinical Development Committee</th>
<th>Remuneration Committee</th>
<th>Finance &amp; Performance Committee</th>
<th>Patient Reference Group</th>
<th>Audit &amp; Governance Committee</th>
<th>East Midlands Affiliated Commissioning Committee</th>
<th>Quality &amp; Risk Committee</th>
<th>Individual Funding Request Panel</th>
<th>Information Management &amp; Technology Committee</th>
<th>Safeguarding Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Member for Patient &amp; Public Involvement</td>
<td>Lay Member</td>
<td>Lay Member</td>
<td>Lay Member with a Lead for Governance</td>
<td>Patient Representative elected from the Patient Reference Group</td>
<td>Independent Secondary Care Doctor</td>
<td>Chief Clinical Officer</td>
<td>GP Lead for Finance &amp; Information</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
<td>Director of Contracting</td>
<td>Director of Outcomes and Information</td>
</tr>
<tr>
<td>Lay Member</td>
<td></td>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>C = Chair</th>
<th>A = Attendance</th>
<th>V = Member</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Member</th>
<th>Governing Body</th>
<th>Clinical Development Committee</th>
<th>Remuneration Committee</th>
<th>Finance &amp; Performance Committee</th>
<th>Patient Reference Group</th>
<th>Audit &amp; Governance Committee</th>
<th>East Midlands Affiliated Commissioning Committee</th>
<th>Quality &amp; Risk Committee</th>
<th>Individual Funding Request Panel</th>
<th>Information Management &amp; Technology Committee</th>
<th>Safeguarding Committee</th>
</tr>
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<tbody>
<tr>
<td>Lay Member for Patient &amp; Public Involvement</td>
<td>Lay Member</td>
<td>Lay Member</td>
<td>Lay Member with a Lead for Governance</td>
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<td>GP Lead for Finance &amp; Information</td>
<td>Accountable Officer</td>
<td>Chief Finance Officer</td>
<td>Director of Contracting</td>
<td>Director of Outcomes and Information</td>
</tr>
<tr>
<td>Lay Member</td>
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</table>

<table>
<thead>
<tr>
<th>C = Chair</th>
<th>A = Attendance</th>
<th>V = Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment Factors</td>
<td>NHS Nottingham West CCG Assessment</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>That the constitution meets the requirements of legislation and is otherwise appropriate</td>
<td>The NHS Nottingham West CCG Constitution follows the Department of Health model constitution framework, with proposed variations are reflective of national guidelines.</td>
<td></td>
</tr>
<tr>
<td>That each of the members is a provider of primary medical services</td>
<td>Variations to the constitution do not involve the addition or removal of members as providers of primary medical services.</td>
<td></td>
</tr>
<tr>
<td>That the area is appropriate (i.e. that there are no overlapping CCGs and no gaps)</td>
<td>The geographical area is not proposed to be varied from authorisation on 1st April 2013. There are no overlapping CCGs or gaps.</td>
<td></td>
</tr>
<tr>
<td>That the proposed Accountable Officer is appropriate</td>
<td>The changes to the Accountable Officer role are concordant with the guidance provided from the Department of Health and NHS England, and mirror the leadership arrangements of partner CCGs.</td>
<td></td>
</tr>
<tr>
<td>That the CCG has made appropriate arrangements to ensure it is suitable to discharge its functions</td>
<td>The CCG has made appropriate arrangements to be able to discharge its functions as documented in its constitution, approved as part of the CCG’s authorisation on 1st April 2013. The proposed variations, do not impact on the discharge of statutory functions.</td>
<td></td>
</tr>
<tr>
<td>That is has made arrangements to ensure that its Governing Body is correctly constituted and otherwise appropriate</td>
<td>The variations to the Constitution will ensure that the Governing Body of NHS Nottingham West will remain constituted in accordance with national guidance.</td>
<td></td>
</tr>
<tr>
<td>The likely impact of the requested variation on the persons for whom the CCG has responsibility – so the registered and resident population for the CCG</td>
<td>The proposed variations are of a governing administrative nature and as such do not have a significant impact on the registered and resident population of the CCG.</td>
<td></td>
</tr>
<tr>
<td>The likely impact on financial allocations of the CCG and any other CCG affected for the financial year which the variation would take effect</td>
<td>The proposed variations do not have an impact on the financial allocations of the CCG or any other CCG for the financial year in which the variations would take effect.</td>
<td></td>
</tr>
<tr>
<td>The likely impact on NHS England’s functions</td>
<td>The proposed variations do not have an impact on the functions of NHS England.</td>
<td></td>
</tr>
<tr>
<td>The extent to which the CCG has sought the views of the following, what those views are, and how the CCG has taken them into account: - Any unitary local authority and/or upper-tier county council whose area covers the whole or any part of the CCG’s area; - Any other CCG which would be affected; - Any other person or body which in the CCG’s view might be affected by the variation requested</td>
<td>The CCG has actively consulted on the governance review proposals with the Patient Reference Group and taken views into account when considering the changes.</td>
<td></td>
</tr>
<tr>
<td>The extent to which the CCG has sought the views of patients and the public; what those views are; and how the CCG has taken them into account</td>
<td>The CCG has actively consulted on the governance review proposals with the Patient Reference Group and taken views into account when considering the changes.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>How often the CCG has applied for variations of the kind requested</td>
<td>Not applicable.</td>
<td></td>
</tr>
</tbody>
</table>
NHS NOTTINGHAM WEST
CLINICAL COMMISSIONING GROUP

DRAFT CONSTITUTION

Version: NW Constitution – 2.4

NHS Commissioning Board Effective Date: 1st April 2013

Revised: September 2016
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<td>The GP Chair of the Governing Body</td>
<td>40</td>
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<td>Role of the accountable officer</td>
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FOREWORD

Welcome to the constitution of NHS Nottingham West Clinical Commissioning Group (CCG). The membership of the CCG is made up of 12 local GP Practices who are working together to plan and pay for local health services for approximately 94,000 patients. Our area includes Eastwood, Kimberley, Stapleford, Beeston, Bramcote and Chilwell.

Every CCG must have a constitution which sets out:

- the arrangements that it has made to discharge its functions and those of its Governing Body;
- its key processes for decision making, including arrangements for securing transparency in the decision making of the clinical commissioning group and its Governing Body;
- the arrangements made for discharging its duties with regard to registers of interest and managing conflicts of interest.

CCGs (as member organisations) should involve all of their member practices in designing their arrangements to discharge their responsibilities as set out in their constitution.

The constitution applies to the following, all of whom are required to adhere to it as a condition of their appointment:

- the group’s member practices
- the group’s employees
- individuals working on behalf of the group
- anyone who is a member of the group’s Governing Body (including the Governing Body’s Audit and Remuneration committees)
- anyone who is a member of any other committee(s) or sub-committees established by the group or its Governing Body

We will continue to be an innovative, effective and robust CCG. Above all, we are committed to championing the needs of our patient population and developing high-quality health services fit for the future.

We are aligning our resources to ensure we meet the financial challenges that the NHS continues to face. We will continue to commission high-quality and patient-focused services which provide value for money.

We are confident and ambitious about the future of clinical commissioning in NHS Nottingham West.

Vicky Bailey, Chief Officer
INTRODUCTION AND COMMENCEMENT

1.1. Name

1.1.1. The name of this clinical commissioning group is NHS Nottingham West Clinical Commissioning Group (henceforth referred to in this document as “the group”).

1.2. Statutory Framework

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

1.2.2. The NHS Commissioning Board is responsible for determining applications from prospective groups to be established as clinical commissioning groups\(^4\) and undertakes an annual assessment of each established group.\(^5\) It has powers to intervene in a clinical commissioning group where it is satisfied that a group is failing or has failed to discharge any of its functions or that there is a significant risk that it will fail to do so.\(^6\)

1.2.3. Clinical commissioning groups are clinically led membership organisations made up of general practices. The members of the clinical commissioning group are responsible for determining the governing arrangements for their organisations, which they are required to set out in a constitution.\(^7\)

1.3. Status of this Constitution

1.3.1. This constitution is made between the members of NHS Nottingham West Clinical Commissioning Group and has effect from the first day of April 2013, when the NHS Commissioning Board established the group.\(^8\)

1.3.2. The constitution is published on the group’s website at www.nottinghamwestccg.nhs.uk. The constitution document will also be available upon request for inspection at Stapleford Care Centre, the

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1. See section 11 of the 2006 Act, inserted by section 10 of the 2012 Act
2. See section 275 of the 2006 Act, as amended by paragraph 140(2)(c) of Schedule 4 of the 2012 Act
3. Duties of clinical commissioning groups to commission certain health services are set out in section 3 of the 2006 Act, as amended by section 13 of the 2012 Act
4. See section 14C of the 2006 Act, inserted by section 25 of the 2012 Act
5. See section 14Z16 of the 2006 Act, inserted by section 26 of the 2012 Act
6. See sections 14Z21 and 14Z22 of the 2006 Act, inserted by section 26 of the 2012 Act
7. See in particular sections 14L, 14M, 14N and 14O of the 2006 Act, inserted by section 25 of the 2012 Act and Part 1 of Schedule 1A to the 2006 Act, inserted by Schedule 2 to the 2012 Act and any regulations issued
8. See section 14D of the 2006 Act, inserted by section 25 of the 2012 Act
headquarters of NHS Nottingham West Clinical Commissioning Group, and in all of the GP practices that are members of the CCG.

The document is available on request by post from:

NHS Nottingham West Clinical Commissioning Group
Stapleford Care Centre
Church Street
Stapleford
Nottinghamshire
NG9 8DB

Or by email from nottingham.west@nottinghamwestccg.nhs.uk

1.4. Amendment and Variation of this Constitution

1.4.1. This constitution can only be varied in two circumstances.⁹

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

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

2. AREA COVERED

2.1 The geographical area covered by NHS Nottingham West Clinical Commissioning Group is in the Borough of Broxtowe, Nottinghamshire. This was approved by the Strategic Health Authority in its configuration assessment in January 2012.

⁹ See sections 14E and 14F of the 2006 Act, inserted by section 25 of the 2012 Act and any regulations issued
The membership of the CCG is made up of 12 local GP Practices with a population of 94,000 patients. Our area includes Eastwood, Kimberley, Stapleford, Beeston, Bramcote and Chilwell.

There are two practices in Broxtowe borough, Giltbrook and Newthorpe, which are not part of NHS Nottingham West Clinical Commissioning Group. They are part of NHS Nottingham North & East Clinical Commissioning Group. The map of the geographical area of NHS Nottingham West is attached, with the Lower-layer Super Output Areas (LSOAs) defined.

NHS Nottingham North & East and NHS Nottingham West Clinical Commissioning Groups have signed a memorandum of agreement, which details the commissioning arrangements to ensure coverage of all unregistered and registered population in Broxtowe.
The two CCGs have agreed that NHS Nottingham West CCG will take responsibility for commissioning for unregistered patients; and Nottingham North & East has responsibility for those patients registered with the Giltbrook and Newthorpe practices.

3. **MEMBERSHIP**

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

3.1.1. The following practices comprise the members of NHS Nottingham West Clinical Commissioning Group:

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
</tr>
</thead>
</table>
| Abbey Medical Centre              | 63 Central Avenue  
Beeston  
Nottingham  
NG9 2QP |
| Bramcote Surgery                  | 2a Hanley Avenue  
Bramcote  
Nottingham  
NG9 3HF |
| Church Street Medical Centre       | 11b Church Street  
Eastwood  
Nottingham  
NG16 3BS |
| The Surgery, Church Walk          | Church Walk  
Eastwood  
Nottingham  
NG16 3BH |
| Hama Medical Centre               | 11a Nottingham Road  
Kimberley  
Nottingham  
NG16 2NP |
| Hickings Lane Medical Centre      | Ryecroft Street  
Stapleford  
Nottingham  
NG9 8PN |
| Linden Medical Group              | Stapleford Care Centre  
Church Street  
Stapleford  
Nottingham  
NG9 8DB |
| The Manor Surgery                 | Middle Street  
Beeston  
Nottingham  
NG9 1GA |
| The Oaks Medical Centre           | 20 Villa Street  
Beeston  
Nottingham  
NG9 2NY |
<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saxon Cross Surgery</td>
<td>Stapleford Care Centre Church Street</td>
</tr>
<tr>
<td></td>
<td>Stapleford</td>
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<tr>
<td></td>
<td>Nottingham</td>
</tr>
<tr>
<td></td>
<td>NG9 8DB</td>
</tr>
<tr>
<td>The Valley Surgery</td>
<td>81 Bramcote Lane Church Street</td>
</tr>
<tr>
<td></td>
<td>Chilwell</td>
</tr>
<tr>
<td></td>
<td>Nottingham</td>
</tr>
<tr>
<td></td>
<td>NG9 4ET</td>
</tr>
<tr>
<td>The Valley Surgery (branch at Chilwell Meadows)</td>
<td>Ranson Road</td>
</tr>
<tr>
<td></td>
<td>Chilwell</td>
</tr>
<tr>
<td></td>
<td>Nottingham</td>
</tr>
<tr>
<td></td>
<td>NG9 6DX</td>
</tr>
<tr>
<td>West End Surgery</td>
<td>19 Chilwell Road</td>
</tr>
<tr>
<td></td>
<td>Beeston</td>
</tr>
<tr>
<td></td>
<td>Nottingham</td>
</tr>
<tr>
<td></td>
<td>NG9 1EH</td>
</tr>
</tbody>
</table>

3.1.2. Appendix B of this constitution contains the list of practices that have confirmed their agreement to this constitution. All these practices are current providers of primary medical services.

3.2 Eligibility

3.2.1 Providers of primary medical services (as defined in Regulation 2 of the National Health Service (Clinical Commissioning Groups) Regulations 2012) to a registered list of patients under a General Medical, Personal Medical Services or Alternative Provider Medical Services contract, will be eligible to apply for membership of this group.

4. MISSION, VALUES AND STRATEGY

4.1. Mission

4.1.1. The mission of NHS Nottingham West Clinical Commissioning Group is to improve the health and wellbeing of people living in and around Broxtowe, by commissioning high-quality and patient-focused services which provide value for money.

4.1.2. The group will promote good governance and proper stewardship of public resources in pursuance of its goals and in meeting its statutory duties.

4.2. Values

4.2.1. Our values are at the heart of our decision-making. They guide us in the priorities we set for service change and in the way we approach new challenges:
• Clinical leadership at the heart of the organisation,
• Constantly innovate to improve quality and experience for patients,
• Work closely with local providers and partners for the benefit of the whole of our population,
• Apply the best evidence available to improve local services and reduce health inequalities,
• By good governance, openness and sensible use of resources, produce the maximum health outcomes for the whole of our population.

4.3. **Strategic Objectives**

4.3.1. The group’s Strategic Objectives are to:

• Reduce health inequalities in the local population by targeting the health and wellbeing of people with the greatest health needs.
• Improve the quality of our local health services, particularly around health outcomes, patient safety, access and patient satisfaction.
• Organise services around the needs of local service users wherever possible.
• Maintain and optimise the health of people with long term or chronic illness living in our community.
• Focus our available resources where they will deliver the greatest benefit to our population.

4.4. **Principles of Good Governance**

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

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

b) *The Good Governance Standard for Public Services*;

c) the standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the ‘Nolan Principles’;

d) the seven key principles of the *NHS Constitution*;

e) the Equality Act 2010.

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10 Inserted by section 25 of the 2012 Act
11 *The Good Governance Standard for Public Services*, The Independent Commission on Good Governance in Public Services, Office of Public Management (OPM) and The Chartered Institute of Public Finance & Accountability (CIPFA), 2004
12 See Appendix F
13 See Appendix G
f) in accordance with Section 8 of this constitution.

4.4.2 All Governing Body members will act in accordance with the Standards for Members of NHS Boards and Governing Bodies in England.

4.5. Accountability

4.5.1. The group will demonstrate its accountability to its members, local people, stakeholders and the NHS Commissioning Board in a number of ways, including through:

   a) publishing its constitution;
   b) appointing independent lay members and non GP clinicians to its Governing Body in accordance with the Regulations;
   c) holding meetings of its Governing Body in public (except where the group considers that it would not be in the public interest in relation to all or part of a meeting);
   d) providing clear and regular reports to the Practice Members Group and any other information as required by the Group;
   e) publishing annually a commissioning plan;
   f) complying with local authority health overview and scrutiny requirements;
   g) meeting annually in public to publish and present its annual report (which must be published);
   h) producing annual accounts in respect of each financial year which must be externally audited;
   i) having a published and clear complaints process;
   j) complying with the Freedom of Information Act 2000;
   k) providing information to the NHS Commissioning Board as required.

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

   a) the advisory and scrutiny role undertaken by the Practice Members Group behalf of practice members, which will undertaking of an annual assessment of the Governing Body’s performance;
   b) Engagement with member practices and lead clinicians through the Practice Members Group, and the Clinical Development Committee.
c) Regular meetings of the Patient Reference Group in accordance with the Terms of Reference

d) Holding regular engagement events through an agreed NWCCG Events Programme

e) Publishing plans and policies on the internet site

f) Implementation of an annual Communications and Engagement Strategy and Action Plan. Monitoring this through six-monthly reports to the Governing Body

g) Membership of, and regular reporting to, partnership and other key groups. These include the Broxtowe Partnership Board, the Health Task Group, the Children and Young People Health Task Group, the Positive Communities Group, and the Environmental Health Group.

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

5. FUNCTIONS AND GENERAL DUTIES

5.1. Functions

5.1.1. The functions that the group is responsible for exercising are largely set out in the 2006 Act, as amended by the 2012 Act. They relate to:

a) commissioning certain health services (where the NHS Commissioning Board is not under a duty to do so) that meet the reasonable needs of:
   i) all people registered with member GP practices, and
   ii) people who are usually resident within the area and are not registered with a member of any clinical commissioning group;

b) commissioning emergency care for anyone present in the group’s area;

c) paying its employees’ remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the group’s employees;

d) determining the remuneration and travelling or other allowances of members of its Governing Body.
5.1.2. In addition to the functions set out in the preceding paragraph, the Group is also responsible for such primary care commissioning functions as may be delegated by NHS England.\(^{15}\)

5.1.3. In discharging its functions the group will:

a) act\(^{16}\), when exercising its functions to commission health services, consistently with the discharge by the Secretary of State and the NHS Commissioning Board of their duty to *promote a comprehensive health service*\(^ {17}\) and with the objectives and requirements placed on the NHS Commissioning Board through *the mandate*\(^ {18}\) published by the Secretary of State before the start of each financial year by:

i) Delegating responsibility to the Group’s Governing Body to oversee discharge of this duty

ii) Delegating responsibility for delivery to the committees of the Governing Body (including host arrangements) as defined in NHS Nottingham West Accountability Framework (Committee Structure) and Terms of Reference

iii) Delivering the priorities identified in the Group’s Annual Business Plan monitored by the Governing Body through regular reports

iv) The Group’s three Governing Body key roles (Accountable Officer, Chair, and Chief Finance Officer) complying with their duties

v) Delivering duties in accordance with the Group’s Standing orders, Prime Financial Policies, and Scheme of Delegation and Reservation

vi) Delivering duties in accordance with the Group’s Conflict of Interest Policy

vii) Delivering duties in accordance with the NHS Nottingham West Inter-Practice Agreement

b) *meet the public sector equality duty*\(^ {19}\) by:

i) Delegating responsibility to the Group’s Governing Body to assure the discharge of this duty; the Chair of the Governing Body is the named lead for Equality and Diversity

\(^{15}\) See section 13Z of the 2006 Act, inserted by section 23 of the 2012 Act

\(^{16}\) See section 3(1F) of the 2006 Act, inserted by section 13 of the 2012 Act

\(^{17}\) See section 1 of the 2006 Act, as amended by section 1 of the 2012 Act

\(^{18}\) See section 13A of the 2006 Act, inserted by section 23 of the 2012 Act

\(^{19}\) See section 149 of the Equality Act 2010, as amended by paragraphs 184 and 186 of Schedule 5 of the 2012 Act
ii) The Governing Body may delegate responsibility for delivery of this duty to the Quality and Risk Committee. This committee will manage, hold accountability for, and report on these responsibilities as described in the Quality and Risk Committee Terms of Reference.

iii) Implementing a Single Equality and Diversity Strategy and Action Plan to ensure delivery of the requirements of the Equality Delivery system, monitored by the Governing Body through regular reports.

iv) Publish annual information to demonstrate compliance with the Public Sector Equality Duty.

v) Publish the Group’s Equality Objectives, EDS2 Grading and action plan.

c) Work in partnership with its local authority[ies] to develop joint strategic needs assessments and joint health and wellbeing strategies by:

i) Delegating responsibility to the Group’s Governing Body to oversee discharge of this duty.

ii) Being a member of the Nottinghamshire County Health and Wellbeing Board through which integration of health and social care commissioning priorities and delivery of services can be aligned and integrated.

iii) Presenting key strategies and commissioning intentions to the Health and Wellbeing Board to ensure alignment with wider plans and priorities.

iv) Delegating responsibility to the group’s Accountable Officer to ensure that the group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authority.

v) Abiding by the relationship defined in the Memorandum of Understanding between Public Health within NHS Nottinghamshire County Council and Nottinghamshire Clinical Commissioning Groups including NHS Nottingham West Clinical Commissioning Group (for so long as the Memorandum continues in force). This includes:

- Contribute intelligence and capacity to the production of Joint Strategic Needs Assessments which will be led by Public Health and delivered through a programme of targeted needs assessments.
- Identifying shared priorities to inform the production of the Joint Health and Wellbeing Strategy.

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21 See section 116A of the Local Government and Public Involvement in Health Act 2007, as inserted by section 191 of the 2012 Act.
• Publishing commissioning intentions in line with the Public Health priorities including the areas outlined in Healthy Lives Healthy People Update and way forward (DH 2011)
• Utilise specialist Public Health skills to target services at greatest population need and towards a reduction of health inequalities

vi) Incorporating specialist Public Health skills into decision making through Public Health Consultant membership of the Clinical Innovation Group and attendance at Governing Body meetings;

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

5.2.1. Make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements22 by:

a) Delegating responsibility to the Group’s Governing Body to oversee discharge of this duty

b) Applying the principles and actions as stated in the Communications and Engagement strategy, specifically the key objectives:

i. Open and transparent decision-making processes
ii. Develop formal engagement structures to enable the patient voice to be heard at all levels within the organisation. This includes ‘seldom listened to’ groups.
iii. Implementing feedback mechanisms internally and externally
iv. Identifying opportunities for shared-decision making with patients, carers and communities
v. Greater partnership working with stakeholders

c) Working with the Patient Reference Group (PRG) in accordance with its Terms of Reference to support the delivery of this duty

d) Holding regular engagement events through an agreed NWCCG Events Programme

e) Lay membership on both the Governing Body and its committees.

5.2.2. Promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS Constitution23 by:

a) Delegating responsibility to the Group’s Governing Body to oversee discharge of this duty

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22 See section 14Z2 of the 2006 Act, inserted by section 26 of the 2012 Act
23 See section 14P of the 2006 Act, inserted by section 26 of the 2012 Act and section 2 of the Health Act 2009 (as amended by 2012 Act)
b) Delivering against the Group’s Communications and Engagement strategy

c) Securing governance arrangements which are founded on the NHS Constitution and its principles

d) Enabling open and transparent communications and engagement with local patients and other stakeholders to ensure feedback from, and ongoing dialogue with local people and partners

5.2.3 **Act effectively, efficiently and economically** by:

a) Delegating responsibility to the Group’s Governing Body to oversee discharge of this duty

b) Providing assurance of compliance through regular reporting to the Governing Body from the Finance and Performance Committee and the Audit and Governance Committee

c) Providing assurance of delivery against plan to the Governing Body from the Finance and Performance Committee

d) Providing assurance through reporting against the Governing Body’s Assurance Framework

e) Efficient allocation of resources to deliver the local priorities identified in the Group’s Annual Business Plan

f) The Group’s Accountable Officer will comply with their duty to ensure that the Group exercises its functions effectively, efficiently and economically thus ensuring the improvement in quality of services and the health of the population whilst maintaining value for money

g) Providing assurance of the Group’s Financial Strategy and the shared QIPP plans through the Finance and Performance Committee

h) Effectively collaborating with other local Clinical Commissioning Groups and Local Authorities where appropriate and in the interests of local people, to enable more effective and efficient working and economies of scale

5.2.4 Act with a view to **securing continuous improvement to the quality of services** by:

a) Delegating responsibility to the Group’s Governing Body to assure discharge of this duty

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24 See section 14Q of the 2006 Act, inserted by section 26 of the 2012 Act

25 See section 14R of the 2006 Act, inserted by section 26 of the 2012 Act
b) Delegating responsibility for delivery to the Quality and Risk Committee. This committee will manage, hold accountability for, and report on these responsibilities as described in the Quality and Risk Committee Terms of Reference.

c) Adhering to the Governing Body’s Assurance Framework which provides a single process for managing local priorities, standards and Integrated Governance arrangements and ensures that quality is scrutinised at a number of levels from Governing Body down to provider scrutiny panels.

d) The Group’s Accountable Officer will comply with his/her duty to ensure that the group exercises its functions effectively, efficiently and economically thus ensuring the improvement in quality of services and the health of the population whilst maintaining value for money.

e) Support the NHS Commissioning Board to improve the quality of specialised services, using contractual mechanisms, including CQUINs and the quality schedule, and through collaborative commissioning arrangements.

f) Creating a culture which supports continuous improvement in clinical effectiveness, safety and experience of services commissioned by the Group through:

i) Clinical and other leadership with a relentless focus on continuous improvement in all aspects of quality, safety and value for money.

ii) Actively seeking the views of patients, carers and the wider community about how services need to be improved and learning from these.

iii) Promoting and encouraging the reporting of errors and near misses, using them as a basis for continuous learning and quality improvement.

iv) Receiving patient, carer and staff complaints and concerns sympathetically, investigating promptly and using them to improve services.

v) Promoting a culture of continuous improvement in provider organisations through contracting and monitoring arrangements.

vi) Having in place systems and processes that secure continuous improvement throughout the commissioning cycle.

vii) Collaborative arrangements to deliver against local and shared QIPP plans.

viii) Development and training of clinicians and staff, including mandatory training such as safeguarding.

5.2.5 Assist and support the NHS Commissioning Board in relation to the Board’s duty to improve the quality of primary medical services
d by:

a) Delegating responsibility to the Group’s Governing Body to oversee discharge of this duty

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b) Defining the commitment to provide high quality care as a principle of membership within the Group’s Inter-Practice Agreement

c) Support and monitoring processes for compliance with the Care Quality Commission registration requirements

d) Regular meetings with the GMS/PMS contract team

e) Reporting mechanisms to monitor delivery of this duty

f) Encouraging practice members to hold each other to account for performance and the delivery of improvement actions as part of their role Practice Members Group

g) Governing body clinical leads to assume a leadership role for challenging and improving the quality of primary care

5.2.6 Have regard to the need to reduce inequalities\(^{27}\) by:

a) Delegating responsibility to the Group’s Governing Body to assure the discharge of this duty

b) Ensure that, in exercising its functions, the Governing Body has regard to the need to:

• Reduce inequalities between patients with respect to their ability to access health services
• Reduce inequalities between patients with respect to their health outcomes

c) Working in partnership with a wide range of local stakeholders and partners to address CCG wide challenges as well as specific deprived communities within the Group.

d) Monitoring delivery of the key aim to “Drive up the quality of care in order to improve health outcomes and reduce unwarranted clinical variation” within the Governing Body assurance framework.

e) Monitoring delivery of the Group’s Annual Business Plan through reports to the Governing Body from the Group’s committees.

f) Delivering against the priorities of the Health and Well Being Strategy

g) Allocating health resources on a ‘fair shares’ basis

\(^{27}\) See section 14T of the 2006 Act, inserted by section 26 of the 2012 Act
h) Working with local people to encourage and support them in taking appropriate responsibility for self-care and management, and to make responsible, informed choices about healthcare

5.2.7 *Promote the involvement of patients, their carers and representatives in decisions about their healthcare*\(^2\)\(^8\) by:

a) Delegating responsibility to the Group’s Governing Body to assure discharge of this duty; one of the designated Lay Members has a lead role for patient and public involvement

b) The Governing Body will work with the Patient Reference Group, a Committee of the Governing Body with responsibilities for making recommendations and observations to the Group in accordance with the Terms of Reference. The Patient Reference Group (PRG) comprises two PPG members from each GP Practice’s Patient Participation Group.

c) As well as the two lay members appointed to the Governing Body to take the lead for PPI and for Governance, one member of the PRG will be elected by its members to represent them on the Governing Body.

d) Two members of the PRG will be elected by its members to represent them on the Clinical Development Committee and the Quality and Risk Committee.

e) Applying the principles and actions as stated in the Communications and Engagement strategy, specifically the key objectives:

i. Open and transparent decision-making processes

ii. Develop formal engagement structures to enable the patient voice to be heard at all levels within the organisation. This includes ‘seldom listened to’ groups.

iii. Implementing feedback mechanisms internally and externally

iv. Identifying opportunities for shared-decision making with patients, carers and communities

f) Developing new and existing Patient Participation Groups (PPGs), and using the information and feedback obtained from them, via the Patient Reference Group, to inform decision-making by the Governing Body and its committees

5.2.8 Act with a view to *enabling patients to make choices*\(^2\)\(^9\) by:

a) Delegating responsibility to the Group’s Governing Body to oversee discharge of this duty.

b) Delivering the NHS pledges and patient rights included in the NHS Constitution.

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\(^{28}\) See section 14U of the 2006 Act, inserted by section 26 of the 2012 Act

\(^{29}\) See section 14V of the 2006 Act, inserted by section 26 of the 2012 Act
c) Ensuring the provision of NHS services free of charge, apart from certain limited exceptions sanctioned by Parliament.

d) Promoting provision of relevant patient information and shared decision making such as that described in the Group’s communication strategy.

5.2.9 **Obtain appropriate advice**\(^{30}\) from persons who, taken together, have a broad range of professional expertise in healthcare and public health by:

a) Delegating responsibility to the Group’s Governing Body to oversee discharge of this duty

b) The Practice Members Group provides clinical leadership to the Governing Body and its committees. With membership from every constituent practice, all practices are represented in discussions about reserved matters and commissioning decisions.

c) The Clinical Development Committee is a Committee of the Governing Body with delegated authority from the Governing Body. It provides a clinical focus on the design and delivery of pathways and services as described in the terms of reference. The membership of the Clinical Development Committee will include stakeholders from providers, local authority and patients.

d) Engaging with the Health and Well Being Board

e) Linking into clinical senates as well as professionals in community, secondary and tertiary care to obtain a broad range of clinical expertise to inform commissioning

f) Seeking public health advice as described in the Memorandum of Understanding between Public Health (for so long as the Memorandum continues in force) within Nottinghamshire County Council and Nottinghamshire Clinical Commissioning Groups including this Group.

g) Engaging with the Local Medical Committee, as local statutory representatives of General Practitioners.

h) Engaging with key providers on an on-going basis, through the infrastructure, to ensure delivery against targets as well as a long-term strategic approach

i) Involving clinicians and other health and social care professionals in committees, groups and programmes as appropriate to ensure the most effective outcomes for local people and health and social care services

5.2.10 **Promote innovation**\(^{31}\) by:

\(^{30}\) See section 14W of the 2006 Act, inserted by section 26 of the 2012 Act
a) Delegating responsibility to the Group’s Governing Body to assure discharge of this duty including a named member of the Governing Body taking a lead.

b) Delegating responsibility to develop and deliver new innovative services and ways of working to the Clinical Development Committee as described in the Terms of Reference.

c) Systematically ensuring innovation is core to service development through integration into local QIPP Plans and regular reports to the Governing Body to provide assurance of delivery of these plans.

5.2.11 *Promote research and the use of research*<sup>32</sup> by:

a) Delegating responsibility to the Group’s Governing Body to oversee discharge of this duty.

b) Supporting member GP practices to promote research and gain research accreditation.

c) Promoting
   i) research on matters relevant to the health service
   ii) use in the health service of evidence obtained from research.

d) Maintaining close links with the local National Institute for Health Research (NIHR) Networks including the Primary Care Research Network (PCRN), Comprehensive Local Research Network (CLRN), Collaboration for Leadership in Applied Health Research and Care (CLAHRC) and the local Academic Health Science Network.

5.2.12 Have regard to the need to *promote education and training*<sup>33</sup> for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health service in England so as to assist the Secretary of State for Health in the discharge of his related duty<sup>34</sup> by:

a) Delegating responsibility to the Group’s Governing Body to oversee discharge of this duty.

b) Delegating responsibility to the Accountable Officer to ensure arrangements for the ongoing developments of the group’s own members and staff.

c) Delivering against the Group’s Organisational Development Plan, including the development of current and future clinical and other leaders.
d) Including this duty in all commissioning contracts to ensure that providers of services pay regard to education and training.

e) Ensuring that all providers of services commissioned as part of the health service, including NHS and public health providers as well as private alternative providers, have a duty to cooperate with the secretary of state in the discharge of his duty to ensure an effective system for education and training.

f) Considering the planning, commissioning, and delivery of education and training in carrying out the group’s functions

g) Ensuring the delivery of mandatory and other essential training, such as safeguarding of adults and children

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

a) Delegating responsibility to the Group’s Governing Body to oversee discharge of this duty

b) Delegating responsibility for delivery of integration to the Clinical Development Committee and provision of assurance through regular reports to the Governing Body as described in the terms of reference.

c) Developing and delivering joint commissioning plans with Local Authorities and other partners

d) Engaging with the Overview and Scrutiny Committee for all planned service change.

e) Active participation in the Health and Well Being Board and its committees to ensure integration of health and social care services where appropriate

f) Exercising the group’s functions with a view to securing that provision of health services is integrated with provision of other health services, health related or social care services where this will

i. improve the quality of those services (including the outcomes that are achieved from their provision)

ii. reduce inequalities between persons with respect to their ability to access those services, or

iii. reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

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35 See section 14Z1 of the 2006 Act, inserted by section 26 of the 2012 Act
g) Working collaboratively with other local commissioners and providers within Greater Nottinghamshire to deliver whole system integration and efficiencies where this is in the best interest of the local population. This will incorporate QIPP priorities as appropriate.

h) Involvement of social care professionals in the development and delivery of plans to transform local services, e.g. Frail Older People

i) Membership of partnership groups with all the District Councils that are within the geographical area of the group.

5.2.14 Have regard to primary care commissioning, in respect of impact on services in certain areas\(^{37}\) by:

a) delegating responsibility to recognise and discharge this duty to the Primary Care Commissioning Committee

b) co-ordinating a common approach with other CCGs in the local health community to the commissioning of primary medical care services

5.2.15 Have regard to primary care commissioning, in respect of variation in provision of health services\(^{38}\) by:

a) delegating responsibility to recognise and discharge this duty to the Primary Care Commissioning Committee

b) planning primary medical care services including a needs assessment

c) undertaking reviews of primary medical care

5.3 General Financial Duties

The arrangements for these functions and any delegated responsibility are confirmed in the Standing Orders, the Scheme of Reservation and Delegation and the Prime Financial Policies.

The group will perform its functions so as to:

5.3.1 Ensure its expenditure does not exceed the aggregate of its allotments for the financial year by:

a) Establishing robust budget setting arrangements

b) The Accountable Officer will compile and submit to the Governing Body a Commissioning Strategy which takes into account financial targets and forecast limits of available resources. The plan will contain:

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\(^{37}\) See section 13O

\(^{38}\) See section 13P
(i) A statement of the significant assumptions on which the plan is based;

(ii) Details of major changes in workload, delivery of services or resources required to achieve the plan.

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

(i) be in accordance with the aims and objectives set out in the plan;

(ii) accord with workload and manpower plans;

(iii) be produced following discussion with appropriate budget holders;

(iv) be prepared within the limits of available allotments and income;

(v) identify potential risks.

All budget holders must provide information as required by the Chief Finance Officer to enable budgets to be completed.

c) Budget Delegation

The Accountable Officer may delegate in writing the management of budgets and the authority to spend to appropriately placed and trained budget holders who will be responsible and held to account for committing the resources. The Accountable Officer and delegated budget holders must not exceed the budgetary total set by the Governing Body.

The role and responsibilities of the budget holder is specified in the Budget Control Framework.

d) Budgetary Control and Reporting

The Chief Finance Officer will produce a Budget Control Framework or equivalent which will describe the role and responsibilities of budget holders and managers and the budgetary control process. The Chief Finance Officer will also devise and maintain systems of budgetary control which will include:-

(i) Investigation and reporting of variances

(ii) Monitoring of management action to correct variances

(iii) Arrangements for the authorisation of budget transfers

(iv) Monthly financial reports to the Governing Body containing:

   • Income and expenditure to date showing trends and forecast year-end position
   • Movements in cash

(v) Capital project spend and projected outturn against plan if appropriate

(vi) Explanations of any material variances from plan
(vi) Details of any corrective action where necessary and the Accountable Officer’s/Chief Finance Officer’s view of whether such actions are sufficient to correct the situation.

The Chief Finance Officer is accountable for the monitoring of financial performance against budget and plan (including allotments and income and expenditure), their periodic review, and production of monthly financial performance reports for the Governing Body, focusing on key material issues. Such reports will be presented to the Governing Body, which is responsible for providing assurance.

The Finance and Performance Committee has delegated authority from the Governing Body to monitor budgets and ensure their delivery against plan, reporting all deviations and respective corrective action to the Governing Body.

A shared financial management function exists on behalf of the South Nottinghamshire CCGs.

Budget Holders will identify variances and the reasons for them and inform the Chief Finance Officer of the remedial action they are taking. In the event that the Budget Holder cannot identify sufficient remedial action to bring the budget back into balance, the Chief Finance Officer will identify further remedial action. This iterative process will be undertaken until the Accountable Officer is assured that the total CCG budget is in balance and this can be reported to the Board.

5.3.2 Ensure its use of resources (both its capital resource use and revenue resource use) does not exceed the amount specified by the NHS Commissioning Board for the financial year by:

a) Including total allocations received and their proposed distribution including any sums to be held in reserves, as part of submitting budgets for approval to the Governing Body

b) The Chief Finance Officer updating the Governing Body on significant changes to the initial allocation and the uses of such funds as part of the monthly financial report

c) Ensuring information relating to the group’s accounts or to its income and expenditure, or its use of resources is provided to the NHS Commissioning Board as requested.

d) In addition the arrangements described in 5.3.1 above will also facilitate the meeting of any revenue and capital resource limits.

5.3.3 Take account of any directions issued by the NHS Commissioning Board, in respect of specified types of resource use in a financial year, to ensure the group does not exceed an amount specified by the NHS Commissioning Board by:
The Accountable Officer will ensure the Governing Body is aware of any directions issued by the NHS Commissioning Board and will update the CCG plans/budgets accordingly so that any specified amounts are not exceeded.

5.3.4 **Publish an explanation of how the group spent any payment in respect of quality made to it by the NHS Commissioning Board by:**

Providing a note at the end of the year on this in the Annual Report.

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

5.4.1 The group will:

a) comply with all relevant regulations;

b) comply with directions issued by the Secretary of State for Health or the NHS Commissioning Board; and

c) take account, as appropriate, of documents issued by the NHS Commissioning Board.

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

6 **DECISION MAKING: THE GOVERNING STRUCTURE**

6.1 **Authority to act**

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

a) any of its members;

b) its Governing Body;

c) employees;

d) a committee of the group.

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

a) the group’s scheme of reservation and delegation; and

b) for committees, their terms of reference
6.2 Scheme of Reservation and Delegation

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

a) those decisions that are reserved for the membership as a whole;

b) those decisions that are the responsibilities of its Governing Body (and its committees), the group’s committees and sub-committees, individual members and employees.

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

6.3 General

6.3.1 In discharging functions of the group that have been delegated to its Governing Body (and its committees), committees, joint committees, and individuals must:

a) comply with the group’s principles of good governance,

b) operate in accordance with the group’s scheme of reservation and delegation,

c) comply with the group’s standing orders,

d) comply with the group’s arrangements for discharging its statutory duties,

e) where appropriate, ensure that member practices have had the opportunity to contribute to the group’s decision making process.

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

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

a) identify the roles and responsibilities of those clinical commissioning groups who are working together;

b) identify any pooled budgets and how these will be managed and reported in annual accounts;

c) specify under which the group’s scheme of reservation and delegation and supporting policies the collaborative working arrangements will operate;

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39 See Appendix D
40 See section 4.4 on Principles of Good Governance above
41 See appendix D
42 See appendix C
43 See chapter 5 above
d) specify how the risks associated with the collaborative working arrangement will be managed between the respective parties;

e) identify how disputes will be resolved and the steps required to terminate the working arrangements;

f) specify how decisions are communicated to the collaborative partners

6.4 Joint Commissioning arrangements with other Clinical Commissioning Groups

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

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

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

6.4.3 For the purposes of the arrangements described at paragraph 6.4.2, the CCG may:

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

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

6.4.5 For the purposes of the arrangements described at paragraph 6.4.2 above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 6.4.3. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.4.6 Where the CCG makes arrangements with another CCG as described at paragraph 6.4.2 above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:

   a) How the parties will work together to carry out their commissioning functions;
   b) The duties and responsibilities of the parties;
   c) How risk will be managed and apportioned between the parties;
   d) Financial arrangements, including, if applicable, payments towards a pooled fund e) and management of that fund;
   e) Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.
6.4.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 6.4.2 above.

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

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

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

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

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

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

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

6.5.3 The arrangements referred to in paragraph 6.5.2 above may include other CCGs.

6.5.4 Where joint commissioning arrangements pursuant 6.5.2 above are entered into, the parties may establish a joint committee to exercise the commissioning functions in question.

6.5.5 Arrangements made pursuant to 6.5.2 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

6.5.6 Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 6.5.2 above, the CCG shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

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

6.5.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 6.5.2 above.

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

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

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

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

6.6 Joint commissioning arrangements with NHS England for the exercise of NHS England’s functions

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

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

a) Exercise such functions as specified by NHS England under delegated arrangements;

b) Jointly exercise such functions as specified with NHS England.

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

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

6.6.5 For the purposes of the arrangements described at paragraph 6.6.2 above, NHS England and the CCG may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.
6.6.6 Where the CCG enters into arrangements with NHS England as described at paragraph 6.6.2 above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

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

6.6.7 The liability of NHS England to carry out its functions will not be affected where it and the CCG enter into arrangements pursuant to paragraph 6.6.2 above.

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

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

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

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

6.7 Joint Arrangements

6.7.1 The Group has entered into joint arrangements with the following clinical commissioning groups (CCGs):

   a) Mansfield and Ashfield Clinical Commissioning Group
   b) Newark and Sherwood Clinical Commissioning Group
   c) Nottingham West Clinical Commissioning Group
   d) Rushcliffe Clinical Commissioning Group
   e) Bassetlaw Clinical Commissioning Group
   f) Nottingham City Clinical Commissioning Group

Memorandums of Understanding, signed by the relevant commissioning partners, describe the nature of the collaborative arrangements in place. These include the contractual and quality management of shared providers, such as acute providers, mental health, and the Commissioning Support Service; the delivery of shared QIPP programmes; the management or registered and unregistered patients falling outside a respective CCG’s boundary; and Urgent Care arrangements.
6.7.2 The Group has the following joint committees with the clinical commissioning groups listed in 6.7.1:

   a) Individual Funding Request Panel (led by Nottingham West Clinical Commissioning Group)
   b) Information Governance, Management and Technology Committee (led by Rushcliffe Clinical Commissioning Group)
   c) Quality & Risk Committee (led by Nottingham North and East Clinical Commissioning Group). This incorporates the Learning and Review Group
   d) Safeguarding Committee (led by Newark and Sherwood Clinical Commissioning Group)

6.7.3 The group has joint committees with the following local authority(ies):

   i) Broxtowe Borough Council
   ii) Nottinghamshire County Council

6.7.4 The group is involved in joint committees with these Local Authorities as follows:

   a) Clinical Development Committee
   b) Joint Commissioning Groups
   c) Broxtowe Partnership Board
   d) Health & Wellbeing Board

6.7.5 The group is the nominated host CCG of a joint committee of 19 East Midlands Clinical Commissioning Groups which has been established to enable collaborative working on the development and maintenance of:

   • Policies for services which CCGs have responsibility for commissioning; and
   • New policies identified as being appropriate for identical implementation on a regional scale.

Accordingly the East Midlands Affiliated Commissioning Committee (EMACC) has been established in accordance with section 14Z3 of the NHS Act 2006 and the constitutions of each of the CCGs listed below:

   • NHS Southern Derbyshire CCG
   • NHS North Derbyshire CCG
   • NHS Erewash CCG
   • NHS Hardwick CCG
   • NHS Nottingham City CCG
   • NHS Nottingham West CCG
   • NHS Nottingham North & East CCG
   • NHS Rushcliffe CCG
   • NHS Newark & Sherwood CCG
   • NHS Mansfield & Ashfield CCG
   • NHS Corby CCG
6.8 The Governing Body

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

a) ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the Group’s principles of good governance (its main function);

b) following directions of its Member Practices as agreed by the Practice Members Group.

c) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;

d) approving any functions of the group that are specified in regulations;

e) duty to promote a comprehensive health service

f) meet the public sector equality duty

g) ensure partnership working with the local authority to develop joint strategic needs assessments and joint health and wellbeing strategies

h) ensure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements

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44 See section 14L(3)(c) of the 2006 Act, as inserted by section 25 of the 2012 Act
45 See section 4.4 on Principles of Good Governance above
46 See section 14L(5) of the 2006 Act, inserted by section 25 of the 2012 Act
i) promote awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS constitution

j) act with a view to securing continuous improvement to the quality of services

k) assist and support the NHS Commissioning Board in relation to the Board’s duty to improve quality of primary medical services

l) have regard to the need to reduce inequalities

m) lead on the setting of the Group’s vision and strategy

n) approve the group’s commissioning plans

o) assure the performance of the Group and provide assurance relating to the management of strategic risk

p) assure the involvement of patients, their carers and representatives in decisions about their healthcare

q) act with a view to enabling patients to make choices

r) obtain appropriate advice from persons who, taken together, have a broad range of professional expertise in healthcare and public health

s) promote innovation

t) promote research and the use of research

u) have regard to the need to promote education and training for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health services in England so as to assist the Secretary of State for Health in the discharge of his related duty

v) Act with a view to promoting integration

6.8.2 Composition of the Governing Body – In accordance with the Regulations, the Governing Body shall comprise of:

- The GP Chair (the designated Clinical Leader)
- A GP acting on behalf of member practices
- Lay member who will lead on patient and public involvement matters and deputy chair
- Lay member which will lead on audit, governance, remuneration and conflict of interest matters
- Lay member
- A Registered Nurse
• A secondary care specialist doctor
• The Accountable Officer
• The Chief Finance Officer
• A Patient Reference Group member, elected from the group

6.8.3 Accountability to Member Practices

The Governing Body is accountable to its member practices via the Practice Members Group (PMG). The PMG is a committee of the members of the CCG. This relationship is detailed within an Inter-Practice Agreement, signed by all member practices. The PMG is responsible for ensuring the representation of member views in all matters discussed by the Governing Body and its committees and sub-committees; for holding the Governing Body to account and ensuring the appropriate scrutiny and challenge as well as clinical support, expertise and advice; and for providing recommendations and observations to the Governing Body, including those based on patient/carer feedback and experience within member practices.

6.8.4 Committees of the Governing Body - the Governing Body, has appointed the following committees:

a) Audit and Governance Committee – the audit and governance committee, which is accountable to the Governing Body, provides the Governing Body with an independent and objective view of the clinical commissioning group's financial reporting and internal control principles and ensures an appropriate relationship with both internal and external auditors is maintained. The Governing Body is responsible for approving and keeping under review the terms of reference for the audit and governance committee, which includes information on the membership of the audit and governance committee.

b) Remuneration Committee – the remuneration committee, which is accountable to the Governing Body makes decisions on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme. The Governing Body is responsible for approving and keeping under review the terms of reference for the remuneration committee, which includes information on the membership of the remuneration committee.

c) Quality and Risk Committee – the Quality and Risk Committee is a joint committee for the Nottinghamshire County CCGs and is hosted by Nottingham North and East Clinical Commissioning. The committee acts on behalf of the Governing Body to fulfil its obligations in respect of clinical governance, risk management, quality impact assessments, oversight of quality scrutiny panels for providers and equality and diversity. It makes recommendations to the Governing Body for decision. The Governing Body is responsible for approving and keeping under review the terms of reference for the Quality and Risk Committee which includes information on the
membership of the Quality and Risk Committee. The group or the Governing Body has conferred or delegated the following functions to the Quality and Risk Committee:

i. Patient safety (including the monitoring of Serious Untoward Incidents and Never Events, and regular reporting to the National Reporting and Learning System)

ii. Clinical governance

iii. Clinical and corporate risk management

iv. Scrutiny for provider contracts

v. Monitoring complaints and complaints handling

vi. The identification and management of quality issues arising from patient feedback, including complaints and Serious Untoward Incidents

vii. Patient advice and liaison

viii. Health and Safety

ix. Equality and Diversity

x. Infection prevention and control

The committee prepares a monthly quality report, which is discussed in the monthly meetings of the Governing Body.

d) Individual Funding Request Panel (IFR) – The IFR Panel is a joint committee for the Nottinghamshire County CCGs and is hosted by NHS Nottingham West Clinical Commissioning and is accountable to the Governing Body. It considers all Individual Funding Requests and decides whether to support or not support these individual requests on the basis of the information provided with the request on behalf of the Groups. It makes recommendations to the Governing Body for decision. The Individual Funding Request Committee also has responsibility for developing and agreeing protocols for accessing services or treatment not within contract, either for NHS or non-NHS providers where a service level agreement or contract does not exist. The Governing Body is responsible for approving and keeping under review the terms of reference for the Individual Funding Request Committee which includes information on the membership of the Individual Funding Request Committee.

e) Clinical Development Committee (CDC) – The CDC is a committee of the group. Comprised of clinical leads and experts, two patient representatives (elected by the Patient Reference Group) key CCG officers, public health and local authority and patient representatives, it is authorised to advise the group on priority areas for service redesign and innovation, taking account of local health needs, and by identifying new and emerging opportunities for service change and service integration. Ensuring clinical leadership and involvement in all programmes, it will develop innovative proposals for service change which meet the opportunities identified, and suggest means of resolving problems associated with the implementation of agreed service changes, proposing the deployment of management resources as necessary. It will identify key stakeholders associated with service changes, and secure the necessary representation as required. It will develop methodologies which ensure the effective evaluation and review of agreed service changes,
ensuring quality measures are included, and support the delivery of the CCG’s objectives and plans. The Governing Body is responsible for approving and keeping under review the terms of reference for the CDC which includes information on the membership of the Committee.

f) **Patient Reference Group (PRG)** – The PRG is a committee of the group and is authorised to appropriately and effectively represent the patients, public and carers of Nottingham West in the business of the group through active participation. It serves as an advisory committee with responsibilities for providing recommendations and observations to the Governing Body and its committees and sub-committees, including in relation to the identification of commissioning priorities. It provides a two-way communication channel between patients, the public of Nottingham West, and the group. It coordinates the engagement of patients and the public in the consultation, planning and commissioning of health services in Nottingham West. It can influence the consultation, planning and commissioning of health services in Nottingham West through active participation and involvement, and ensure careful evaluation of projects to identify strengths and weaknesses and learn lessons. The work of this committee ensures that decision-making throughout the Group is directly informed by feedback from patients, carers and other local people, and that such feedback is acted upon as appropriate. The Governing Body is responsible for approving and keeping under review the terms of reference for the Patient Reference Group which includes information on the membership of the Patient Reference Group.

g) **The Information Governance, Management and Technology Committee (IG, M&T)** - The IG, M&T is hosted by Rushcliffe Clinical Commissioning Group and is accountable to the Group’s Governing Body, oversees information governance arrangements on behalf of all of the groups and its members have delegated authority from the CCGs to make decisions in respect of all matters relating to information governance and information management. It makes recommendations to the Governing Body for decision. The Governing Body is responsible for approving and keeping under review the terms of reference for the Information Governance, Management and Technology Committee which includes information on the membership of the Information Governance Management and Technology Committee.

h) **The Safeguarding Committee** – the safeguarding committee is hosted by Newark and Sherwood Clinical Commissioning Group and is accountable to the Group’s Governing Body, is responsible for the oversight of systems processes and standards which are in place to safeguard vulnerable adults and children across the services provided and commissioned by Nottinghamshire Clinical Commissioning Groups. It makes recommendations to the Governing Body for decision. The Group or the Governing Body has conferred or delegated the following functions to the Safeguarding Committee:

i. Risk Management
ii. Monitoring serious incidents relating to safeguarding
iii. Scrutiny of safeguarding arrangements across commissioned and contracted services.
iv. Approval of Strategies, policies procedures and guidance relating to safeguarding

The Board Nurse and Director of Quality and Patient Safety is the Group’s nominated lead for Safeguarding, and represents the Group on the Safeguarding committee.

The Governing Body has approved and keeps under review the terms of reference for the Safeguarding Committee, which includes information on the membership of the Committee.

i) **Finance and Performance Committee** – the Finance and Performance Committee has delegated authority from the Governing Body to monitor budgets and activity and ensure their delivery against plan, reporting all deviations and respective corrective action to the Governing Body. The Committee will be responsible for monitoring delivery against QIPP and financial recovery plans. The Committee will also oversee the financial plan assumptions and principles. The Governing Body is responsible for approving and keeping under review the terms of reference for the Finance and Performance Committee which includes information on the membership of the Finance and Performance Committee.

j) **Primary Care Commissioning Committee** - which is accountable to the Group’s governing body and is responsible for, inter alia, delegated primary care functions to be delivered in accordance with this committee’s terms of reference, which includes information on its membership47.

k) **East Midlands Affiliated Commissioning Committee** – has been established a joint committee which enables the CCGs to work collaboratively on the development and maintenance of:
   - Policies for services which CCGs have responsibility for commissioning; and
   - New policies identified as being appropriate for identical implementation on a regional scale.

The vision for the East Midlands Affiliated Commissioning Committee is to maximise resources, reduce duplication and ensure the development of clinical and cost effective policies that improve the quality of care for patients. The Governing Body is responsible for approving and keeping under review the terms of reference for the Committee which includes information on the membership of the Committee.

7 ROLES AND RESPONSIBILITIES

7.1 **Clinical Leads, Representatives and Member Practices**

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47 See terms of reference of the Primary Care Commissioning Committee
7.1.1 **Governing Body GP Leads**

GP members of the Governing Body represent the views of member practices at the Governing Body and, as relevant, at its committees. Their role is:

a) To provide clinical leadership to the Governing Body

b) Working with practice representatives, champion the implementation within member practices of programmes agreed by the group

c) Ensure that the views of practice members are represented, reporting to the Governing Body any salient practice concerns, suggestions and feedback, thus enabling two-way communication between the Governing Body and the PMG and member practices.

d) Together with other clinical leads serving on the Clinical Development Committee, hold designated portfolios to be reviewed periodically by the Governing Body and/or its delegated committees. Providing the clinical leadership of key strategic programmes, leads will be responsible for successful delivery for the benefit of local people, ensuring the appropriate resources required, and the involvement of key parties as appropriate throughout, including clinicians, patients and carers, and partners.

e) Provide constructive clinical challenge and support to practices with the aim of improving the quality of primary care, and ensure clinical processes to hold practices to account for the delivery of recommendations.

e) To provide clinical leadership and support to junior GPs, nurses, trainees and others, and support the implementation of the organisational development plan in respect of developing strong clinical leadership across the Group.

g) At all times to behave as a professional clinician and serve as ambassador for the Group.

7.1.2 **Practice Members Group**

The Practice Members Group (PMG) comprises all practice representatives (GP leads and practice managers from each practice). It is chaired by a PMG member elected by practice representatives. Meeting at least once annually it holds the Governing Body to account (including an annual review of the Governing Body’s performance), ensures that decisions reflect the views of practice members, and enables clinical leadership.

7.1.3 **Practice Representatives**

Practice representatives, including GP leads and practice managers, represent their practice’s views and act on behalf of the practice in matters relating to the Group. The role of each practice representative is to:

a) Represent the practice views in inputting to and driving forward commissioning decisions thereby contributing to the strategic development of the Group.
b) Provide clinical input to decision making based on primary care and practice based experiences

c) Ensure that their practice’s views and context are taken into consideration in all decisions relevant to the Group.

d) Assimilate and use patient feedback as intelligence in driving forward the strategic direction

e) Take a balanced view of the clinical and management agenda and draw on clinical skills and knowledge of primary care to input into discussions/debates/decisions at the practice forum

f) Be committed to the Group by making suggestions and actively engaging in decision making

g) Recognise the benefits of being in a Group and use to support the growth and development of their individual practice and quality of care for patients

h) Feedback decisions to their practice and update the practice on Group progress and news

i) Support the Group in delivering improved quality in primary care through practice behaviours and engagement with the Group.

j) Engage their practice in the decision making for reserved matters

k) Challenge constructively the performance of others and be open to challenge and suggestions from other practice representatives to ensure continuous improvement and high quality patient and carer services. Hold others, and be held to account on the implementation of recommendations and actions for improvement.

7.1.4 Individual GPs and member practice staff

GPs and other practice staff are expected to participate in the operation of the group, through implementing service changes and other initiatives agreed by the group; offering suggestions, feedback and comments; and noting and acting on, where appropriate, relevant group correspondence and information. Individuals within member practices are expected to act in accordance with the group’s values at all times, and to contribute to the realisation of its vision and strategic priorities.

7.1.5 The Inter-practice Agreement between individual member practices clarifies in more detail the expectations and obligations of all parties.

7.2 Members of the Group’s Governing Body
7.2.1 Guidance on the roles of members of the group’s Governing Body is set out in a separate document. (Appendix C Standing Orders Section 2) In summary, each member of the Governing Body should share responsibility as part of a team to ensure that the group exercises its functions safely, effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

7.2.2 In addition to responsibilities relevant to position, individual members will hold Governing Body lead positions. The Governing Body Nurse and Director of Quality and Patient Safety is the nominated lead for patient safety, safeguarding, and the Mental Health Capacity Act; and the GP Leads are the lead for innovation, research, and informatics.

7.3 The GP Chair of the Governing Body

The GP Chair of the governing body is responsible for:

a) leading the Governing Body, ensuring it remains continuously able to discharge its duties and responsibilities as set out in this constitution;

b) building and developing the Group’s Governing Body and its individual members;

c) ensuring that the Group has proper constitutional and governance arrangements in place;

d) ensuring that, through the appropriate support, information and evidence, the Governing Body is able to discharge its duties;

e) supporting the Accountable Officer in discharging the responsibilities of the organisation;

f) contributing to building a shared vision of the aims, values and culture of the organisation;

g) leading and influencing to achieve clinical and organisational change to enable the group to deliver its commissioning responsibilities;

h) overseeing governance and particularly ensuring that the Governing Body and the wider group behaves with the utmost transparency and responsiveness at all times;

i) ensuring that public and patients’ views are heard and their expectations understood and, where appropriate as far as possible, met;

j) ensuring that the organisation is able to account to its local patients, stakeholders and the NHS Commissioning Board;
k) ensuring that the Group builds and maintains effective relationships, particularly with the individuals involved in overview and scrutiny from the relevant local authority(ies).

l) Where the Chair of the Governing Body is also the senior clinical voice of the group they will take the lead in interactions with stakeholders, including the NHS Commissioning Board.

7.4 The Deputy Chair of the Governing Body

7.4.1 The Deputy chair of the Governing Body deputises for the chair of the Governing Body where he or she has a conflict of interest or is otherwise unable to act. Where the Deputy Chair of the Governing Body has a conflict of interest, the members of the meeting will select an appropriate Chair from amongst themselves, assuming that the meeting remains quorate.

7.5 Role of the Accountable Officer

7.5.1 As a statutory role the Accountable Officer is responsible for ensuring that the organisation meets its obligations under the Health and Social Care Act 2012, namely to ensure the Group complies with its:

a) duty to exercise its functions safely, effectively, efficiently and economically

b) duty to exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness

c) financial obligations, including those relating to accounting and auditing

d) obligations relating to information requests

e) duty to provide information to the NHS Commissioning Board, following requests from the Secretary of State

f) obligations under any other provision of the NHS Act 2006 specified by the Governing Body for these purposes

g) performs its functions in a way which provides good value for money

7.5.2 The Accountable Officer will provide strong strategic leadership to ensure that:

a) patients and the public are involved in the Group’s decision making with respect to the planning of services that are provided to them

b) clinical leadership is at the heart of the organisation

c) member practices are actively engaged in setting the direction of the organisation and in ensuring that its strategic objectives are delivered.
7.6 Role of the Chief Finance Officer

7.6.1 The Chief Finance Officer is a member of the Governing Body and is responsible for providing financial advice to the group and for supervising financial control and accounting systems.

7.6.2 This role of Chief Finance Officer has been summarised in a national document as:

   a) being the Governing Body’s professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;

   b) making appropriate arrangements to support, monitor on the Group’s finances;

   c) overseeing robust audit and governance arrangements leading to propriety in the use of the Group’s resources;

   d) being able to advise the Governing Body on the effective, efficient and economic use of the Group’s allocation to remain within that allocation and deliver required financial targets and duties; and

   e) producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to the NHS Commissioning Board;

   f) prepare detailed financial policies that underpin the Group’s prime financial policies;

   g) approve arrangements for discharging the Group’s statutory financial duties;

   h) approve pooled commissioning funding arrangements.

7.7 Joint Appointments with other Organisations

7.7.1 The Group has the following joint appointments with other organisations:

   a) The Chief Finance Officer and their team are employed by NHS Nottingham North and East Clinical Commissioning Group and shall work on behalf of Nottingham North and East Clinical Commissioning Group, Nottingham West Clinical Commissioning Group and Rushcliffe Clinical Commissioning Group.

   b) The Director of Quality and Patient Safety and their team are employed by NHS Nottingham North and East CCG and shall work on behalf of,
Nottingham North and East Clinical Commissioning Group, Nottingham West Clinical Commissioning Group and Rushcliffe Clinical Commissioning Group.

c) The Director of Outcomes and Information and their team are employed by NHS Rushcliffe CCG and shall work on behalf of Nottingham North and East Clinical Commissioning Group, Nottingham West Clinical Commissioning Group and Rushcliffe Clinical Commissioning Group.

d) The Director of Contracting/Deputy Chief Officer (Nottingham West CCG) and their team are employed by NHS Nottingham West CCG and shall work on behalf of Nottingham North and East Clinical Commissioning Group, Nottingham West Clinical Commissioning Group and Rushcliffe Clinical Commissioning Group.

7.7.2 All joint appointments are supported by a memorandum of understanding between the organisations who are party to these.
8 STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST

8.1 Standards of Business Conduct

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

8.1.2 They must comply with the group’s policy on business conduct, including the requirements set out in the policy for managing conflicts of interest. This policy will be available on the group’s website at www.nottinghamwestccg.nhs.uk These documents are also available to patients and the public upon application, either by:

   a) Post to NHS Nottingham West Clinical Commissioning Group, Stapleford Care Centre, Stapleford, Nottinghamshire NG9 8DB

   b) Email to nottingham.west@nottinghamwestccg.nhs.uk

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

8.2 Conflicts of Interest

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

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

8.2.3 A conflict of interest will include:

   a) a direct pecuniary interest: where an individual may financially benefit from the consequences of a commissioning decision (for example, as a provider of services);
b) an indirect pecuniary interest: for example, where an individual is a
partner, member or shareholder in an organisation that will benefit
financially from the consequences of a commissioning decision;

c) a non-pecuniary interest: where an individual holds a non-remunerative or
not-for profit interest in an organisation, that will benefit from the
consequences of a commissioning decision (for example, where an
individual is a trustee of a voluntary provider that is bidding for a contract);

d) a non-pecuniary personal benefit: where an individual may enjoy a
qualitative benefit from the consequence of a commissioning decision
which cannot be given a monetary value (for example, a reconfiguration of
hospital services which might result in the closure of a busy clinic next
door to an individual’s house);

e) where an individual is closely related to, or in a relationship, including
friendship, with an individual in the above categories.

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

8.3 Declaring and Registering Interests

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

a) the members of the group;

b) the members of its Governing Body;

c) the members of its committees (including joint committees) or sub-
committees and the committees or sub-committees of its Governing
Body; and

d) its employees

e) the members of any advisory panels or groups

8.3.2 The registers will be published on the group’s website at
www.nottinghamwestccg.nhs.uk

These documents are also available to patients and the public upon
application, either by:-

a) Post to NHS Nottingham West Clinical Commissioning Group,
Stapleford Care Centre, Stapleford, Nottinghamshire NG9 8DB

b) Email to nottingham.west@nottinghamwestccg.nhs.uk

8.3.3 Individuals will declare any interest that they have, in relation to a decision to be
made in the exercise of the commissioning functions of the group, in writing to
the Governing Body, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

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

8.3.5 The Head of Quality, Governance and Engagement will ensure that the register(s) of interest are reviewed quarterly, and updated whenever a new or revised interest is declared.

8.4 Managing Conflicts of Interest: general

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

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

8.4.3 Arrangements for the management of conflicts of interest are to be determined by the Accountable Officer and will include the requirement to put in writing to the relevant individual arrangements for managing the conflict of interests or potential conflicts of interests, within a week of declaration. The arrangements will confirm the following:

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

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

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

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

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

b) 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.

8.4.6 The chair of the meeting will then determine how this should be managed and inform the member of their decision. Where no arrangements have been confirmed, the chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual will then comply with these arrangements, which must be recorded in the minutes of the meeting.

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

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

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

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

8.4.11 This may include:

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

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

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

ii) an individual appointed by a member to act on its behalf in the dealings between it and the Group;
a. a member of a relevant Health and Wellbeing Board;
b. a member of a Governing Body of another Group.

These arrangements must be recorded in the minutes.

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

8.4.13 The Accountable Officer will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

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

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

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

8.6 Transparency in Procuring Services

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

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

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

   b) service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way.
8.6.3 Copies of this Procurement Strategy will be available on the group’s website at www.nottinghamwestccg.nhs.uk These documents are also available to patients and the public upon application, either by:-

a) Post to NHS Nottingham West Clinical Commissioning Group, Stapleford Care Centre, Stapleford, Nottinghamshire NG9 8DB
b) Email to nottingham.west@nottinghamwestccg.nhs.uk

8.6.4 The Group will maintain a register of procurement decisions taken, including:

a) details of the decision
b) who was involved in the making the decision
c) a summary of any conflicts of interest in relation to the decision and how this was managed by the Group

8.6.5 The register will be updated whenever a procurement decision is taken.

8.6.6 The register will be published on the Group’s website at www.nottinghamwestccg.nhs.uk and made available for inspection, by appointment, at the Group’s administrative offices at Stapleford Care Centre, Church Street, Stapleford, Nottingham, NG9 8DB.
9 THE GROUP AS AN EMPLOYER

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

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

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

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

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

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

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

9.8 The group will ensure that its employees have access to such expert advice and training opportunities as the Governing Body consider reasonable in order to exercise their responsibilities effectively.

9.9 The group recognises and confirms that nothing in or referred to in this Constitution (including in relation to the issue of any press release or other public statement or disclosure) will prevent or inhibit the making of any protected disclosure (as defined in the Employment Rights Act 1996, as amended by the Public Interest Disclosure Act 1998) by any member of the group, any member of its governing body, any member of any of its committees or sub committees or the committees or sub-committees of its governing body, or any employee of the group or of any of its member, nor will it affect the rights of any worker (as defined in that Act) under that Act”.

9.10 Copies of this Code of Conduct, together with the other policies and procedures outlined in this chapter, will be available on the group’s website at www.nottinghamwestccg.nhs.uk
10 TRANSPARENCY, WAYS OF WORKING AND STANDING ORDERS

10.1 General

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

10.1.2 Key communications issued by the group, including the notices of procurements, public consultations, Governing Body meeting dates, times, venues, and certain papers will be published on the group’s website at www.nottinghamwestccg.nhs.uk. These documents are also available to patients and the public upon application, either by:

a) Post to NHS Nottingham West Clinical Commissioning Group, Stapleford Care Centre, Stapleford, Nottinghamshire NG9 8DB

b) Email to nottingham.west@nottinghamwestccg.nhs.uk

10.2 Standing Orders

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

10.2.1.1 *Standing orders (Appendix C)* – which sets out the arrangements for meetings and the appointment processes to elect the group’s representatives and appoint to the group’s committees, including the Governing Body;

10.2.1.2 *Scheme of reservation and delegation (Appendix D)* – which sets out those decisions that are reserved for the membership as a whole and those decisions that are the responsibilities of the group’s Governing Body, the Governing Body’s committees and sub-committees, the group’s committees and sub-committees, individual members and employees;

10.2.1.3 *Prime financial policies (Appendix E)* – which sets out the arrangements for managing the group’s financial affairs.
### APPENDIX A
DEFINITIONS OF KEY DESCRIPTIONS USED IN THIS CONSTITUTION

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

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<table>
<thead>
<tr>
<th><strong>Individual Member</strong></th>
<th>Any GP who is a partner in, or is employed by, a Member Practice, or who practices in the Group’s area under a contract issued by the NHS Commissioning Board or other NHS body</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lay member</strong></td>
<td>a lay member of the Governing Body, appointed by the group. A lay member is an individual who is not a member of the group or a healthcare professional (i.e. an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002) or as otherwise defined in regulations</td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td>a provider of primary medical services to a registered patient list, who is a member of this group (see tables in Chapter 3 and Appendix B)</td>
</tr>
<tr>
<td><strong>Practice representatives</strong></td>
<td>an individual appointed by a practice (who is a member of the group) to act on its behalf in the dealings between it and the group, under regulations made under section 89 or 94 of the 2006 Act (as amended by section 28 of the 2012 Act) or directions under section 98A of the 2006 Act (as inserted by section 49 of the 2012 Act)</td>
</tr>
<tr>
<td><strong>Registers of interests</strong></td>
<td>registers a group is required to maintain and make publicly available under section 14O of the 2006 Act (as inserted by section 25 of the 2012 Act), of the interests of: • the members of the group; • the members of its Governing Body; • the members of its committees or sub-committees and committees or sub-committees of its Governing Body; and • its employees.</td>
</tr>
<tr>
<td><strong>Staff (or employees)</strong></td>
<td>All individuals employed by the Group under a contract of employment (i.e. employees), and those whose services are provided under some other contractual arrangement (i.e. Bank, interim, temporary or similar)</td>
</tr>
</tbody>
</table>
### APPENDIX B - LIST OF MEMBER PRACTICES

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbey Medical Centre</td>
<td>63 Central Avenue Beeston Nottingham NG9 2QP</td>
</tr>
<tr>
<td>Bramcote Surgery</td>
<td>2a Hanley Avenue Bramcote Nottingham NG9 3HF</td>
</tr>
<tr>
<td>Church Street Medical Centre</td>
<td>11b Church Street Eastwood Nottingham NG16 3BS</td>
</tr>
<tr>
<td>The Surgery, Church Walk</td>
<td>Church Walk Eastwood Nottingham NG16 3BH</td>
</tr>
<tr>
<td>Hama Medical Centre</td>
<td>11a Nottingham Road Kimberley Nottingham NG16 2NP</td>
</tr>
<tr>
<td>Hickings Lane Medical Centre</td>
<td>Ryecroft Street Stapleford Nottingham NG9 8PN</td>
</tr>
<tr>
<td>Linden Medical Group</td>
<td>Stapleford Care Centre Church Street Stapleford Nottingham NG9 8DB</td>
</tr>
<tr>
<td>The Manor Surgery</td>
<td>Middle Street Beeston Nottingham NG9 1GA</td>
</tr>
<tr>
<td>The Oaks Medical Centre</td>
<td>20 Villa Street Beeston Nottingham NG9 1GA</td>
</tr>
<tr>
<td>Saxon Cross Surgery</td>
<td>Stapleford Care Centre Church Street Stapleford Nottingham NG9 2NY</td>
</tr>
<tr>
<td>The Valley Surgery</td>
<td>81 Bramcote Lane Chilwell Nottingham NG9 4ET</td>
</tr>
<tr>
<td>The Valley Surgery (branch at Chilwell Meadows)</td>
<td>Ranson Road Chilwell Nottingham NG9 6DX</td>
</tr>
</tbody>
</table>
| West End Surgery | 19 Chilwell Road  
Beeston  
Nottingham  
NG9 1EH |
APPENDIX C – STANDING ORDERS

1. STATUTORY FRAMEWORK AND STATUS

1.1. Introduction

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

1.1.2. The standing orders, together with the group’s scheme of reservation and delegation\(^49\) and the group’s prime financial policies\(^50\), provide a procedural framework within which the group discharges its business. They set out:

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

b) the appointment of member practice representatives;

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

d) the process to delegate powers,

e) the declaration of interests and standards of conduct.

These arrangements must comply, and be consistent where applicable, with requirements set out in the 2006 Act (as amended by the 2012 Act) and related regulations and take account as appropriate\(^51\) of any relevant guidance.

1.1.3. The standing orders, scheme of reservation and delegation and prime financial policies have effect as if incorporated into the group’s constitution. Group members, employees, members of the Governing Body, members of the Governing Body’s committees and sub-committees, members of the group’s committees and sub-committees and persons working on behalf of the group should be aware of the existence of these documents and, where necessary, be familiar with their detailed provisions. Failure to comply with the standing orders, scheme of reservation and delegation and prime financial policies may be regarded as a disciplinary matter that could result in dismissal.

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

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\(^{49}\) See Appendix D

\(^{50}\) See Appendix E

\(^{51}\) Under some legislative provisions the group is obliged to have regard to particular guidance but under other circumstances guidance is issued as best practice guidance.
1.2.1. The 2006 Act (as amended by the 2012 Act) provides the group with powers to delegate the group’s functions and those of the Governing Body to certain bodies (such as committees) and certain persons. The group has decided that certain decisions may only be exercised by the group in formal session. These decisions and also those delegated are contained in the group’s scheme of reservation and delegation (see Appendix D).

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

2.1. Composition of membership

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

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

2.1.3. The behaviour and expectations of member practices within the Group will be as described in the Inter Practice Agreement (IPA) between Member Practices of the group.

2.2. Key Roles

2.2.1. Paragraph 6.8.2 of the group’s constitution sets out the composition of the group’s Governing Body whilst Chapter 7 of the group’s constitution together with the Inter Practice Agreement identifies certain key roles and responsibilities within the group and it’s Governing Body. These standing orders set out how the group appoints individuals to these key roles.

2.3. The GP Chair of the Governing Body

2.3.1. The GP Chair, as listed in paragraph 6.8.2 of the group’s constitution, is subject to the following appointment process:

a) Nominations – when the post is, or about to become, vacant, GPs interested in serving as GP Chair (of the Governing Body) should express their interest to the Practice Members Group, via the Head of Governance, Quality and Engagement, producing a brief manifesto for circulation; applicants should note that the post is comprised of both roles that cannot be split or shared.

b) Eligibility – candidates must be registered practising GPs, practise in one of the Group’s member practices, and be approved or accredited through any stipulated assessment process, including any required by the NHS National Commissioning Board (NHSCB), within 3 months of taking office;
candidates must disclose any criminal record, their GMC disciplinary record (including any fitness to practice issues) and any current or potential conflict of interest issues.

c) **Appointment process** – the Practice Members Group will request that the Head of Governance, Quality and Engagement put in place a process. This may include the LMC, if required, at the determination of the membership. All members will be notified of the candidates, who will be subject to an interview to confirm competency to be put forward for election. The interview panel will be made up of members and external partners. The process will be organised by the Head of Governance, Quality and Engagement.

Should an election be required, arrangements will be made to conduct any ballot by post over a period of not more than 21 days; ballots will be determined by simple majority on the basis of a single vote per current member GP. The results of a ballot, including a summary of voting analysed by candidate, will be recorded and made available to members, though individual voting will remain confidential. The candidate who receives the highest number of votes will take the post. In the event it is not possible to declare a single successful candidate, a second ballot will be conducted, over a period of not more than 10 days, between those candidates who together received the highest number of votes in the first ballot.

d) **Term of office** – the post holder will serve for a period of three years, unless removed from office or resigning from the post.

e) **Eligibility for reappointment** – provided they meet the eligibility criteria at 2.2.2(b) above, GPs may put themselves forward for reappointment without limit on the number of terms served.

f) **Grounds for removal from office** – a serving GP Chair will be automatically removed from office (from both roles), without notice, in the event that s/he is removed from the List of Registered Medical Practitioners (note: removed from office temporarily, if suspended pending investigation), or ceases to practise in one of the Group’s member practices, or is not approved/ accredited through NHSCB or other assessment process(es) where that requirement is stipulated for the position, or following the passing of a vote of no confidence by member practices of the Group at a meeting duly convened in accordance with the Standing Order 3 below (Meetings and Resolutions of the Clinical Commissioning Group). If the office is vacated, the Practice Members Group will immediately nominate a temporary successor who will remain in that position until a new GP Chair is appointed.

g) **Notice period** – a post holder wishing to resign the post should give a minimum of 90 days’ notice, in writing, addressed to the Accountable Officer, who will notify the Practice Members Group to allow that body to seek nominations and initiate proceedings for an election without delay. Proceedings to appoint a successor after a completed term of office should be initiated by the Head of Governance, Quality and Engagement such that
the newly-elected appointee may take office on completion of the term of his/her predecessor

2.4. **GP Governing Body Member acting on behalf of member practices**

2.4.1. GP Governing Body Member acting on behalf of member practices, as listed in paragraph 6.8.2 of the group’s constitution, is subject to the following appointment process:

a) **Nominations** – when a post is, or is about to become, vacant, GPs interested in serving as a GP Governing Body member (and in a specified Lead role in the Clinical Development Committee) should express their interest to the Practice Members Group, via the Head of Governance, Quality and Engagement.

b) **Eligibility** – candidates must be registered practising GPs, practising in one of the Group’s member practices; candidates must disclose any criminal record, their GMC disciplinary record (including any fitness to practice issues) and any current or potential conflict of interest issues

c) **Appointment process** – the Practice Members Group will request that the Head of Governance & Integration put in place a process. This may include the LMC, if required, at the determination of the membership. All members will be notified of the candidates, who will be subject to an interview to confirm competency to be put forward for election. The interview panel will be made up of members and external partners. The process will be organised by the Head of Governance & Integration. Should an election be required arrangements will be made to conduct any ballot by email over a period of not more than 21 days; ballots will be determined by simple majority on the basis of a single vote per current member GP. The results of a ballot, including a summary of voting analysed by candidate, will be recorded and made available to members, though individual voting will remain confidential. The candidate who receives the highest number of votes will take the post. In the event it is not possible to declare a single successful candidate, a second ballot will be conducted, over a period of not more than 10 days, between those candidates who together received the highest number of votes in the first ballot

d) **Grounds for removal from office** – a serving GP governing body member will be automatically removed from office (from both roles), without notice, in the event that s/he is removed from the List of Registered Medical Practitioners (note: removed from office temporarily, if suspended pending investigation), or ceases to practise in one of the Group’s member practices, or following the passing of a vote of no confidence by member practices of the Group at a meeting duly convened in accordance with the Standing Order 3 below (Meetings and Resolutions of the Clinical Commissioning Group)

e) **Notice period** – a post holder wishing to resign the post should give a minimum of 90 days’ notice, in writing, addressed to the Accountable Officer,
who will notify the Membership Forum to allow that body to seek nominations and initiate proceedings for an election without delay. Election proceedings to appoint a successor after a completed term of office should be initiated by the Head of Governance & Integration such that the newly-elected appointee may take office on completion of the term of his/her predecessor

2.5. **Secondary Care Specialist Doctor**

2.5.1. The Secondary Care Specialist Doctor, as listed in paragraph 6.8.2 of the group’s constitution, is subject to the following appointment process:

   a) **Nominations** – advertisement and/or nominations from NHS bodies;

   b) **Eligibility** – Be a doctor who is, or has been, a secondary care specialist, who has a high level of understanding of how care is delivered in a secondary care setting. The individual cannot be employed by any organisation from which Nottingham West Clinical Commissioning Group secures any significant volume of provision. The following further criteria deem the individual ineligible:

      i) Those not eligible to work in the UK.

      ii) A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order.

      iii) A person who has in the last five years been dismissed from employment by a health service body otherwise than because of redundancy.

      iv) A person who has received a prison sentence or suspended sentence of three months or more in the last five years.

      v) A person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years.

      vi) A health care professional whose registration is subject to conditions, or who is subject to proceedings before a fitness to practise committee of the relevant regulatory body, or who is the subject of an allegation or investigation which could lead to such proceedings.

      vii) A person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

      viii) Where he/she has become ineligible to stand for a position as a result of the declaration of any Conflict of Interest under section 8.2.
ix) A person who has at any time been removed from the management or control of a charity. It is also likely that the regulations will require that only one partner or spouse can be on the governing body.

x) A serving civil servant within the Department of Health, or member / employees of the Care Quality Commission or elected as a council or parliamentary member.

xi) The person is otherwise excluded as a result of Regulation 12 (1) of the Regulations

c) **Appointment process** –

i) Position will be advertised externally to the CCG through local / national media and other sources

ii) NHS Organisations will be contacted for nominations

iii) Interview with Governing Body members

d) **Term of office** – 3 years

e) **Eligibility for reappointment** – the Secondary Care Doctor is eligible for reappointment for one further term.

f) **Grounds for removal from office** –

i) If a receiving order is made against him or her makes any arrangement with his or her creditors.

ii) If in the opinion of the Governing Body (having taken appropriate professional advice in cases where it is deemed necessary) he/she becomes or is deemed to be of unsound mind.

iii) If he/she shall for a period of 5 consecutive meetings of the Governing Body have been absent and shall at the discretion of the Governing Body be vacated from his office.

iv) If he/she shall be convicted of a criminal offence whereby the sentence imposed shall be for a minimum of 6 months imprisonment (whether such sentence is held to be suspended or conditional).

v) If he/she shall have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the Governing Body or the Clinical Commissioning Group and is likely to bring the Governing Body and/or Clinical Commissioning Group into disrepute. This includes but is not limited to dishonesty,
misrepresentation (either knowingly or fraudulently), defamation of any Member of the Governing Body being slander or libel), abuse of position, non declaration of a known conflict of interest, seeking to lead or manipulate a decision of the Board in a manner that would ultimately be in favour of that Member whether financially or otherwise.

vi) Where he/she has become ineligible to stand for a position as a result of the declaration of any Conflict of Interest.

vii) When in position, is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

viii) When in position, becomes removed from the management or control of a charity. It is also likely that the regulations will require that only one partner or spouse can be on the Governing Body.

ix) Is employed as a serving civil servant within the Department of Health, or members /employees of the Care Quality Commission.

x) Where the PMG have passed a vote of No Confidence in the Governing Body as described in the Inter Practice Agreement.

xi) Where he/she has become ineligible to stand for a position as a result of the declaration of any Conflict of Interest.

g) Notice period – 3 months in writing

2.6. Elected Patient Representative of the Patient Reference Group

2.6.1. The Elected Patient Representative from the Patient Reference Group, as listed in paragraph 6.8.2 of the group’s constitution, is subject to the following appointment process:

a) **Nominations** – application;

b) **Eligibility** – Any qualified individual can apply for the position, subject to no conflicts of interest. The following criteria deem the individual ineligible.

i) Those not eligible to work in the UK.

ii) A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order.
iii) A person who has in the last five years been dismissed from employment by a health service body otherwise than because of redundancy.

iv) A person who has received a prison sentence or suspended sentence of three months or more in the last five years.

v) A person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years.

vi) A health care professional whose registration is subject to conditions, or who is subject to proceedings before a fitness to practise committee of the relevant regulatory body, or who is the subject of an allegation or investigation which could lead to such proceedings.

vii) A person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

viii) A person who has at any time been removed from the management or control of a charity. It is also likely that the regulations will require that only one partner or spouse can be on the governing body.

ix) A serving civil servant within the Department of Health, or member / employees of the Care Quality Commission or elected as a council or parliamentary member.

c) **Appointment process** –

i) All members of the Patient Reference Group will be notified and invited to submit applications

ii) Applications will be considered by members of the CCG Governing Body

iii) Those candidates assessed as eligible to apply will be subject to an election process conducted through the PRG, including a presentation and question and answer session.

d) **Term of office** – 3 years;

e) Eligibility for reappointment – The Elected Patient Representative from the Patient Reference Group is eligible for reappointment for one further term.
f) Grounds for removal from office –

i) If a receiving order is made against him or her makes any arrangement with his or her creditors.

ii) If in the opinion of the Governing Body (having taken appropriate professional advice in cases where it is deemed necessary) he/she becomes or is deemed to be of unsound mind.

iii) If he/she shall for a period of 5 consecutive meetings of the Governing Body or the PRG have been absent and shall at the discretion of the Governing Body or PRG be vacated from his office.

iv) If he/she shall be convicted of a criminal offence whereby the sentence imposed shall be for a minimum of 6 months imprisonment (whether such sentence is held to be suspended or conditional).

v) If he/she shall have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the Governing Body or the Clinical Commissioning Group and is likely to bring the Governing Body and/or Clinical Commissioning Group into disrepute. This includes but is not limited to dishonesty, misrepresentation (either knowingly or fraudulently), defamation of any Member of the Governing Body being slander or libel), abuse of position, non declaration of a known conflict of interest, seeking to lead or manipulate a decision of the Board in a manner that would ultimately be in favour of that Member whether financially or otherwise.

vi) Where he/she has become ineligible to stand for a position as a result of the declaration of any Conflict of Interest under section 8.2.

vii) When in position, is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

viii) When in position, becomes removed from the management or control of a charity. It is also likely that the regulations will require that only one partner or spouse can be on the governing body.

ix) Is employed as a serving civil servant within the Department of Health, or members /employees of the Care Quality Commission.

g) Notice period – 3 months in writing
2.7. Lay Member Audit and Remuneration

2.7.1. The Lay Member Audit and Remuneration as listed in paragraph 6.8.2 of the group’s constitution, is subject to the following appointment process:

a) **Nominations** – by application

b) **Eligibility** – Any qualified individual can apply for the position, subject to no conflicts of interest. The following criteria deem the individual ineligible.

i) Those not eligible to work in the UK.

ii) A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order.

iii) A person who has in the last five years been dismissed from employment by a health service body otherwise than because of redundancy.

iv) A person who has received a prison sentence or suspended sentence of three months or more in the last five years.

v) A person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years.

vi) A health care professional whose registration is subject to conditions, or who is subject to proceedings before a fitness to practise committee of the relevant regulatory body, or who is the subject of an allegation or investigation which could lead to such proceedings.

vii) A person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

viii) A person who has at any time been removed from the management or control of a charity. It is also likely that the regulations will require that only one partner or spouse can be on the governing body.

ix) A serving civil servant within the Department of Health, or member / employees of the Care Quality Commission or elected as a council or parliamentary member.

c) **Appointment process** –

i) Position will be advertised externally to the CCG through local media and other sources
ii) Interview with members of the Audit Committee and Governing Body (including Accountable Officer and Chief Finance Officer)

d) Term of office – 3 years

e) Eligibility for reappointment – The Lay Member is eligible for reappointment for one further term.

f) Grounds for removal from office

i) If a receiving order is made against him or her makes any arrangement with his or her creditors.

ii) If in the opinion of the Governing Body (having taken appropriate professional advice in cases where it is deemed necessary) he/she becomes or is deemed to be of unsound mind.

iii) If he/she shall for a period of 5 consecutive meetings of the Governing Body have been absent and shall at the discretion of the Governing Body be vacated from his office.

iv) If he/she shall be convicted of a criminal offence whereby the sentence imposed shall be for a minimum of 6 months imprisonment (whether such sentence is held to be suspended or conditional).

v) If he/she shall have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the Governing Body or the Clinical Commissioning Group and is likely to bring the Governing Body and/or Clinical Commissioning Group into disrepute. This includes but is not limited to dishonesty, misrepresentation (either knowingly or fraudulently), defamation of any Member of the Governing Body being slander or libel), abuse of position, non declaration of a known conflict of interest, seeking to lead or manipulate a decision of the Board in a manner that would ultimately be in favour of that Member whether financially or otherwise.

vi) Where he/she has become ineligible to stand for a position as a result of the declaration of any Conflict of Interest under section 8.2.

vii) When in position, is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

viii) When in position, becomes removed from the management or control of a charity. It is also likely that the regulations will require that only one partner or spouse can be on the governing body.
ix) Is employed as a serving civil servant within the Department of Health, or member / employees of the Care Quality Commission or elected as a council or parliamentary member.

g) **Notice period** – 3 months in writing

### 2.8. Lay Member Patient and Public Involvement (and Deputy Chair)

2.8.1. The Lay Member Patient and Public Involvement as listed in paragraph 6.8.2 of the group’s constitution, is subject to the following appointment process:

a) **Nominations** – by application

b) **Eligibility** – Any qualified individual can apply for the position, subject to no conflicts of interest. The following criteria deem the individual ineligible.

i) Those not eligible to work in the UK.

ii) A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order.

iii) A person who has in the last five years been dismissed from employment by a health service body otherwise than because of redundancy.

iv) A person who has received a prison sentence or suspended sentence of three months or more in the last five years.

v) A person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years.

vi) A health care professional whose registration is subject to conditions, or who is subject to proceedings before a fitness to practise committee of the relevant regulatory body, or who is the subject of an allegation or investigation which could lead to such proceedings.

vii) A person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

viii) A person who has at any time been removed from the management or control of a charity. It is also likely that the regulations will require that only one partner or spouse can be on the governing body.
ix) A serving civil servant within the Department of Health, or member / employees of the Care Quality Commission or elected as a council or parliamentary member.

c) Appointment process –

i) Position will be advertised externally to the CCG through local media and other sources

ii) Interview with members of the Governing Body and Patient Reference Group

d) Term of office – 3 years

e) Eligibility for reappointment – The Lay Member is eligible for reappointment for one further term.

f) Grounds for removal from office

i) If a receiving order is made against him or her makes any arrangement with his or her creditors.

ii) If in the opinion of the Governing Body (having taken appropriate professional advice in cases where it is deemed necessary) he/she becomes or is deemed to be of unsound mind.

iii) If he/she shall for a period of 5 consecutive meetings of the Governing Body have been absent and shall at the discretion of the Governing Body be vacated from his office.

iv) If he/she shall be convicted of a criminal offence whereby the sentence imposed shall be for a minimum of 6 months imprisonment (whether such sentence is held to be suspended or conditional).

v) If he/she shall have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the Governing Body or the Clinical Commissioning Group and is likely to bring the Governing Body and/or Clinical Commissioning Group into disrepute. This includes but is not limited to dishonesty, misrepresentation (either knowingly or fraudulently), defamation of any Member of the Governing Body being slander or libel), abuse of position, non-declaration of a known conflict of interest, seeking to lead or manipulate a decision of the Board in a manner that would ultimately be in favour of that Member whether financially or otherwise.

vi) Where he/she has become ineligible to stand for a position as a result of the declaration of any Conflict of Interest under section 8.2.
vii) When in position, is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

viii) When in position, becomes removed from the management or control of a charity. It is also likely that the regulations will require that only one partner or spouse can be on the governing body.

ix) Is employed as a serving civil servant within the Department of Health, or member / employees of the Care Quality Commission or elected as a council or parliamentary member.

g) Notice period – 3 months in writing

2.9. Lay Member

2.9.1. The Lay Member as listed in paragraph 6.8.2 of the group’s constitution, is subject to the following appointment process:

a) Nominations – by application

b) Eligibility – Any qualified individual can apply for the position, subject to no conflicts of interest. The following criteria deem the individual ineligible.

i) Those not eligible to work in the UK.

ii) A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order.

iii) A person who has in the last five years been dismissed from employment by a health service body otherwise than because of redundancy.

iv) A person who has received a prison sentence or suspended sentence of three months or more in the last five years.

v) A person who has been dismissed by a former employer (within or outside the NHS) on the grounds of misconduct within the last 5 years.

vi) A health care professional whose registration is subject to conditions, or who is subject to proceedings before a fitness to practise committee of the relevant regulatory body, or who is the subject of an allegation or investigation which could lead to such proceedings.

vii) A person who is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under
section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

viii) A person who has at any time been removed from the management or control of a charity. It is also likely that the regulations will require that only one partner or spouse can be on the governing body.

ix) A serving civil servant within the Department of Health, or member / employees of the Care Quality Commission or elected as a council or parliamentary member.

c) **Appointment process** –

i) Position will be advertised externally to the CCG through local media and other sources

ii) Interview with members of the Governing Body and Patient Reference Group

d) **Term of office** – 3 years

e) **Eligibility for reappointment** – The Lay Member is eligible for reappointment for one further term.

f) **Grounds for removal from office**

i) If a receiving order is made against him or her makes any arrangement with his or her creditors.

ii) If in the opinion of the Governing Body (having taken appropriate professional advice in cases where it is deemed necessary) he/she becomes or is deemed to be of unsound mind.

iii) If he/she shall for a period of 5 consecutive meetings of the Governing Body have been absent and shall at the discretion of the Governing Body be vacated from his office.

iv) If he/she shall be convicted of a criminal offence whereby the sentence imposed shall be for a minimum of 6 months imprisonment (whether such sentence is held to be suspended or conditional).

v) If he/she shall have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the Governing Body or the Clinical Commissioning Group and is likely to bring the Governing Body and/or Clinical Commissioning Group into disrepute. This includes but is not limited to dishonesty, misrepresentation (either knowingly or fraudulently), defamation of any
Member of the Governing Body being slander or libel), abuse of position, non-declaration of a known conflict of interest, seeking to lead or manipulate a decision of the Board in a manner that would ultimately be in favour of that Member whether financially or otherwise.

vi) Where he/she has become ineligible to stand for a position as a result of the declaration of any Conflict of Interest under section 8.2.

vii) When in position, is under a disqualification order under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

viii) When in position, becomes removed from the management or control of a charity. It is also likely that the regulations will require that only one partner or spouse can be on the governing body.

ix) Is employed as a serving civil servant within the Department of Health, or member / employees of the Care Quality Commission or elected as a council or parliamentary member.

g) **Notice period** – 3 months in writing

### 2.10. **Accountable Officer**

The Accountable Officer as listed in paragraph 6.8.2 of the group’s constitution, is subject to the following appointment process:

a) **Nominations** – an Accountable Officer must be appointed to the governing body, and will be the chief officer of, and employed by, the Group, or, under exceptional circumstances, an officer imposed by the NHSCB for a fixed period, not exceeding six months; the post, when vacant, will be advertised in the usual manner.

b) **Eligibility** – candidates must be able to demonstrate significant senior-level managerial experience, meeting any designated person specification or job description, and have successfully completed the NHSCB assessment process, and any subsequent process(es) for CCG top roles, and be a candidate acceptable to the NHSCB.

c) **Appointment Process** – a selection process will be devised and conducted by the governing body

d) **Term of Office** - the accountable officer will serve for the duration of his/her employment
e) **Eligibility for reappointment** - provided the post holder continues to meet the eligibility criteria at 2.2.7(b) above, and remains in employment with the Group, there is no reappointment process.

f) **Grounds for Removal from Office** - the post holder will be automatically removed from office, without notice, in the event that s/he fails to satisfy the requirements of the NHSCB assessment process(es), or, where employment is terminated by resignation, redundancy or as a result of disciplinary proceedings.

g) **Notice Period** – a post holder wishing to resign the post should give a minimum of 3 months’ notice, in writing, addressed to the GP Chair of the Governing Body, notwithstanding the notice requirements of the post holders’ employment.

2.11. The following positions will be employed by the relevant CCGs with responsibilities shared across Clinical Commissioning Groups.

2.11.1. The **Chief Finance Officer** and their team are employed by NHS Nottingham North and East Clinical Commissioning Group and shall work on behalf of Nottingham North and East Clinical Commissioning Group, NHS Nottingham West Clinical Commissioning Group and Rushcliffe Clinical Commissioning Group.

2.11.2. The **Director of Nursing and Quality (Registered Nurse)** and their team are employed by NHS Nottingham North and East CCG and shall work on behalf of Nottingham North and East Clinical Commissioning Group, NHS Nottingham West Clinical Commissioning Group and Rushcliffe Clinical Commissioning Group. The post holder will function as the Governing Body Nurse.

2.11.3. The **Director of Outcomes and Information** and their team are employed by NHS Rushcliffe CCG and shall work on behalf of Nottingham North and East Clinical Commissioning Group, NHS Nottingham West Clinical Commissioning Group and Rushcliffe Clinical Commissioning Group.

2.11.4. The **Director of Contracting and Deputy Chief Officer** and their team are employed by NHS Nottingham West Clinical Commissioning Group and shall work on behalf of NHS Nottingham West Clinical Commissioning Group, Nottingham North and East Clinical Commissioning Group and Rushcliffe Clinical Commissioning Group.

3. **MEETINGS OF THE CLINICAL COMMISSIONING GROUP**

3.1. **Calling meetings**

3.1.1. Ordinary meetings of the group shall be held at regular intervals at such times and places as the group may determine.

3.1.2. The Chair may call a meeting of the Governing Body at any time.
3.1.3. One-third or more members of the Governing Body may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the members signing the requisition may forthwith call a meeting.

3.1.4. Before each meeting of the Governing Body a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the CCG’s principal office at least three clear days before the meeting, (required by the Public Bodies (Admission to Meetings) Act 1960 Section 1 (4) (a)).

3.2. Agenda, supporting papers and business to be transacted

3.2.1. Items of business to be transacted for inclusion on the agenda of a meeting need to be notified to the Chair of the meeting at least 10 working days (i.e. excluding weekends and bank holidays) before the meeting takes place. Supporting papers for such items need to be submitted at least 10 working days before the meeting takes place. The agenda and supporting papers will be circulated to all members of a meeting at least 5 working days before the date the meeting will take place.

3.2.2. Agendas and certain papers for the group’s Governing Body – including details about meeting dates, times and venues - will be published on the group’s website at www.notttinghamwestccg.nhs.uk

3.2.3. These documents are also available to patients and the public upon application, either by:-

   a) Post to NHS Nottingham West Clinical Commissioning Group, Stapleford Care Centre, Stapleford, Nottinghamshire NG9 8DB

   b) Email to nottingham.west@nottinghamwestccg.nhs.uk

3.3. Petitions

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

3.4. Chair of a meeting

3.4.1. At any meeting of the group or its Governing Body or of a committee or sub-committee, the Chair of the group, Governing Body, committee or sub-committee, if any and if present, shall preside. If the Chair is absent from the meeting, the deputy Chair, if any and if present, shall preside.

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

3.5. **Chair’s ruling**

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

3.6. **Quorum**

3.6.1. A quorum will be at least two thirds of the whole number of governing body one GP Clinical member, one other clinical member, one lay member, one non-clinical member and one officer member.

3.6.2. An officer in attendance for a Governing Body member but without formal acting up status may not count towards the quorum.

3.6.3. If the Chair or member has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

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

3.7. **Decision making**

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

a) **Eligibility** – An individual who has been formally appointed to act up for a Governing Body member shall be entitled to exercise voting rights. An individual attending a Governing Body without formal acting up status may not exercise voting rights. An individual’s status when attending a meeting shall be recorded in the minutes. In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote;

b) **Majority necessary to confirm a decision** – majority;
c) **Casting vote** – Chair in the event of no overall majority;

d) **Dissenting views** – Where members have dissenting views and abstain from voting, this will be recorded in the minutes of the meeting.

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

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

3.7.4. The Governing Body is required to consider issues felt necessary by members of the PMG as described in the Inter Practice Agreement.

3.8. **Emergency powers and urgent decisions**

3.8.1. The powers which the Governing Body has reserved to itself within these Standing Orders (see Standing Order 1.2) may in emergency or for an urgent decision be exercised by the Accountable Officer and the Chair having consulted at least two other members. The exercise of such powers by the Accountable Officer and the Chair shall be reported to the next formal meeting of the Governing Body in public session for formal ratification.

3.9. **Suspension of Standing Orders**

3.9.1. Except where it would contravene any statutory provision or any direction made by the Secretary of State for Health or the NHS Commissioning Board, any part of these standing orders may be suspended at any meeting, provided two-thirds of group members are in agreement.

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

3.9.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Governing Body’s Audit and Governance Committee for review of the reasonableness of the decision to suspend standing orders.

3.10. **Record of Attendance**

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

3.11. Minutes

3.11.1. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

3.11.2. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

3.11.3. Minutes shall be circulated in accordance with members’ wishes and as described in the Inter Practice Agreement.

3.11.4. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

3.12. Admission of public and the press

3.12.1. Admission and exclusion on grounds of confidentiality of business to be transacted.

   i) The public and representatives of the press may attend all meetings of the Governing Body, but shall be required to withdraw upon the Governing Body resolving as follows:-
   
   ii) “That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest”, Section 1 (2) Public Bodies (Admission to Meetings) Act 1960.”

3.12.2. Guidance should be sought from the Governing Body’s Freedom of Information Lead to ensure correct procedure is followed on matters to be included in the exclusion.

3.12.3. General Disturbances - The Chair (or Deputy-Chair) or the person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the clinical commissioning group’s business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Governing Body resolving as follows:

   - “That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Governing Body to complete its business without the presence of the public”. Section 1(8) Public Bodies (Admission to Meetings) Act 1960.
3.12.4. **Business proposed to be transacted when the press and the public have been excluded from a meeting** - Matters to be dealt with by the Governing Body following the exclusion of representatives of the press, and other members of the public, as provided in (i) and (ii) above, shall be confidential to the members of the Governing Body.

3.12.5. Members and Officers or any employee of the clinical commissioning group in attendance shall not reveal or disclose the contents of papers marked 'In Confidence' or minutes headed 'Items Taken in Private' outside of the group, without the express permission of the Governing Body. This prohibition shall apply equally to the content of any discussion during the Governing Body meeting which may take place on such reports or papers.

3.12.6. **Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings** - Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the group or Committees thereof. Such permission shall be granted only upon resolution of the Governing Body.

4. **APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES**

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

4.1.1. Following agreement of the Practice Members Group, the group may appoint committees and sub-committees of the group, subject to any regulations made by the Secretary of State\(^\text{52}\), and make provision for the appointment of committees and sub-committees of its Governing Body. Where such committees and sub-committees of the group, or committees and sub-committees of its Governing Body, are appointed they are included in Chapter 6 of the group’s constitution.

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

4.1.3. The provisions of these standing orders shall apply where relevant to the operation of the Governing Body, the Governing Body’s committees and sub-committee and all committees and sub-committees unless stated otherwise in the committee or sub-committee’s terms of reference.

4.2. **Terms of Reference**

4.2.1. Terms of reference shall have effect as if incorporated into the constitution.

\(^{52}\) See section 14N of the 2006 Act, inserted by section 25 of the 2012 Act
4.3. Delegation of Powers by Committees to Sub-committees

4.3.1. Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the group.

4.4. Approval of Appointments to Committees and Sub-Committees

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

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

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

6. USE OF SEAL AND AUTHORISATION OF DOCUMENTS

6.1. Clinical Commissioning Group’s seal

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

   a) the Accountable Officer;
   b) the Chair of the Governing Body;
   c) the Chief Finance Officer;

6.2. Execution of a document by signature

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

   a) the Accountable Officer
   b) the Chair of the Governing Body
   c) the Chief Finance Officer
7. OVERLAP WITH OTHER CLINICAL COMMISSIONING GROUP POLICY STATEMENTS / PROCEDURES AND REGULATIONS

7.1. Policy statements: general principles

7.1.1. The group will from time to time agree and approve policy statements / procedures which will apply to all or specific groups of staff employed by NHS Nottingham West Clinical Commissioning Group. The decisions to approve such policies and procedures will be recorded in an appropriate group minute and will be deemed where appropriate to be an integral part of the group’s standing orders.
APPENDIX D – SCHEME OF RESERVATION & DELEGATION

1. SCHEDULE OF MATTERS RESERVED TO THE CLINICAL COMMISSIONING GROUP AND SCHEME OF DELEGATION

1.1. The arrangements made by the group as set out in this scheme of reservation and delegation of decisions shall have effect as if incorporated in the group’s constitution.

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

1.3. The Inter Practice Agreement can only be altered with agreement of the Group’s Membership as described in the Inter Practice Agreement.

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Decision</th>
<th>Reserved to the Membership</th>
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<tbody>
<tr>
<td>REGULATION AND CONTROL</td>
<td>Determine the arrangements by which the members of the group approve those decisions that are reserved for the membership.</td>
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<td>REGULATION AND CONTROL</td>
<td>Consideration and approval of applications to the NHS Commissioning Board on any matter concerning changes to the group’s constitution, including terms of reference for the group’s Governing Body, its committees, membership of committees, the overarching scheme of reservation and delegated powers, arrangements for taking urgent decisions, standing orders and prime financial policies.</td>
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<td>REGULATION AND CONTROL</td>
<td>Exercise or delegation of those functions of the clinical commissioning group which have not been retained as reserved by the group, delegated to the</td>
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<tr>
<td>REGULATION AND CONTROL</td>
<td>Prepare the group’s overarching scheme of reservation and delegation, which sets out those decisions of the group reserved to the membership and those delegated to the group’s Governing Body, committees and sub-committees of the group, or its members or employees and sets out those decisions of the Governing Body reserved to the Governing Body and those delegated to the Governing Body’s committees and sub-committees, members of the Governing Body, an individual who is member of the group but not the Governing Body or a specified person for inclusion in the group’s constitution.</td>
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<td>REGULATION AND CONTROL</td>
<td>Approval of the group’s overarching scheme of reservation and delegation.</td>
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<td>REGULATION AND CONTROL</td>
<td>Prepare the group’s operational scheme of delegation, which sets out those key operational decisions delegated to individual employees</td>
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<td>REGULATION AND CONTROL</td>
<td>Approval of the group’s operational scheme of delegation that underpins the group’s ‘overarching scheme of reservation and delegation’ as set out in its constitution.</td>
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<td>REGULATION AND CONTROL</td>
<td>Prepare detailed financial policies that underpin the clinical commissioning group’s prime financial policies.</td>
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<td>REGULATION AND CONTROL</td>
<td>Approve detailed financial policies.</td>
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<td>REGULATION AND CONTROL</td>
<td>Approve arrangements for managing exceptional funding requests.</td>
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<td>REGULATION AND CONTROL</td>
<td>Set out who can execute a document by signature/use of the seal.</td>
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| PRACTICE MEMBER REPRESENTATIVES & MEMBERS OF THE GOVERNING BODY | Approve the arrangements for:  
  o identifying practice members to represent practices in matters concerning the work of the group; and  
  o appointing clinical leaders to represent the group’s membership on the group’s Governing Body, for example through election (if desired). |                            |                                        |                     |                               |                        |                                        |                      |
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<tr>
<td>PRACTICE MEMBER REPRESENTATIVES &amp; MEMBERS OF THE GOVERNING BODY</td>
<td>Approve the appointment of Governing Body members, the process for recruiting and removing non-elected members to the Governing Body (subject to any regulatory requirements) and succession planning.</td>
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<td>STRATEGY &amp; PLANNING</td>
<td>Approve arrangements for identifying the group’s proposed accountable officer.</td>
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<td>STRATEGY &amp; PLANNING</td>
<td>Agree the vision, values and overall strategic direction of the group.</td>
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<td>Approval of the group’s operating structure.</td>
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<td>Approval of the group’s commissioning plan.</td>
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<td>STRATEGY &amp; PLANNING</td>
<td>Approval of the group’s corporate budgets that meet the financial duties as set out in section 5.3 of the main body of the constitution.</td>
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<td>STRATEGY &amp; PLANNING</td>
<td>Approval of variations to the approved budget where variation would have a significant impact on the overall approved levels of income and expenditure or the group’s ability to achieve its agreed strategic aims.</td>
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<td>ANNUAL REPORTS &amp; ACCOUNTS</td>
<td>Approval of the group’s annual report and annual accounts.</td>
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<td>ANNUAL REPORTS &amp; ACCOUNTS</td>
<td>Approval of the arrangements for discharging the group’s statutory financial duties.</td>
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<td>HUMAN RESOURCES</td>
<td>Approve the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities.</td>
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<td>HUMAN RESOURCES</td>
<td>Approve terms and conditions of employment for all employees of the group including, pensions, remuneration, fees and travelling or other allowances payable to employees and to other persons providing services to the group.</td>
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<td>HUMAN RESOURCES</td>
<td>Approve any other terms and conditions of services for the group's employees</td>
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<td>Determine the terms and conditions of employment for all employees of the group.</td>
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<td>HUMAN RESOURCES</td>
<td>Determine pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.</td>
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<td>HUMAN RESOURCES</td>
<td>Recommend pensions, remuneration, fees and allowances payable to employees and to other persons providing services to the group.</td>
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<td>HUMAN RESOURCES</td>
<td>Approve disciplinary arrangements for employees, including the accountable officer (where he/she is an employee or member of the clinical commissioning group) and for other persons working on behalf of the group.</td>
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<td>HUMAN RESOURCES</td>
<td>Approval of the arrangements for discharging the group's statutory duties as an employer</td>
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<td>Policy Area</td>
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<td>Accountable Officer</td>
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<td>HUMAN RESOURCES</td>
<td>Approve human resources policies for employees and for other persons working on behalf of the group</td>
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<td>QUALITY &amp; SAFETY</td>
<td>Approve arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.</td>
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<tr>
<td>QUALITY &amp; SAFETY</td>
<td>Approve arrangements for supporting the NHS Commissioning Board in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services</td>
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<td>OPERATIONAL &amp; RISK MANAGEMENT</td>
<td>Prepare and recommend an operational scheme of delegation that sets out who has responsibility for operational decisions within the group.</td>
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<td>OPERATIONAL &amp; RISK MANAGEMENT</td>
<td>Approve the group’s counter fraud and security management arrangements.</td>
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<td>OPERATIONAL &amp; RISK MANAGEMENT</td>
<td>Approval of the group’s risk management arrangements.</td>
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<td>OPERATIONAL &amp; RISK MANAGEMENT</td>
<td>Approve arrangements for risk sharing and or risk pooling with other organisations (for example arrangements for pooled funds with other clinical commissioning groups or pooled budget arrangements under section 75 of</td>
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<td>OPERATIONAL &amp; RISK MANAGEMENT</td>
<td>Approval of a comprehensive system of internal control, including budgetary control, that underpin the effective, efficient and economic operation of the group.</td>
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<td>OPERATIONAL &amp; RISK MANAGEMENT</td>
<td>Approve proposals for action on litigation against or on behalf of the clinical commissioning group.</td>
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<td>OPERATIONAL &amp; RISK MANAGEMENT</td>
<td>Approve the group’s arrangements for business continuity and emergency planning</td>
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<td>INFORMATION GOVERNANCE</td>
<td>Approve the group’s arrangements for handling complaints.</td>
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<td>INFORMATION GOVERNANCE</td>
<td>Approval of the arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data</td>
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<td>TENDERING &amp; CONTRACTING</td>
<td>Approval of the group’s contracts for any commissioning support</td>
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<td>TENDERING &amp; CONTRACTING</td>
<td>Approval of the group’s contracts for corporate support (for example finance provision).</td>
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<td>PARTNERSHIP WORKING</td>
<td>Approve decisions that individual members or employees of the group participating in joint arrangements on behalf of the group can make. Such delegated decisions must be disclosed in this scheme of reservation and delegation.</td>
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<td>PARTNERSHIP WORKING</td>
<td>Approve decisions delegated to joint committees established under section 75 of the 2006 Act.</td>
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<tr>
<td>COMMISSIONING &amp; CONTRACTING FOR CLINICAL SERVICES</td>
<td>Approval of the arrangements for discharging the group’s statutory duties associated with its commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.</td>
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<tr>
<td>COMMISSIONING &amp; CONTRACTING FOR CLINICAL SERVICES</td>
<td>Approve arrangements for co-ordinating the commissioning of services with other groups and or with the local authority(ies), where appropriate.</td>
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<td>COMMUNICATIONS</td>
<td>Approving arrangements for handling Freedom of Information requests.</td>
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<td>COMMUNICATIONS</td>
<td>Determining arrangements for handling Freedom of Information requests.</td>
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<td>CONTRACTUAL GP PRACTICE PERFORMANCE</td>
<td>Decision to issue Breach/remedial notices</td>
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<td>CONTRACTUAL GP PRACTICE PERFORMANCE</td>
<td>Removing a contract</td>
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<td>DESIGN AND IMPLEMENT ENHANCED SERVICE INCENTIVE SCHEMES</td>
<td>Approval of local alternative to Quality Outcomes Framework (QOF)</td>
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<td>GENERAL PRACTICE COMMISSIONING</td>
<td>Decisions based on Primary care needs assessment</td>
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<td>GENERAL PRACTICE COMMISSIONING</td>
<td>Establishment of new GP practices</td>
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<td>GENERAL PRACTICE COMMISSIONING</td>
<td>Approval of practice mergers</td>
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<td>GENERAL PRACTICE COMMISSIONING</td>
<td>Authorisation of discretionary payments</td>
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<td>GENERAL PRACTICE BUDGET MANAGEMENT</td>
<td>Enhanced services budget management and approval</td>
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<td>GENERAL PRACTICE BUDGET MANAGEMENT</td>
<td>General practice budget management and approval</td>
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11 INTRODUCTION

11.1 General

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

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

11.1.3 In support of these prime financial policies, the group has prepared more detailed policies, approved by the Accountable Officer, known as detailed financial policies. The group refers to these prime and detailed financial policies together as the group’s financial policies.

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

11.1.5 A list of the group’s detailed financial policies will be published and maintained on the group’s website at www.nottinghamwestccg.nhs.uk

These documents are also available to patients and the public upon application, either by:-

11.1.5.1 Post to NHS Nottingham West Clinical Commissioning Group, Stapleford Care Centre, Stapleford, Nottinghamshire NG9 8DB

11.1.5.2 Email to nottingham.west@nottinghamwestccg.nhs.uk

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

11.1.7 Failure to comply with prime financial policies and standing orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.
11.2 Overriding Prime Financial Policies

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

11.3 Responsibilities and delegation

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

11.3.2 The financial decisions delegated by members of the group are set out in the group’s scheme of reservation and delegation (see Appendix D).

11.4 Contractors and their employees

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

11.5 Amendment of Prime Financial Policies

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

12 INTERNAL CONTROL

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

12.1 The Governing Body is required to establish an audit committee with terms of reference agreed by the Governing Body (see paragraph 6.8.4 of the group’s constitution for further information).
12.2 The Accountable Officer has overall responsibility for the group's systems of internal control.

12.3 The Chief Finance Officer will ensure that:

12.3.1.1 financial policies are considered for review and update annually;

12.3.1.2 a system is in place for proper checking and reporting of all breaches of financial policies; and

12.3.1.3 a proper procedure is in place for regular checking of the adequacy and effectiveness of the control environment.

13 AUDIT

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

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

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

13.3 The Chief Finance Officer will ensure that:

13.3.1.1 the group has a professional and technically competent internal audit function; and

13.3.1.2 the Governing Body approves any changes to the provision or delivery of assurance services to the group.

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

14.1 The Governing Body’s audit and governance committee will satisfy itself that the group has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

14.2 The Governing Body’s audit and governance committee will ensure that the group has arrangements in place to work effectively with NHS Protect.

15 EXPENDITURE CONTROL

15.1 The group is required by statutory provisions\(^{53}\) to ensure that its expenditure does not exceed the aggregate of allotments from the NHS Commissioning Board and any other sums it has received and is legally allowed to spend.

15.2 The Accountable Officer has overall executive responsibility for ensuring that the group complies with certain of its statutory obligations, including its financial and accounting obligations, and that it exercises its functions effectively, efficiently and economically and in a way which provides good value for money.

15.3 The Chief Finance Officer will:

15.3.1.1 provide reports in the form required by the NHS Commissioning Board;

15.3.1.2 ensure money drawn from the NHS Commissioning Board is required for approved expenditure only is drawn down only at the time of need and follows best practice;

15.3.1.3 be responsible for ensuring that an adequate system of monitoring financial performance is in place to enable the group to fulfil its statutory responsibility not to exceed its expenditure limits, as set by direction of the NHS Commissioning Board.

16 ALLOTMENTS\(^ {54}\)

16.1 The group’s Chief Finance Officer will:

16.1.1.1 periodically review the basis and assumptions used by the NHS Commissioning Board for distributing allotments and ensure that these are reasonable and realistic and secure the group’s entitlement to funds;

\(^{53}\) See section 223H of the 2006 Act, inserted by section 27 of the 2012 Act

\(^{54}\) See section 223(G) of the 2006 Act, inserted by section 27 of the 2012 Act.
16.1.1.2 prior to the start of each financial year submit to the Governing Body for approval a report showing the total allocations received and their proposed distribution including any sums to be held in reserve; and

16.1.1.3 regularly update the Governing Body on significant changes to the initial allocation and the uses of such funds.

17 COMMISSIONING STRATEGY, BUDGETS, BUDGETARY CONTROL AND MONITORING

POLICY – the group will produce and publish an annual commissioning plan\textsuperscript{55} that explains how it proposes to discharge its financial duties. The group will support this with comprehensive medium term financial plans and annual budgets

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

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

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

17.4 The Accountable Officer is responsible for ensuring that information relating to the group’s accounts or to its income or expenditure, or its use of resources is provided to the NHS Commissioning Board as requested.

17.5 The Governing Body will approve consultation arrangements for the group’s commissioning plan\textsuperscript{56}

18 ANNUAL ACCOUNTS AND REPORTS

\textsuperscript{55} See section 14Z11 of the 2006 Act, inserted by section 26 of the 2012 Act.

\textsuperscript{56} See section 14Z13 of the 2006 Act, inserted by section 26 of the 2012 Act
POLICY – the group will produce and submit to the NHS Commissioning Board accounts and reports in accordance with all statutory obligations\textsuperscript{57}, relevant accounting standards and accounting best practice in the form and content and at the time required by the NHS Commissioning Board

18.1 The Chief Finance Officer will ensure the group:

18.1.1.1 prepares a timetable for producing the annual report and accounts and agrees it with external auditors and the Governing Body;

18.1.1.2 prepares the accounts according to the timetable approved by the Governing Body;

18.1.1.3 complies with statutory requirements and relevant directions for the publication of annual report;

18.1.1.4 considers the external auditor’s management letter and fully address all issues within agreed timescales; and

18.1.1.5 publishes the external auditor’s management letter on the group’s website at www.nottinghamwestpbc.nhs.uk.

This document is also available to patients and the public upon application, either by:-

18.1.1.5.1 Post to NHS Nottingham West Clinical Commissioning Group, Stapleford Care Centre, Stapleford, Nottinghamshire NG9 8DB

18.1.1.5.2 Email to nottingham.west@nottinghamwestccg.nhs.uk

19 INFORMATION TECHNOLOGY

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

19.1 The Chief Finance Officer is responsible for the accuracy and security of the group’s computerised financial data and shall

19.1.1.1 devise and implement any necessary procedures to ensure adequate (reasonable) protection of the group’s data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

\textsuperscript{57} See paragraph 17 of Schedule 1A of the 2006 Act, as inserted by Schedule 2 of the 2012 Act.
19.1.1.2 ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

19.1.1.3 ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

19.1.1.4 ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Chief Finance Officer may consider necessary are being carried out.

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

20 ACCOUNTING SYSTEMS

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

20.1 The Chief Finance Officer will ensure:

20.1.1 the group has suitable financial and other software to enable it to comply with these policies and any consolidation requirements of the NHS Commissioning Board;

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

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

21 BANK ACCOUNTS

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

21.1 The Chief Finance Officer will:
21.1.1.1 review the banking arrangements of the group at regular intervals to ensure they are in accordance with Secretary of State directions\textsuperscript{58}, best practice and represent best value for money;

21.1.1.2 manage the group’s banking arrangements and advise the group on the provision of banking services and operation of accounts;

21.1.1.3 prepare detailed instructions on the operation of bank accounts.

21.2 The Accountable Officer shall approve the banking arrangements.

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

**POLICY** – the group will
- operate a sound system for prompt recording, invoicing and collection of all monies due
- seek to maximise its potential to raise additional income only to the extent that it does not interfere with the performance of the group or its functions\textsuperscript{59}
- ensure its power to make grants and loans is used to discharge its functions effectively\textsuperscript{60}

22.1 The Chief Finance Officer is responsible for:

22.1.1 designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, and collection and coding of all monies due;

22.1.2 establishing and maintaining systems and procedures for the secure handling of cash and other negotiable instruments;

22.1.3 approving and regularly reviewing the level of all fees and charges other than those determined by the NHS Commissioning Board or by statute. Independent professional advice on matters of valuation shall be taken as necessary;

22.1.4 for developing effective arrangements for making grants or loans.

### 23 TENDERING AND CONTRACTING PROCEDURE

**POLICY** – the group:

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\textsuperscript{58} See section 223H(3) of the NHS Act 2006, inserted by section 27 of the 2012 Act

\textsuperscript{59} See section 14Z5 of the 2006 Act, inserted by section 26 of the 2012 Act.

\textsuperscript{60} See section 14Z6 of the 2006 Act, inserted by section 26 of the 2012 Act.
• will ensure proper competition that is legally compliant within all purchasing to ensure we incur only budgeted, approved and necessary spending
• will seek value for money for all goods and services
• shall ensure that competitive tenders are invited for
  o the supply of goods, materials and manufactured articles;
  o the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the Department of Health); and
  o for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens) for disposals

23.1 The Accountable Officer may only negotiate contracts on behalf of the group, and the group may only enter into contracts, within the statutory framework set up by the 2006 Act, as amended by the 2012 Act. Such contracts shall comply with:

23.1.1.1 the group’s standing orders;

23.1.1.2 the Public Contracts Regulation 2006, any successor legislation and any other applicable law; and

23.1.1.3 take into account as appropriate any applicable NHS Commissioning Board or the Independent Regulator of NHS Foundation Trusts (Monitor) guidance that does not conflict with (b) above.

23.2 In all contracts entered into, the group shall endeavour to obtain best value for money. The Accountable Officer shall nominate an individual who shall oversee and manage each contract on behalf of the group.

23.3 The Chief Finance Officer will prepare detailed procedures on the tendering and contracting process.

24 COMMISSIONING

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

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

24.2 The Accountable Officer will establish arrangements to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure and activity for each contract.
24.3 The Chief Finance Officer will maintain a system of financial monitoring to ensure the effective accounting of expenditure under contracts. This should provide a suitable audit trail for all payments made under the contracts whilst maintaining patient confidentiality.

25 RISK MANAGEMENT AND INSURANCE

**POLICY** – the group will put arrangements in place for evaluation and management of its risks

25.1 The CCG Governing Body has a duty to assure itself that the Group has effectively identified the risks it faces, and that it has processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders.

25.2 The Governing Body will discharge this duty as follows:

- Identify risks to the achievement of it strategic objectives
- Monitor these risks via the Board Assurance Framework
- Ensure that there is a structure in place for the effective management of risk throughout the Group by implementation of an Integrated Risk Management Framework
- Approve and review policies and strategies for risk management on an annual basis
- Receive regular reports from both the Audit and Governance Committee, and the Quality and Risk Committee.
- Demonstrate leadership, active involvement and support for risk management.

26 PAYROLL

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

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

26.1.1 is supported by appropriate (i.e. contracted) terms and conditions;

26.1.2 has adequate internal controls and audit review processes;

26.1.3 has suitable arrangements for the collection of payroll deductions and payment of these to appropriate bodies.

26.2 In addition the Chief Finance Officer shall set out comprehensive procedures for the effective processing of payroll
27 NON-PAY EXPENDITURE

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

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

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

27.3 The Chief Finance Officer will:

27.3.1 advise the Governing Body on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the scheme of reservation and delegation;

27.3.2 be responsible for the prompt payment of all properly authorised accounts and claims;

27.3.3 be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable.

28 CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

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

28.1 The Accountable Officer will

28.1.1 ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon plans;

28.1.2 be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

28.1.3 shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges;

28.1.4 be responsible for the maintenance of registers of assets, taking account of the advice of the Chief Finance Officer concerning the form
of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

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

29  RETENTION OF RECORDS

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

29.1 The Accountable Officer shall:

29.1.1 be responsible for maintaining all records required to be retained in accordance with NHS Code of Practice Records Management 2006 and other relevant notified guidance;

29.1.2 ensure that arrangements are in place for effective responses to Freedom of Information requests;

29.1.3 publish and maintain a Freedom of Information Publication Scheme.

30  TRUST FUNDS AND TRUSTEES

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

30.1 The Chief Finance Officer shall ensure that each trust fund which the group is responsible for managing is managed appropriately with regard to its purpose and to its requirements.
APPENDIX F - NOLAN PRINCIPLES

1. The ‘Nolan Principles’ set out the ways in which holders of public office should behave in discharging their duties. The seven principles are:

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

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

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

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

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

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

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

Source: *The First Report of the Committee on Standards in Public Life (1995)*[^61]

[^61]: Available at http://www.public-standards.gov.uk/
APPENDIX G – NHS CONSTITUTION

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

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

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

3. **the NHS aspires to the highest standards of excellence and professionalism** - in the provision of high quality care that is safe, effective and focused on patient experience; in the people it employs, and in the support, education, training and development they receive; in the leadership and management of its organisations; and through its commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population. Respect, dignity, compassion and care should be at the core of how patients and staff are treated not only because that is the right thing to do but because patient safety, experience and outcomes are all improved when staff are valued, empowered and supported.

4. The patient will be at the heart of everything the NHS does. – It should support individuals to promote and manage their own health. NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. As part of this, the NHS will ensure that in line with the Armed Forces Covenant, those in the armed forces, reservists, their families and veteran are not disadvantaged in accessing health services in the area they reside. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services.

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

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

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

Source: The NHS Constitution: The NHS belongs to us all (July 2015)\textsuperscript{62}

\textsuperscript{62} http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132961
### APPENDIX H – CHECKLIST FOR A CLINICAL COMMISSIONING GROUP’S CONSTITUTION

<table>
<thead>
<tr>
<th>Essential/Optional</th>
<th>Content</th>
<th>Included</th>
</tr>
</thead>
</table>
| Essential          | The constitution must specify:  
  - the **name of the clinical commissioning group**;  
  - the **members of the group**; and  
  - the **area of the group**  

The name of the group must comply with such requirements as may be prescribed |          |
| Essential          | The constitution must specify the **arrangements made by the clinical commissioning group for the discharge of its functions** (including its functions in determining the terms and conditions of its employees) |          |
| Optional           | The arrangements may include provision:  
  - for the appointment of committees or sub-committees of the clinical commissioning group; and  
  - for any such committees to consist of or include persons other than members or employees of the clinical commissioning group |          |
| Optional           | The arrangements may include provision for any functions of the clinical commissioning group to be exercised on its behalf by:  
  - any of its members or employees;  
  - its Governing Body; or  
  - a committee or sub-committee of the group |          |
| Essential          | The constitution must specify the **procedure to be followed by the clinical commissioning group in making decisions** |          |
| Essential          | The constitution must specify the **arrangements made by the clinical commissioning group for discharging its duties in respect of registers of interest and management of conflicts of interest** as specified under section 14O(1) to (4) of the 2006 Act, as inserted by section 25 of the 2012 Act |          |
| Essential          | The constitution must also specify the **arrangements made by the clinical commissioning group for securing that there is transparency about the decisions of the group and the manner in which they are made**  

The provisions made above must secure that there is effective participation by each member of the clinical commissioning group in the exercise of the group’s functions |          |
| Essential          | The constitution must specify the **arrangements made by the clinical commissioning group for the discharge of the functions of its Governing Body** |          |
| Essential          | The arrangements must include:  
  - provision for the appointment of the audit committee and remuneration committee of the Governing Body |          |
<table>
<thead>
<tr>
<th>Essential/Optional</th>
<th>Content</th>
<th>Included</th>
</tr>
</thead>
</table>
| Optional           | The arrangements may include:  
  - provision for the audit committee (but not the remuneration committee) to include individuals who are not members of the Governing Body  
  - provision for the appointment of other committees or sub-committees of the Governing Body. These may include provision for a committee or sub-committee to include individuals who are not members of the Governing Body but are:  
    - members of the clinical commissioning group, or  
    - individuals of a description specified in the constitution |
| Optional           | The arrangements may include provision for any functions of the Governing Body to be exercised on its behalf by:  
  - any committee or sub-committee of the Governing Body,  
  - a member of the Governing Body;  
  - a member of the clinical commissioning group who is an individual (but is not a member of the Governing Body); or  
  - an individual of a description specified in the constitution |
| Essential          | The constitution must specify the **procedure to be followed by the Governing Body in making decisions** |
| Essential          | The constitution must also specify the **arrangements made by the clinical commissioning group for securing that there is transparency about the decisions of the Governing Body and the manner in which they are made**  
  This provision must include provision for meetings of governing bodies to be open to the public, except where the clinical commissioning group considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting |
| Essential          | In its constitution, the clinical commissioning group must describe the **arrangements** which it has made and include a statement of the principles which it will follow in implementing those arrangements, **to secure that individuals to whom health services are being or may be provided pursuant to its commissioning arrangements are involved** (whether by being consulted or provided with information or in other ways):  
  - in the planning of the commissioning arrangements by the group;  
  - in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them; and  
  - in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact |
Standards for members of NHS boards and Clinical Commissioning Group governing bodies in England

November 2013

All members of NHS boards and CCG governing bodies should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities.

To justify the trust placed in me by patients, service users, and the public, I will abide by these Standards at all times when at the service of the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and well-being of patients and service users, supporting them to keep mentally and physically well, to get better when they are ill and, when they cannot fully recover, to stay as well as they can to the end of their lives.

I understand that I must act in the interests of patients, service users, and the community I serve, and that I must uphold the law and be fair and honest in all my dealings.
Personal behaviour

1. As a Member\(^1\) I commit to:

   The values of the NHS Constitution
   Promoting equality
   Promoting human rights
   in the treatment of patients and service users, their families and carers, the community, colleagues and staff, and in the design and delivery of services for which I am responsible.

2. I will apply the following values in my work and relationships with others:

   - **Responsibility**: I will be fully accountable for my work and the decisions that I make, for the work and decisions of the board\(^2\), including delegated responsibilities, and for the staff and services for which I am responsible
   - **Honesty**: I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a board member
   - **Openness**: I will be open about the reasoning, reasons, and processes underpinning my actions, transactions, communications, behaviours, and decision-making and about any conflicts of interest
   - **Respect**: I will treat patients and service users, their families and carers, the community, colleagues and staff with dignity and respect at all times
   - **Professionalism**: I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a board member and that I reflect on and identify any gaps in my knowledge and skills, and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound
   - **Leadership**: I will lead by example in upholding and promoting these Standards, and use them to create a culture in which their values can be adopted by all
   - **Integrity**: I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours, and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

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\(^1\) The term ‘Member’ is used throughout this document to refer to members of NHS boards and CCG governing bodies in England.

\(^2\) The term ‘board’ is used throughout this document to refer collectively to NHS boards and CCG governing bodies in England.
Technical competence

3. As a Member, for myself, my organisation, and the NHS, I will seek:
   Excellence in clinical care, patient safety, patient experience, and the accessibility of services
   To make sound decisions individually and collectively
   Long term financial stability and the best value for the benefit of patients, service users, and the community.

4. I will do this by:
   - Always putting the safety of patients and service users, the quality of care, and patient experience first, and enabling colleagues to do the same
   - Demonstrating the skills, competencies, and judgement necessary to fulfil my role, and engaging in training, learning, and continuing professional development
   - Having a clear understanding of the business and financial aspects of my organisation’s work and of the business, financial, and legal contexts in which it operates
   - Making the best use of my expertise and that of my colleagues while working within the limits of my competence and knowledge
   - Understanding my role and powers, the legal, regulatory, and accountability frameworks and guidance within which I operate, and the boundaries between the executive and the non-executive
   - Working collaboratively and constructively with others, contributing to discussions, challenging decisions, and raising concerns effectively
   - Publicly upholding all decisions taken by the board under due process for as long as I am a member of the board
   - Thinking strategically and developmentally
   - Confidently and competently using data and other forms of intelligence, including patient complaints and feedback, to improve the quality of care
   - Understanding the health needs of the population I serve
   - Reflecting on personal, board, and organisational performance, and on how my behaviour affects those around me; and supporting colleagues to do the same
   - Looking for the impact of decisions on the services we and others provide, on the people who use them, and on staff
   - Listening to patients and service users, their families and carers, the community, colleagues, and staff, and making sure people are involved in decisions that affect them
   - Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community, colleagues, and staff, and ensuring that messages have been understood.
Business practices

5. As a Member, for myself and my organisation, I will seek:
   To ensure my organisation is fit to serve its patients and service users, and the community
   To be fair, transparent, measured, and thorough in decision-making and in the management of public money
   To be ready to be held publicly to account for my organisation's decisions and for its use of public money.

6. I will do this by:
   - Declaring any personal, professional, or financial interests and ensuring that they do not interfere with my actions, transactions, communications, behaviours, or decision-making, and removing myself from decision-making when they might be perceived to do so
   - Taking responsibility for ensuring that any harmful behaviour, misconduct, or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns that I identify
   - Ensuring that effective incident reporting, disclosure, complaints, and whistleblowing procedures are in place and in use
   - Condemning any practices that could inhibit or prohibit the reporting of concerns by members of the public, staff, or board members about standards of care or conduct
   - Ensuring that staff provide high quality care in a listening, supportive, learning environment
   - Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions
   - Respecting patients' rights to consent, privacy and confidentiality, and access to information, while enabling the legitimate sharing of information between care teams and professionals for the purposes of a patient's direct care
   - Being open about the evidence, reasoning, and reasons behind decisions about budget, resource, and contract allocation
   - Seeking assurance that my organisation's financial, operational, and risk management frameworks are sound, effective, and properly used, and that the values in these Standards are put into action in the design and delivery of services
   - Ensuring that my organisation's contractual and commercial relationships are honest, legal, regularly monitored, and compliant with best practice in the management of public money
   - Working in partnership and co-operating with local and national bodies to support the delivery of safe, high quality care
   - Ensuring that my organisation's dealings are made public, unless there is a justifiable and properly documented reason for not doing so.
**Executive Summary**

- There are a number of significant financial pressures emerging in the year to date position. These give rise to a risk that the 1% surplus target will not be delivered.
- A significant deterioration in the underlying position has been reported to NHS England.
- NUH Local price on-going review and discussion continue around the impact of future years Local Prices.

If paper is for approval, have the following impact assessments been completed?

<table>
<thead>
<tr>
<th>Quality Impact Assessment</th>
<th>Equality Impact Assessment</th>
<th>Privacy Impact Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Implications:** (please tick where relevant)

- Integration
- Reducing inequality
- Constitution
- Governance
- Innovation
- Learning and Development
- Patient Choice
- Patient & Public Involvement
- Quality of Services
- QIIPP
- Research
- Sustainability

**Finance checked by:** (IL)

**Appendices**

Appendix 1 – Finance Report

**Report History**

Monthly to Governing Body to Approve

**Recommendation**

The Governing Body is asked to:

- NOTE -The financial position of the CCG for April 2016 to August 2016.
Finance report for the period ending 31 August 2016

Governing Body report
Introduction

- This report summarises the financial position of the CCG
- The table below summarises the key financial duties and targets and internal key financial indicators for the CCG:

<table>
<thead>
<tr>
<th>Key Financial Duties</th>
<th>YTD RAG Rating</th>
<th>Forecast RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remain within the Revenue Resource Limit (£133,585k full year)</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>Achieve the required Surplus (£1,211k full year)</td>
<td>Green</td>
<td>Amber</td>
</tr>
<tr>
<td>Remain within Running Cost Allowance (£2,023k full year)</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>Remain within the Cash Balance Limit</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>Better Payments Practice Code</td>
<td>Green</td>
<td>Green</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Internal Financial Indicators</th>
<th>YTD RAG Rating</th>
<th>Forecast RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>QIPP – achievement of overall target (£5,190k full year)</td>
<td>Amber</td>
<td>Amber</td>
</tr>
<tr>
<td>QIPP – achievement of recurrent target</td>
<td>Amber</td>
<td>Amber</td>
</tr>
<tr>
<td>Risk Reserves – level utilised to balance position</td>
<td>Amber</td>
<td>Amber</td>
</tr>
<tr>
<td>Underlying Surplus – maintain 1% of RRL</td>
<td>Amber</td>
<td>Amber</td>
</tr>
<tr>
<td>Co-commissioning – spend remains within budget</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>Acute Contract – spend remains within budget</td>
<td>Amber</td>
<td>Amber</td>
</tr>
<tr>
<td>Continuing healthcare – spend remains within budget</td>
<td>Amber</td>
<td>Amber</td>
</tr>
<tr>
<td>Prescribing – spend remains within budget</td>
<td>Green</td>
<td>Green</td>
</tr>
</tbody>
</table>
Month 05 Summary

➢ The CCG is forecasting to meet all of its statutory financial duties in 2016/17. The continued overspending on acute services and the impact of the local prices now transacted in the contract are posing significant risks to the CCG. In addition the continued overspending on Continuing Healthcare/Funded Nursing Care including the revised price impact and non-delivery of QIPP continues to add to the financial pressures the CCG has to manage.

➢ The CCG has met the surplus target for the period to date. There is a risk that the 1% surplus target for the full year may not be met, additional QIPP schemes have been identified which will mitigate this risk.

➢ Running Costs are within target. The CCG has spent £758k on running costs for the reporting period.

➢ The CCG achieved its cash target in this reporting period.

➢ The CCG is forecasting to remain within its overall resource limit

➢ The CCG financial position has been maintained by utilising £380k of reserves.
Month 05 Summary

- The CCG has seen a significant deterioration of the planned underlying surplus position. This has serious consequences for the 17/18 financial plan.
- The CCG has had a 40% increase to FNC prices as a result of a national review. This has resulted in an estimated full year cost pressure of £358k. FNC assessment procedures are under review to ensure the criteria is being correctly applied.
- The CCG has formed a Continuing Healthcare (CHC) turnaround group with The Mid-Notts CCGs and City care (the provider) having bi-weekly meetings on analysing and challenging changes at a service area level.
- NUH Local price review - non-recurrent agreement has been made for 16/17 which has impacted on the CCG’s current level of reserves available. On-going review and discussions continue around the impact of future year Local Prices.
Resource Limit

- There has been no change to the Resource Limit for the CCG in this reporting period. The table below shows the current RL:

<table>
<thead>
<tr>
<th></th>
<th>Year to date</th>
<th></th>
<th>Full year forecast outturn</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Recurrent £000</td>
<td>Non Recurrent £000</td>
<td>Total £000</td>
</tr>
<tr>
<td>Opening Revenue Resource Limit (RRL)</td>
<td>52,107</td>
<td>861</td>
<td>52,968</td>
</tr>
<tr>
<td><strong>Month 05</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP Development Programme - reception and clerical training</td>
<td>8</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total RRL</strong></td>
<td>52,107</td>
<td>869</td>
<td>52,976</td>
</tr>
</tbody>
</table>

Summary Financial Position Year to Date

- £380K of reserves used to date to balance the position
- Acute £351K over plan year to date
- Continuing Care £466K over plan includes FNC price impact £149k
- Prescribing £246k under plan
- Running Costs £85k under plan
- Mental Health £30k under plan
- Community Service £3k under plan
- Other budgets £73k under plan
- See Appendix 1 for full Operating Cost statement
**Key Areas – Risk, Over and Underspend Areas**

<table>
<thead>
<tr>
<th>AREAS</th>
<th>YTD Variance</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nottingham University Hospital Trust - NUHT</td>
<td>363</td>
<td>The month 5 variance is based on month 4 activity data uplifted for month 5 reporting. The month 4 activity data shows over performance on multiple points of delivery in the following - General Medicine, Trauma &amp; Orthopaedics, Maternity, Urology, Ophthalmology, Breast Surgery, Pain Management, Clinical Oncology and Clinical Haematology. Outpatient procedures is the area with the largest overspend (20%), followed by Direct Access (14%) and Drugs/Devices (12%). The NUH charges have been impacted by the local prices agreed which have been transacted backed to the 1-July-2016. The Impact for 16/17 is £318k. This has been funded in the budget from reserves, leading to a reduction in risk reserves available for the remainder of the year.</td>
</tr>
<tr>
<td>Circle</td>
<td>25</td>
<td>The month 5 variance is based on month 4 activity data uplifted for month 5 reporting. Month 4 activity data shows Circle is overspending on multiple points of delivery. The variance position reported also includes a 2015/16 non-recurrent benefit therefore the net position does not fully reflect the recurrent pressure.</td>
</tr>
<tr>
<td>SFHT</td>
<td>86</td>
<td>The month 5 variance is based on month 4 activity data uplifted for month 5 reporting. Month 4 is showing an over spend, however, the data shows a high level of un-coded activity. The CCG has made a forecast adjustment for this and other coding and counting issues they believe need amending. Mansfield and Ashfield CCG (as contract lead) are working with the Trust and are aiming to have this resolved as soon as possible.</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>466</td>
<td>Continuing Health Care (CHC) actual costs have risen month on month, with the main contributors so far this year being Children and Older Peoples packages. This is concerning given the level of growth included in the 2016/17 plan. Further work to understand the increased costs is underway and a turnaround action plan is now in place. FNC has had a price increase in July 16 (backdated to 1st April 16) with a year to date impact of £149k, which results in an expected full year impact of £358k. The increase is due to the Department of Health (DH) centrally imposing a 40% price increase following an independent review.</td>
</tr>
<tr>
<td>Prescribing</td>
<td>(246)</td>
<td>The prescribing position reflects only 3 months of actual 2016/17 spend at this stage. There has been a change in the PPA (Prescription Pricing Authority) budget phasing at month 5 with a higher level of budget phased into the first half of the year. This has resulted in a significant beneficial swing to the prescribing position.</td>
</tr>
</tbody>
</table>
QIPP

- QIPP is forecast to achieve plan, however, this position is supported by non-recurrent QIPP from reserves. The table below shows a summary by scheme headings and the delivery to date and forecast against plan.

<table>
<thead>
<tr>
<th>Work Stream</th>
<th>Year to date £'000</th>
<th>Forecast £'000</th>
<th>RAG FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>71</td>
<td>0</td>
<td>(71)</td>
</tr>
<tr>
<td>Community Services</td>
<td>168</td>
<td>168</td>
<td>0</td>
</tr>
<tr>
<td>Contracting</td>
<td>32</td>
<td>32</td>
<td>0</td>
</tr>
<tr>
<td>Elective Care</td>
<td>547</td>
<td>304</td>
<td>(243)</td>
</tr>
<tr>
<td>Non Elective care</td>
<td>421</td>
<td>162</td>
<td>(259)</td>
</tr>
<tr>
<td>Other CCG Targets</td>
<td>253</td>
<td>1</td>
<td>(252)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>225</td>
<td>426</td>
<td>201</td>
</tr>
<tr>
<td>Reserves</td>
<td>181</td>
<td>805</td>
<td>624</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,898</td>
<td>1,898</td>
<td>-</td>
</tr>
</tbody>
</table>

- QIPP target £5,190k.
- Forecast delivery with the support of £1,317K reserves.
- Prescribing currently over performing due to better than anticipated savings on Category M drugs.
- There is a continued risk around the delivery of non-elective QIPP schemes as the Urgent Care Vanguard has been funded for the longer term development of 111 hubs.
Other Key Areas

- **Running cost**
  - The CCG running costs are forecast to be within the £2,023k allowance for the year.
  - The CCG has spent £758k on running costs for the reporting period, against a budget of £843k.

- **Better Payment Practice Code (BPPC)**
  - NHS Organisations have a target of paying 95% of invoices from both NHS providers and external (Non-NHS) organisations within 30 days by number and value. The CCG is forecasting to achieve these targets.
  - The CCG’s BPPC performance for the year to date is shown in the table below:

<table>
<thead>
<tr>
<th></th>
<th>Non-NHS (%)</th>
<th>NHS (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume</td>
<td>99.76%</td>
<td>99.37%</td>
</tr>
<tr>
<td>Value</td>
<td>99.91%</td>
<td>99.77%</td>
</tr>
</tbody>
</table>

- **Statement of Financial Position and Cash**
  - The statement of Financial Position can be found in Appendix 3.
  - The Cash Management regime requires the CCG to have a balance at the end of the month, of not more than 1.25% of that month’s drawdown. This equates to £108k for the reporting period. The actual Cash balance the end of the reporting period is £244k. The CCG expects to remain within the Maximum Cash Drawdown for 2016/17.

- **Primary Care Co-Commissioning**
  - The Primary Care Co-commissioning position shows a small under performance and the forecast for the year is in line with plan.

**Better Care Fund (BCF)**

- BCF spend is currently on plan.
Key Messages

- There are a number of significant financial pressures emerging in the year to date position. These give rise to a risk that the 1% surplus target will not be delivered.
- A significant deterioration in the underlying position has been reported to NHS England.
- The CCG has formed a Continuing Healthcare (CHC) turnaround group with the Mid-Notts CCGs and City care (the provider) having bi-weekly meetings on analysing and challenging changes at a service area level.
- NUH Local price on-going review and discussion continue around the impact of future years Local Prices.

Recommendations

The CCG Governing Body is asked to:

- NOTE the financial position of the CCG for the reporting period and the risks faced in delivering 2016/17 planned surplus.
- APPROVE the Finance Report for the reporting period.

Jonathan Bemrose
Chief Finance Officer
12 September 2016
### APPENDIX 1

#### 04M Nottingham West CCG Operating Cost Statement

<table>
<thead>
<tr>
<th>For the Period Ending: 31st August 2016</th>
<th>Values</th>
<th>Annual budget (£'000)</th>
<th>YTD budget (£'000)</th>
<th>YTD Actual (£'000)</th>
<th>YTD Variance (£'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Co-Commissioning</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GMS/PMS Payments</td>
<td>7,988</td>
<td>3,249</td>
<td>3,246</td>
<td>-3</td>
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<tr>
<td>Property Costs</td>
<td>1,738</td>
<td>724</td>
<td>725</td>
<td>1</td>
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<tr>
<td>Enhanced Services</td>
<td>599</td>
<td>249</td>
<td>253</td>
<td>4</td>
<td></td>
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<tr>
<td>QoF</td>
<td>1,306</td>
<td>544</td>
<td>542</td>
<td>-2</td>
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<tr>
<td>Other</td>
<td>669</td>
<td>80</td>
<td>80</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Co-Commissioning Total</strong></td>
<td>12,300</td>
<td>4,748</td>
<td>4,766</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td><strong>Acute Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUHT</td>
<td>44,245</td>
<td>18,375</td>
<td>18,738</td>
<td>363</td>
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<tr>
<td>SHFT</td>
<td>1,684</td>
<td>701</td>
<td>787</td>
<td>86</td>
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<tr>
<td>EMAS</td>
<td>2,814</td>
<td>1,173</td>
<td>1,180</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Circle - Nottingham Treatment Centre</td>
<td>7,607</td>
<td>3,170</td>
<td>3,195</td>
<td>25</td>
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<tr>
<td>FCN/Independent</td>
<td>1,765</td>
<td>735</td>
<td>668</td>
<td>-87</td>
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</tr>
<tr>
<td>Other</td>
<td>2,935</td>
<td>1,223</td>
<td>1,180</td>
<td>-43</td>
<td></td>
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<tr>
<td><strong>Acute Services Total</strong></td>
<td>61,050</td>
<td>25,377</td>
<td>25,728</td>
<td>351</td>
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<tr>
<td><strong>Mental Health Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHT</td>
<td>8,016</td>
<td>3,173</td>
<td>3,104</td>
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</tr>
<tr>
<td>Low Secure/Other</td>
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<td>505</td>
<td>533</td>
<td>30</td>
<td></td>
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<tr>
<td>IAPT</td>
<td>567</td>
<td>234</td>
<td>243</td>
<td>9</td>
<td></td>
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<tr>
<td><strong>Mental Health Services Total</strong></td>
<td>9,790</td>
<td>3,912</td>
<td>3,882</td>
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</tr>
<tr>
<td><strong>Better Care Fund</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUHT</td>
<td>3,859</td>
<td>1,217</td>
<td>1,217</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Better Care Fund Total</strong></td>
<td>3,859</td>
<td>1,217</td>
<td>1,217</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Community Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHP</td>
<td>8,231</td>
<td>3,371</td>
<td>3,350</td>
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<td></td>
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<tr>
<td>Other</td>
<td>1,972</td>
<td>672</td>
<td>660</td>
<td>14</td>
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<tr>
<td><strong>Community Services Total</strong></td>
<td>10,203</td>
<td>4,043</td>
<td>4,040</td>
<td>-3</td>
<td></td>
</tr>
<tr>
<td><strong>Commissioning - Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NUHT</td>
<td>1,944</td>
<td>464</td>
<td>460</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td><strong>Commissioning - Other Total</strong></td>
<td>1,944</td>
<td>464</td>
<td>460</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td><strong>CHC / FNC Total</strong></td>
<td>9,946</td>
<td>4,144</td>
<td>4,010</td>
<td>466</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>14,534</td>
<td>6,071</td>
<td>5,823</td>
<td>-248</td>
<td></td>
</tr>
<tr>
<td>Out of Hours</td>
<td>802</td>
<td>334</td>
<td>334</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>LES</td>
<td>318</td>
<td>132</td>
<td>124</td>
<td>-8</td>
<td></td>
</tr>
<tr>
<td>Pathways</td>
<td>1,075</td>
<td>448</td>
<td>444</td>
<td>-4</td>
<td></td>
</tr>
<tr>
<td>GPIT</td>
<td>231</td>
<td>88</td>
<td>80</td>
<td>-58</td>
<td></td>
</tr>
<tr>
<td>Meds Management Clinical</td>
<td>311</td>
<td>135</td>
<td>113</td>
<td>-17</td>
<td></td>
</tr>
<tr>
<td><strong>Primary Care Total</strong></td>
<td>17,271</td>
<td>7,203</td>
<td>6,870</td>
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</tr>
<tr>
<td><strong>Programme Corporate Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme Corporate Costs</td>
<td>81</td>
<td>30</td>
<td>48</td>
<td>-13</td>
<td></td>
</tr>
<tr>
<td><strong>Programme Corporate Costs Total</strong></td>
<td>81</td>
<td>30</td>
<td>48</td>
<td>-13</td>
<td></td>
</tr>
<tr>
<td><strong>Mgt &amp; Admin Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PAY</td>
<td>1,414</td>
<td>589</td>
<td>562</td>
<td>-27</td>
<td></td>
</tr>
<tr>
<td>NON-PAY</td>
<td>609</td>
<td>254</td>
<td>196</td>
<td>-58</td>
<td></td>
</tr>
<tr>
<td><strong>Mgt &amp; Admin Total</strong></td>
<td>2,023</td>
<td>843</td>
<td>758</td>
<td>-85</td>
<td></td>
</tr>
<tr>
<td><strong>Provisions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions</td>
<td>170</td>
<td>170</td>
<td>170</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Provisions Total</strong></td>
<td>170</td>
<td>170</td>
<td>170</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Developments &amp; Reserves</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developments / Risk</td>
<td>574</td>
<td>239</td>
<td>230</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Committed</td>
<td>2,559</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Contingency</td>
<td>604</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Reserves Total</strong></td>
<td>3,757</td>
<td>380</td>
<td>380</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Planned Surplus Budget</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>1,211</td>
<td>503</td>
<td>503</td>
<td>0</td>
<td>-503</td>
</tr>
<tr>
<td><strong>Planned Surplus Total</strong></td>
<td>1,211</td>
<td>503</td>
<td>503</td>
<td>0</td>
<td>-503</td>
</tr>
<tr>
<td><strong>TOTAL AVAILABLE RESOURCE</strong></td>
<td>131,585</td>
<td>52,076</td>
<td>52,473</td>
<td>-503</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2

- Total NWCCG Reserves Position
- NWCCG NUH Variance
- NWCCG Prescribing Variance
- NWCCG Circle Variance
- NWCCG Continuing Care Variance
## APPENDIX 3

### STATEMENT OF FINANCIAL POSITION
AS AT 31st August 2016

<table>
<thead>
<tr>
<th>Audited Open Bal at Apr-16 £</th>
<th>Closing Balance for period £'000s</th>
<th>Net Change £'000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total non-current assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>678</td>
<td>6,160</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>46</td>
<td>184</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>724</td>
<td>6,344</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>724</td>
<td>6,344</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>-4,320</td>
<td>-10,771</td>
</tr>
<tr>
<td>Provisions</td>
<td>-85</td>
<td>-85</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td>-4,405</td>
<td>-10,856</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td>-3,681</td>
<td>-4,512</td>
</tr>
<tr>
<td><strong>Non-current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>-644</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>-4,325</td>
<td>-4,512</td>
</tr>
<tr>
<td><strong>Financed By Taxpayers’ equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Fund</td>
<td>-4,325</td>
<td>-4,512</td>
</tr>
<tr>
<td><strong>Total taxpayer’s equity</strong></td>
<td>-4,325</td>
<td>-4,512</td>
</tr>
</tbody>
</table>
Meeting Title: NHS Nottingham West CCG  
Governing Body:  
Date: 15 September 2016  

Paper Title: Detailed Financial Policies (including the operational scheme of delegation)  
Agenda Item: NW/GB/16/371  

Lead Director  
Report Author: Jonathan Bemrose – Chief Finance Officer  

Purpose (tick one only):  
☐ Approval  
☐ Acknowledge/ Note  
☐ Review  
☐ For Information  

Executive Summary: A number of revisions have been made to the Detailed Financial Policies and the operational scheme of delegation:  
- Insertion of new paragraph 3.2 and revision to Appendix 1 Section 3a to reflect requirement for additional approval for consultancy appointments  
- Revision of Section 3c for NHSE co-commissioning staff hosted by Mansfield and Ashfield CCG for authorising primary care payments  
- Insertion of new paragraph 3.3 and revision to Appendix 1 3a to reflect additional controls for off–payroll arrangements  

If paper is for approval, have the following impact assessments been completed?  

<table>
<thead>
<tr>
<th>Quality Impact Assessment</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Equality Impact Assessment</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Privacy Impact Assessment</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
</table>

Implications: (please tick where relevant)  

- Integration  
- Reducing inequality  
- Constitution  
- Governance  
- Innovation  
- Learning and Development  
- Patient Choice  
- Patient & Public Involvement  
- Quality of Services  
- QIPP  
- Research  
- Sustainability  

Finance checked by: (initials)  

Appendices  
Report History  

Recommendation: The Governing Body is asked to:  

APPROVE the revised Detailed Financial Policies (including the operational scheme of delegation)
## DETAILED FINANCIAL POLICIES

INCLUDING THE OPERATIONAL SCHEME OF DELEGATION

SEPTEMBER 2016

VERSION 6

<table>
<thead>
<tr>
<th>Version No</th>
<th>Author</th>
<th>Date</th>
<th>Comments</th>
<th>Approved by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clare Hopewell</td>
<td>Nov 2012</td>
<td>Agreed with South Nottinghamshire CCGs’ Senior Management Team with input from Neil Moore, Technical Procurement Lead</td>
<td>Accountable Officer and Governing Body at the Governing Body Meeting on the 15 November 2012</td>
</tr>
<tr>
<td>2</td>
<td>Clare Hopewell</td>
<td>Dec 2013</td>
<td>Annual Review – South Notts CCG’s Senior Management and Finance Team and GEM procurement expert</td>
<td>Accountable Officer and Governing Body at the Governing Body Meeting on the 30 January 2014</td>
</tr>
<tr>
<td>3</td>
<td>Clare Hopewell</td>
<td>May 2014</td>
<td>Revision Section 3c in light of the internal audit report “Key Financial Systems &amp; Payroll”</td>
<td>Governing Body 22 May 2014</td>
</tr>
<tr>
<td>4</td>
<td>Ian Livsey</td>
<td>September 2014</td>
<td>Revision Section 3b to add Director of Commissioning</td>
<td>Governing Body 23 October 2014</td>
</tr>
<tr>
<td>5</td>
<td>Clare Hopewell</td>
<td>July 2015</td>
<td>Revision Section 3c to change from GEM to Citycare for Continuing Care Invoices</td>
<td>Governing Body 23 July 2015</td>
</tr>
<tr>
<td>6</td>
<td>Craig Sharples</td>
<td>September 2016</td>
<td>Insertion of new paragraph 3.2 and revision to Appendix 1 Section 3a to reflect requirement for additional approval for consultancy appointments</td>
<td>Governing Body 29 September 2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Revision of Section 3c for NHSE co-commissioning staff hosted by Mansfield and Ashfield CCG for authorising primary care payments</td>
<td></td>
</tr>
<tr>
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<td>Insertion of new paragraph 3.3 and revision to Appendix 1 3a to reflect additional controls for off – payroll arrangements</td>
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Introduction

This document contains the detailed financial policies of the CCG that together with the prime financial policies has effect as if incorporated into the CCG’s constitution.

Background

The Clinical Commissioning Group’s (CCG) constitution contains a number of prime financial policies that contribute to good corporate governance, internal control and managing risks. They enable sound administration; lessen the risk of irregularities and support commissioning and delivery of effective, efficient and economical services. The prime financial policies are to be used in conjunction with the scheme of reservation and delegation which is also incorporated in the CCG’s constitution.

These prime financial policies are supplemented by more detailed policies, approved by the Accountable Officer and an Operational Scheme of Delegation, approved by the Governing Body, that provide further procedural advice in the following areas of financial governance:-

- Custody of Seal, Sealing of Documents and Signature of Documents
- Budgetary delegation, budgetary control & reporting
- Tendering & contracting
- Payroll
- Non-pay
- Disposals & condemnations, losses & special payments
- Information Technology
- Acceptance of Gifts by Staff and Link to Standards of Business Conduct
- Operational Scheme of Delegation

These more detailed policies read in conjunction with the prime financial policies and the overarching Scheme of Reservation & Delegation are aimed at supporting the Accountable Officer, Chief Finance Officer or any other authorised officer, member or person working on behalf of the CCG in discharging their responsibilities on a day to day basis.
1. Custody of Seal, Sealing of Documents and Signature of Documents

1.1 Custody of Seal
The common seal of the CCG shall be kept by the CCG’s Lead for Governance in a secure place.

1.2 Sealing of Documents
Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of the Accountable Officer, the Chair of the Governing Body or the Chief Finance Officer and shall be attested by them.

1.3 Register of Sealing
The Accountable Officer shall keep a register in which he/she, or another manager of the CCG authorised by him/her, shall enter a record of the sealing of every document.

1.4 Use of Seal – General guide
A seal would normally need to be applied on the following types of document:
   a) the transfer deed for a purchase or sale of freehold land or lease
   b) a lease
   c) a licence or deed which is supplemental to a lease, for example licences to carry out works, licences to assign, licences to underlet, a surrender of a lease
   d) other miscellaneous deeds including planning agreements such as Section 106 Agreements, Deeds of Guarantee and Deeds of Easements (rights)
   e) where the Department of Health or another statutory body insists on a document being sealed and following advice from the CCG’s legal advisors this is appropriate
   f) a construction contract and/or collateral warranty.

1.5 Signature of documents
Where any document will be a necessary step in legal proceedings on behalf of the CCG, it shall, unless any enactment otherwise requires or authorises, be signed by the Accountable Officer, the Chair of the Governing Body or the Chief Finance Officer.

In land transactions, the signing of certain supporting documents will be delegated to Managers and set out clearly in the Scheme of Delegation but will not include the main or principal documents affecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).
2. Budgetary Delegation and Budgetary Control & Reporting

2.1 Budgetary Delegation
The Accountable Officer may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:
   a) the amount of the budget;
   b) the purpose(s) of each budget heading;
   c) individual and group responsibilities;
   d) authority to exercise virement;
   e) achievement of planned levels of service;
   f) the provision of regular reports.

The Accountable Officer and delegated budget holders must not exceed the budgetary total or virement limits set by the Governing Body.

Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Accountable Officer, subject to any authorised use of virement.

Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Accountable Officer, as advised by the Chief Finance Officer.

The Operational Scheme of Delegation, attached as Appendix 1, summaries the matters delegated by the Accountable Officer, and to whom they are delegated.

2.2 Budgetary Control and Reporting
The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:
   a) monthly financial reports to the Governing Body meetings in a form approved by the Governing Body containing:
      (i) income and expenditure to date showing trends and forecast year-end position;
      (ii) movements in working capital;
      (iii) movements in cash and capital;
      (iv) capital project spend and projected outturn against plan (if applicable);
      (v) explanations of any material variances from plan;
      (vi) details of any corrective action where necessary and the Accountable Officer's and/or Chief Finance Officer’s view of whether such actions are sufficient to correct the situation;
   b) monthly finance performance reports (part of practice packs) to member practices highlighting major variances for consideration;
   c) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
   d) investigation and reporting of variances from financial and manpower budgets;
   e) monitoring of management action to correct variances;
   f) arrangements for the authorisation of budget virements.

Each Budget Holder is responsible for ensuring that:
a) any likely overspend or reduction of income which cannot be met by virement is not incurred without the prior consent of the Governing Body;
b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement;
c) no permanent employees are appointed without the approval of the Accountable Officer other than those provided for within the available resources and manpower establishment as approved by the Governing Body.
3. Tendering and Contracting

The procedure for making all contracts by or on behalf of the CCG shall comply with the CCG’s Standing Orders and Prime Financial Policies supplemented by these detailed financial policies as appropriate.

3.1 EU Directives Governing Public Procurement
   a) Directives by the Council of the European Union promulgated by the Department Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these detailed financial policies.
   b) CCGs should obtain support from the Greater East Midlands Commissioning Support Unit to ensure compliance when engaging in tendering procedures (see Section 5 of Appendix 1 – Operational Scheme of Delegation regarding EU Procurement Limits).

3.2 Consultancy Spend over £50k
The Department of Health confirmed on the 2 June 2015 in a letter to the CCG’s Accountable Officer that controls over consultancy would apply with immediate effect for all CCGs, Arms’ Length Bodies, NHS Trusts and Foundation Trusts in receipt of financial support. That is:

“All consultancy contracts above £50,000 would require approval in advance from Monitor or TDA. An organisation intending to procure or let a consultancy contract will submit a request for approval to TDA or Monitor who will then consider whether in their view it represents good value for money. The decision on approval will be made by a panel of senior staff from Monitor or the TDA.”

This control therefore now applies to CCGs and must be adhered to as part of the tender/contracting procedure.

3.3 Off pay-roll engagements
NHS England and NHS Improvement have confirmed that controls over off pay roll engagements would apply with immediate effect for all CCGs and CSUs. That is:

“All CCG engagements above £600 per day but below £800 (per day) will require approval from the relevant NHS England Director of Commissioning Operations and their Director of Finance. Engagements above £800 (per day) will require additional approval from Regional Directors and Regional Directors of Finance, and any proposed arrangements greater than £900 (per day) will also require the approval of the NHS England Commercial Executive Committee”.

Business cases need to be submitted for approval as per above controls.

3.4 Capital Investment Manual and other Department of Health Guidance
The CCG shall comply as far as is practicable with the requirements of the Department of Health “Capital Investment Manual” and “Estate code” in respect of capital investment and estate and property transactions or any other technical guidance that may be from time to time issued. Where this is not practicable, any deviation from the guidance should be documented as part of the procurement process and signed off by the CFO.

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3.5 Formal Competitive Tendering

General Applicability

In accordance with the prime financial policies, the CCG shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

Approved limits for quotations and tenders are prescribed in the Appendix 1 - The Operational Scheme of Delegation - and these will be reviewed at least annually.

Health Care Services

The Accountable Officer is responsible for ensuring the CCG enters into suitable Service Level Agreements (SLAs)/NHS Standard Contracts with service commissioners for the provision of NHS services.

All SLAs/NHS Standard Contracts should aim to implement the agreed priorities contained within the CCG’s strategic and operational plans and the local Joint Strategic Needs Assessment. In discharging this responsibility, the Accountable Officer should take into account, and include as appropriate in the service specification/Key Performance Indicators (KPIs):

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS National Performance Assessment Framework;
- that SLAs/NHS Standard Contracts build where appropriate on existing Joint Investment Plans;
- that SLAs/NHS Standard Contracts are based on integrated care pathways.

A good SLA/NHS Standard Contract will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Accountable Officer to ensure that the CCG works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA/NHS Standard Contract will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the CCG can jointly manage risk with all interested parties.

The Accountable Officer, will need to ensure that regular reports are provided to the Governing Body detailing actual and forecast expenditure against the SLA/NHS Standard Contract as appropriate.

3.6 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures need not be applied where:

a) the estimated expenditure or income does not, or is not reasonably expected to, exceed £50,000; or
b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

c) regarding disposals as set out in Section 3.16;

Formal tendering procedures may be waived in the following circumstances:

d) in very exceptional circumstances where the Accountable Officer (or the CFO) decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate CCG record;

e) where the requirement is covered by an existing contract;

f) where Framework Agreements such as those managed by Government Procurement Services (GPS) or other compliant Frameworks are in place and have been approved by the Governing Body;

g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

i) where specialist expertise is required and is available from only one source;

j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the CCG is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel’s opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned. The Chief Finance Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(m) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate CCG record (SO1 Form) and reported to the Audit Committee at each meeting.

3.7 Fair and Adequate Competition

The CCG shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

3.8 List of Approved Firms

The CCG shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Chief Finance Officer it
is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Accountable Officer.

3.9 Building and Engineering Construction Works
Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Department of Health approval.

3.10 Items which subsequently breach thresholds after original approval
Items estimated to be below the limits set in these detailed financial policies for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Accountable Officer, and be recorded in an appropriate CCG record.

3.11 Contracting/Tendering Procedure

Invitation to tender
i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

ii) All invitations to tender shall state that no tender will be accepted unless:
   • submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the CCG (or the word "tender" followed by the subject to which it related) and the latest date and time for the receipt of such tender addressed to the Accountable Officer or nominated Manager;
   • that tender envelopes/packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer;
   • or if using an e-tendering solution such as Bravo e-tendering solution all such instructions including the date and how to respond shall be included within the instructions to bidders.

iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable

iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

v) Every tender must have given, or give a written undertaking, not to engage in collusive tendering or other restrictive practice.

Receipt and safe custody of tenders
The Accountable Officer or his/her nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.
The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

**Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Accountable Officer and not from the originating department.

(ii) Where the estimated value of the tender is £100,000 or greater, a CCG Director must be one of the approved persons present for the opening of the tenders. The CCG’s Governance Lead will count as a Director for the purposes of opening tenders. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the CCG’s Operational Scheme of Delegation (Appendix 1).

(iii) The ‘originating’ Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Chief Finance Officer or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(v) All CCG Directors will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department. The CCG’s Governance Lead will count as a Director for the purposes of opening tenders.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Accountable Officer, or a person authorised by him/her, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were received and opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender and suitably initialled.

Each entry to this register shall be signed by those present. A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his/her own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

(ix) If using an e-tendering solution such as Bravo e-tendering solution, the receipt, safe-keeping, opening and recording of tenders shall be in accordance with the control system contained within the system and approved by the Accountable Officer.
Admissibility

i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Accountable Officer.

ii) Where only one tender is sought and/or received, the Accountable Officer and Chief Finance Officer shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the CCG.

Late tenders

i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Accountable Officer or his/her nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Accountable Officer or his/her nominated officer or if the process of evaluation and adjudication has not started.

iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Accountable Officer or his/her nominated officer.

iv) Accepted late tenders will be reported to the Governing Body.

Acceptance of formal tenders

i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his/her tender before the award of a contract will not disqualify the tender.

ii) Tenders shall be awarded either on the basis of the lowest price or the Most Economically Advantageous Tender (MEAT), all such methodology to be agreed by the Accountable Officer before commencement of the tender process. The reasons for the decision shall be set out in either the contract file, or other appropriate record.

iii) For the sale of goods or services the award will be made based upon the highest price to be received by the CCG, unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

iv) In line with ii above, It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:
   a. experience and qualifications of team members;
   b. understanding of client’s needs;
   c. feasibility and credibility of proposed approach;
   d. ability to complete the project on time.
v) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the CCG and which is not in accordance with these Instructions except with the authorisation of the Accountable Officer.

vi) The use of these procedures must demonstrate that the award of the contract was:

a. not in excess of the going market rate / price current at the time the contract was awarded;
b. that best value for money was achieved.

vii) All Tenders should be treated as confidential and should be retained for inspection.

_Tender reports to the CCG Governing Body_
Reports to the CCG Governing Body will be made on an exceptional circumstance basis only.

_List of approved firms_
_a) Responsibility for maintaining list_
A manager nominated by the Accountable Officer shall on behalf of the CCG maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the CCG is satisfied. All suppliers must be made aware of the CCG’s terms and conditions of contract.

_b) Building and Engineering Construction Works_
_i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147)._

_ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation._

_iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested._

_c) Financial Standing and Technical Competence of Contractors_
The Chief Finance Officer may make or institute any enquiries he/she deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

_Exceptions to using approved contractors_
If in the opinion of the Accountable Officer and the Chief Finance Officer or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required...
and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Accountable Officer should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

3.12 Quotations: Competitive and non-competitive

General Position on quotations
Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not exceed £50,000.

Competitive Quotations
i) Quotations should be obtained from at least 3 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the CCG.

ii) Quotations should be in writing unless the Accountable Officer or his/her nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone.

iii) Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

iv) All quotations should be treated as confidential and should be retained for inspection.

v) The Accountable Officer or his/her nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the CCG, or the highest if payment is to be received by the CCG, then the choice made and the reasons why should be recorded in a permanent record.

Non-Competitive Quotations
Non-competitive quotations in writing may be obtained in the following circumstances and where approval has been gained by the Accountable Officer or CFO:

(i) The supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the delegated budget manager, possible or desirable to obtain competitive quotations;

(ii) The supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) Miscellaneous services, supplies and disposals;

(iv) Where the goods or services are for building and engineering maintenance the AO will identify a responsible works manager who must certify that the first two conditions (i.e. (i) and (ii) above apply.

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Quotations to be within Financial Limits
No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the CCG and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Accountable Officer or Chief Finance Officer.

(See Appendix 1 Operational Scheme of Delegation (Section 5) – all limits for quotes, tenders and EU procurement are inclusive of VAT irrespective of whether this is reclaimable or not).

3.13 Authorisation of Tenders and Competitive Quotations
Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and the awarding of a contract may be decided by designated managers to the value of the contract as determined in the CCG Governing Body’s scheme of delegation.

Formal authorisation must be put in writing. In the case of authorisation by the CCG Governing Body this shall be recorded in their minutes.

3.14 Instances where formal competitive tendering or competitive quotation is not required
Where competitive tendering or a competitive quotation is not required, the CCG should adopt one of the following alternatives:

a) the CCG shall use the Greater East Midlands Commissioning Support Unit for procurement of all goods and services unless the Accountable Officer or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

b) if the CCG does not use the Greater East Midlands Commissioning Support Unit - where tenders or quotations are not required, because expenditure is below £10,000, the CCG shall procure goods and services in accordance with procurement procedures approved by the Chief Finance Officer.

3.15 Private Finance for capital procurement
The CCG should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Governing Body proposes, or is required, to use finance provided by the private sector the following should apply:

a) The Accountable Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate team at the Department of Health for approval or treated as per current guidelines.

c) The proposal must be specifically agreed by the Governing Body of the CCG.

d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

3.16 Compliance requirements for all contracts
The Governing Body may only enter into contracts on behalf of the CCG within the statutory powers delegated to it by the Secretary of State and shall comply with:
a) The CCG's Standing Orders and Financial Policies;
b) EU Directives and other statutory provisions;
c) Such of the NHS Standard Contract Conditions as are applicable;
d) Contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;
e) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited;
f) In all contracts made by the CCG, the Governing Body shall endeavour to obtain best value for money by use of all systems in place. The Accountable Officer shall nominate an officer who shall oversee and manage each contract on behalf of the CCG.

3.17 Personnel and Agency or Temporary Staff Contracts
The Accountable Officer shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

3.18 Disposals
Competitive Tendering or Quotation procedures shall not apply to the disposal of:

a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Accountable Officer or his/her nominated officer;
b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the CCG;
c) items to be disposed of with an estimated sale value of less than £10,000, this figure to be reviewed on a periodic basis;
d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
e) land or buildings concerning which Department of Health guidance has been issued but subject to compliance with such guidance.

3.19 In-house Services
The Accountable Officer shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The CCG may also determine from time to time that in-house services should be market tested by competitive tendering.

In all cases where the Governing Body determines that in-house services should be subject to competitive tendering the following groups shall be set up:

a) Specification group, comprising the Accountable Officer or nominated officer/s and specialist provided to work on behalf of the CCG.
b) In-house tender group, comprising a nominee of the Accountable Officer and CCG technical support.
c) Evaluation team, comprising normally a specialist officer provided to work on behalf of the CCG, a Greater East Midlands (GEM) supplies officer and a Chief Finance Officer Representative. For services having a likely annual expenditure exceeding £100,000, a non-officer member should be a member of the evaluation team.
All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

The evaluation team shall make recommendations to the Governing Body.

The Accountable Officer shall nominate an officer to oversee and manage the contract on behalf of the CCG.
4. Payroll

The Chief Finance Officer is responsible for:
   a) specifying timetables for submission of properly authorised time records and other notifications;
   b) the final determination of pay and allowances;
   c) making payment on agreed dates;
   d) agreeing method of payment.

The Chief Finance Officer will issue instructions regarding
   a) verification and documentation of data;
   b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
   c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;
   d) security and confidentiality of payroll information;
   e) checks to be applied to completed payroll before and after payment;
   f) authority to release payroll data under the provisions of the Data Protection Act;
   g) methods of payment available to various categories of employee and officers;
   h) procedures for payment by cheque, bank credit, or cash to employees and officers;
   i) procedures for the recall of cheques and bank credits;
   j) pay advances and their recovery;
   k) maintenance of regular and independent reconciliation of pay control accounts;
   l) separation of duties of preparing records and handling cash;
   m) a system to ensure the recovery from those leaving the employment of the CCG of sums of money and property due by them to the CCG.

 Appropriately nominated managers have delegated responsibility for:
   a) submitting time records, and other notifications in accordance with agreed timetables;
   b) completing time records and other notifications in accordance with the Chief Finance Officer's instructions and in the form prescribed by the Chief Finance Officer;
   c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil employment obligations in circumstances that suggest they have left without notice, the Chief Finance Officer must be informed immediately.

Regardless of the arrangements for providing the payroll service, the Chief Finance Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangement are made for the collection of payroll deductions and payment of these to appropriate bodies.
5. Non-Pay Expenditure

The Governing Body will approve the level of non-pay expenditure on an annual basis and the Accountable Officer will determine the level of delegation to budget managers. The delegated limits for non-pay requisitioning and ordering are included at Appendix 1. Directions governing competitive tendering and quotations are included within Section 3 of these detailed financial policies.

The Accountable Officer will set out:
(a) the list of managers who are authorised to place requisitions for the supply of goods and services;
(b) the maximum level of each requisition and the system for authorisation above that level.
(c) procedures on the seeking of professional advice regarding the supply of goods and services.

5.1 Requisitioning
The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the CCG. In so doing, the advice of the CCG’s adviser on supply (GEM Supplies Officer) shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Finance Officer (and/or the Accountable Officer) shall be consulted.

5.2 Official Orders
Official Orders must:
  a) be consecutively numbered;
  b) be in a form approved by the Chief Finance Officer;
  c) state the CCG’s terms and conditions of trade;
  d) only be issued to, and used by, those duly authorised by the Accountable Officer.

5.3 System of Payment and Payment Verification
The Chief Finance Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance, targets or best practice.

The Chief Finance Officer will:
  a) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
     (i) A list of budget holders, members and employees (including specimens of their signatures) authorised to certify invoices.
     (ii) Certification that:
       • goods have been duly received, examined and are in accordance with specification and the prices are correct;
       • work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
       • in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have
been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Chief Finance Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

b) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in paragraph below 5.4 “Prepayments”.

5.4 Prepayments
Prepayments are only permitted where exceptional circumstances apply. In such instances:

a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (e.g. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%).

b) The appropriate budget holder must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the CCG if the supplier is at some time during the course of the prepayment agreement unable to meet his/her commitments;

c) The Chief Finance Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Accountable Officer if problems are encountered.

5.5 Duties of Managers and Officers
Managers and officers must ensure that they comply fully with the guidance and limits specified by the Chief Finance Officer and that:

a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Finance Officer in advance of any commitment being made;

b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Section 8 of the Constitution. Section 7 below and the principles outlined in the national guidance contained in HSG 93(5) “Standards of Business Conduct for NHS Staff”; the Code of Conduct
for NHS Managers 2002; and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry).

e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Finance Officer on behalf of the Accountable Officer;
f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;
g) verbal orders must only be issued very exceptionally - by an employee designated by the Accountable Officer and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
i) goods are not taken on trial or loan in circumstances that could commit the CCG to a future uncompetitive purchase;
j) changes to the list of employees and officers authorised to certify invoices are notified to the Chief Finance Officer;
k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Finance Officer;
l) petty cash records are maintained in a form as determined by the Chief Finance Officer.
6. Disposals and Condemnations, Losses and Special Payments

6.1 Disposals and Condemnations Procedures
   a) The Chief Finance Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.
   b) When it is decided to dispose of a CCG asset, the Head of Department or authorised deputy will determine and advise the Chief Finance Officer of the estimated market value of the item, taking account of professional advice where appropriate.
   c) All unserviceable articles shall be:
      • condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Finance Officer;
      • recorded by the Condemning Officer in a form approved by the Chief Finance Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Finance Officer.
   d) The Condemning Officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Finance Officer who will take the appropriate action.

6.2 Losses and Special Payments Procedures
   a) The Chief Finance Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
   b) Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their Head of Department, who must immediately inform the Accountable Officer and the Chief Finance Officer or inform an officer charged with responsibility for responding to concerns involving loss who will then appropriately inform the Chief Finance Officer and/or Accountable Officer. Where a criminal offence is suspected, the Chief Finance Officer must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Chief Finance Officer must inform the relevant Local Counter Fraud Specialists (LCFS) and Operational Fraud Team (OFT) in accordance with Secretary of State for Health’s Directions.

Suspected Fraud
The Chief Finance Officer must notify the NHS Counter Fraud Services (CFS) and the External Auditor of all frauds.

   c) For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Finance Officer must immediately notify:
      • the Governing Body, and
      • the External Auditor.
   d) Within limits delegated to it by the Department of Health, the Governing Body shall approve the writing-off of losses.
   e) The Chief Finance Officer shall be authorised to take any necessary steps to safeguard the CCG’s interests in bankruptcies and company liquidations
   f) For any loss, the Chief Finance Officer should consider whether any insurance claim can be made.
   g) The Chief Finance Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.
h) No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

i) All losses and special payments must be reported to the Audit Committee quarterly in arrears.
7. Acceptance of Gifts by Staff and Link to Standards of Business Conduct

(See overlap with “Standards of Business Conduct and Managing Conflicts of Interest” Section 8 of the Constitution and Section 5.5 above)

The Chief Finance Officer shall ensure that all staff are made aware of the CCG policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 ‘Standards of Business Conduct for NHS Staff’; the Code of Conduct for NHS Managers 2002; and the ABPI Code of Professional Conduct relating to hospitality/gifts from pharmaceutical/external industry and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions.
Appendix 1 – Operational Scheme of Delegation

1.1. The arrangements made by the CCG as set out in the Overarching Scheme of Reservation and Delegation of decisions shall have effect as if incorporated in the CCG's Constitution.

1.2. The CCG remains accountable for all of its functions, including those that it has delegated.

1.3. Appendix D of the Constitution is the Overarching Scheme of Reservation & Delegation (Schedule of Matters Reserved to the CCG and Scheme of Delegation) and details the arrangements made by the CCG for discharging its functions.

1.4. The Schedule below details the Operational Scheme of Delegation (and financial authority limits). These should be read in conjunction with the Prime Financial Policies (Appendix E of the Constitution).

1.5. This is prepared by the Accountable Officer and sets out those key operational decisions delegated to individual employees of the CCG (it is not for inclusion in the CCG's Constitution).

1.6. The approval of the CCG's Operational Scheme of Delegation that underpins the CCG's “Overarching Scheme of Reservation and Delegation” as set out in its Constitution, is reserved to the Governing Body.
<table>
<thead>
<tr>
<th>Ref</th>
<th>Matter delegated</th>
<th>Delegated to</th>
<th>Reference Documents</th>
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<tbody>
<tr>
<td>1</td>
<td>Management of Budgets (responsible for keeping pay and</td>
<td>Governing Body (see overarching</td>
<td>Prime Financial Policies S.7</td>
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<tr>
<td></td>
<td>non-pay expenditure within approved budgets and retaining</td>
<td>non-pay expenditure within approved budgets and retaining income levels)</td>
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<td></td>
<td>Approval of Budgets</td>
<td>Scheme of Delegation)</td>
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<td></td>
<td>Level of delegation to CCG Senior Management Team/Heads</td>
<td>Accountable Officer (AO)</td>
<td></td>
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<td></td>
<td>Heads of Service</td>
<td>CCG Senior Manager/Head of Service</td>
<td></td>
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<td></td>
<td>Level of delegation to Budget Managers</td>
<td>(a) Designated budget holder</td>
<td>Budget Managers Manual</td>
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<td></td>
<td>Responsibility for maintaining expenditure within approved</td>
<td>(b) CCG Senior Manager</td>
<td></td>
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<td>budgets:</td>
<td>(c) Chief Finance Officer (CFO)</td>
<td>Detailed Financial Policies S.2</td>
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<td></td>
<td>(a) at individual budget level (pay and non-pay)</td>
<td>Budget Holder/Manager is permitted to</td>
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<td>(b) for the totality of services covered by the area</td>
<td>incur costs in accordance with their</td>
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<td>(c) for all other areas e.g. Reserves</td>
<td>budgets &amp; authorisation limits (see Section 3 below)</td>
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<td></td>
<td>Approval to Spend</td>
<td>CFO</td>
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<td></td>
<td>Monitoring of Financial Performance</td>
<td>Virements within a budget holders</td>
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<td>Delegated Virement Limits</td>
<td>approved budget are permitted in</td>
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<td>Approval of overspends or reductions in income that cannot</td>
<td>accordance with virement rules.</td>
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<td>be met by virement</td>
<td>CFO</td>
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<tr>
<td>2</td>
<td>Bank accounts</td>
<td>Approved by the CFO and reported to the next Governing Body meeting.</td>
<td>Prime Financial Policies S.11</td>
</tr>
<tr>
<td></td>
<td>Opening of new (Government Banking Services) Bank Accounts</td>
<td></td>
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<td></td>
<td>Notification of changes to banking arrangements, with the exception of changes in signatories</td>
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<td></td>
<td>Banking procedures</td>
<td>CFO</td>
<td></td>
</tr>
<tr>
<td>3a</td>
<td>Revenue Administrative (Non Commissioning Spend) Spend on Goods and Services</td>
<td>In line with budget management responsibilities (i.e. delegated budgets) and subject to quoting &amp; tendering as required (see Section 5 below):-</td>
<td>Budget Managers Manual</td>
</tr>
<tr>
<td></td>
<td>- Limits for Requisition and Invoice approval (all values are inclusive of VAT irrespective of whether this is reclaimable or not):</td>
<td></td>
<td>Detailed Financial Policies S.2 &amp; S.3</td>
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<td></td>
<td>(a) up to £10,000</td>
<td>(a) Band 5 and above</td>
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<td>(b) from £10,001 to £50,000</td>
<td>(b) Band 7 and above</td>
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<td>(c) from £50,001 to £75,000</td>
<td>(c) Band 8b and above</td>
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<td>(d) from £75,001 to £100,000</td>
<td>(d) CCG Senior Manager</td>
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<td>(e) from £100,001 to £250,000</td>
<td>(e) AO or CFO</td>
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<td>(f) from £250,001 to £500,000</td>
<td>(f) AO and CFO</td>
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<td></td>
<td>(g) £500,001 and above</td>
<td>(g) AO, Following Governing Body Approval</td>
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<td></td>
<td>Procurement of Professional Services (additional controls are required due to the need to closely monitor Running Costs)</td>
<td>CCGs are required to secure advance approval from NHS England before procuring or letting a consultancy project over £50,000.</td>
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<td></td>
<td>(a) Legal Advice</td>
<td>(a) AO or deputy AO</td>
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<td></td>
<td>(b) Specialist advice e.g. IT, clinical enquiries</td>
<td>(b) AO or deputy AO</td>
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<td></td>
<td>(c) Specific Projects e.g. specific reviews</td>
<td>(c) AO or CFO</td>
<td></td>
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<tr>
<td>Ref</td>
<td>Matter delegated</td>
<td>Delegated to</td>
<td>Reference Documents</td>
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<td></td>
<td>Off Pay Roll Engagements</td>
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<td>(a) £600 per day - £800 per day</td>
<td>CCGs are required to secure advance approval from NHS England before</td>
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<td>(b) £800 per day - £900 per day</td>
<td>employing or continuing to employ off pay roll staff.</td>
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<td>(c) Over £900 per day</td>
<td>(a) NHSE Director of Commissioning Operations and Director of Finance</td>
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<td></td>
<td>(b) NHSE Regional Director and Regional Director of Finance</td>
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<td>(c) NHS England Commercial Executive Committee</td>
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</table>
### Ref 3b: Revenue Programme Spend: Commissioning contracts

with Providers including other NHS bodies, contracts with Foundation Trusts, and partnership agreements with local authorities

(a) For the commissioning of NHS healthcare services:
   - (i) up to £999,999 (contract variation up to £99,999)
   - (ii) from £1m to £4,999,999 (contract variation £100,000 - £499,999)
   - (iii) from £5m to £50m (contract variation £500,000 - £999,999)
   - (iv) above £50m (contract variation £1m or more)

(b) For the commissioning of non-NHS healthcare services:
   - (i) up to £99,999 (contract variation up to £9,999)
   - (ii) from £100,000 to £499,999 (contract variation £10,000 - £499,999)
   - (iii) from £500,000 to £5m (contract variation £500,000 - £500,000)
   - (iv) above £5m (contract variation above £500,000)

(c) For the provision of non-healthcare services:
   - (i) up to £14,999 (contract variation up to £999)
   - (ii) from £15,000 to £99,999 (contract variation £1,000 - £4,999)
   - (iii) from £100,000 to £499,999 (contract variation £5,000 - £24,999)
   - (iv) above £500,000 (contract variation above £25,000)

#### Delegated to

For (a), (b) and (c)

(i) Equivalent of two Heads of Service (one of whom must be the Deputy Chief Finance Officer or CFO and one who must be a Commissioning Team members Band 8 and above)

(ii) Director of Contracting (or Nominated Deputy) and CFO (or Deputy Chief Finance Officer)

(iii) AO and CFO

(iv) AO, after approval by Governing Body

#### Reference Documents

- Budget Managers Manual
- Detailed Financial Policies S.2 & S.3
<table>
<thead>
<tr>
<th>Ref</th>
<th>Matter delegated</th>
<th>Delegated to</th>
<th>Reference Documents</th>
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</table>
| 3c  | Commissioning expenditure: payments under SLA, contracts with Foundation Trusts, or partnership agreements with local authorities:<br>  
(a) up to £499,999<br>  
(b) from £500,000 to £5 million<br>  
(c) from £5,000,001 to £10 million<br>  
(d) £10,000,001 and above<br>  
Continuing Care Invoices:<br>  
  a) up to £10,000<br>  
  b) up to £50,000<br>  
    (Note there are limitations to the CCG’s financial systems in respect of 3a & 3c, therefore additional internal controls have been implemented – see Budget Managers Manual)<br>  
Primary Care Payments<br>  
  a) Up to 50,000 | a) Commissioning Heads of Service who are Band 8 and above<br>  
  b) Director of Contracting or DOI<br>  
  c) CFO or Deputy CFO or AO<br>  
  d) CFO<br>  
  a) Band 6s at Citycare<br>  
  b) Band 7s and over at Citycare<br>  
  (a) Band 8s NHSE Primary Care Team hosted by Mansfield and Ashfield | Budget Managers Manual  
Detailed Financial Policies S.2 |
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<tr>
<th>Ref</th>
<th>Matter delegated</th>
<th>Delegated to</th>
<th>Reference Documents</th>
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<tr>
<td>4</td>
<td>Capital schemes</td>
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<td></td>
<td>(a) Appointment</td>
<td>(a) AO</td>
<td>Budget Managers</td>
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<td>of architects,</td>
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<td>Manual</td>
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<td></td>
<td>quantity surveyors, consultant</td>
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<td>Detailed Financial</td>
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<td>engineers and other professional advisors within EU</td>
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<td>Policies S.2 &amp; S.3</td>
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<td></td>
<td>regulations.</td>
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<td>(b) Granting, terminating or extending leases with an</td>
<td>(b) (subject to prior approval from</td>
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<td>annual charge of:</td>
<td>NHSCB/PropCo as required)</td>
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<td></td>
<td>(i) up to £99,999</td>
<td>(i) CFO</td>
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<td></td>
<td>(ii) £100,000 and above</td>
<td>(ii) AO &amp; CFO</td>
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<td>Ref</td>
<td>Matter delegated</td>
<td>Delegated to</td>
<td>Reference Documents</td>
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</tbody>
</table>
| 5   | Quotation, Tendering & Contracting Procedures | (a) Delegated Budget Holder responsibility  
(b) Budget Managers and Senior Managers  
(c) Formal tendering process  
(d) EC tendering limit: OJEC procurement process to be applied  
(e) Per authorised limits  
Accountable Officer or his/her nominated representative.  
2 senior managers designated by the Accountable Officer and not from the originating department. A CCG Director should be one of the two, where the tender is estimated to be in excess of £100,000. At least three of the lowest (highest if sale) tenders shall be informed that the Governing Body wishes to enter into post offer negotiations. Each of the offerors shall be invited to attend a separate meeting at the CCG Headquarters. Negotiation with each offeror may continue over a series of meetings and the offeror, in writing, shall confirm any amendments finally negotiated. | Detailed Financial Policies S.3 |

Limits for quotes, tenders & EU procurement for all Budget Holders (all values are inclusive of VAT irrespective of whether this is reclaimable or not):

- (a) up to £9,999
- (b) from £10,000 to £49,999 obtaining at least 3 written competitive quotations for goods/services.
- (c) from £50,000 to £101,322*
- (d) £101,323* and above
  * values vary according to Euro/Sterling conversion
- (e) Responsibilities in the Tendering Process:
  - Issuing of tender documentation
  - Receipt and custody of tender documentation
  - Opening of Tenders
  - Post tender negotiation
<table>
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<th>Ref</th>
<th>Matter delegated</th>
<th>Delegated to</th>
<th>Reference Documents</th>
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<tbody>
<tr>
<td></td>
<td>Acceptance of tender other than lowest.</td>
<td>Accountable Officer (reported to the Governing Body). Reasons for acceptance set out in a permanent record.</td>
<td>Detailed Financial Policies S.3</td>
</tr>
<tr>
<td></td>
<td>Single Quote Authorisations</td>
<td>Accountable Officer or Chief Finance Officer. Where only one quote is sought/received the CCG shall as far as practical, determine that the price to be paid is fair and reasonable and details of the investigation recorded.</td>
<td></td>
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<tr>
<td></td>
<td>Single Tender Authorisations</td>
<td>Accountable Officer or Chief Finance Officer. Where only one tender is sought/received the CCG shall as far as practical, determine that the price to be paid is fair and reasonable and details of the investigation recorded.</td>
<td></td>
</tr>
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<td></td>
<td>Waiving of quotations/tenders subject to SO's</td>
<td>Accountable Officer or Chief Finance Officer with delegated responsibility (to be reported annually to the Audit Committee)</td>
<td></td>
</tr>
</tbody>
</table>

6 Setting of Fees and Charges

Fees and Charges e.g. course fees, private use of NHS equipment and facilities (photocopying, rooms) | CFO | Prime Financial Policies S.12 |
<table>
<thead>
<tr>
<th>Ref</th>
<th>Matter delegated</th>
<th>Delegated to</th>
<th>Reference Documents</th>
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<tr>
<td>7</td>
<td>Personnel &amp; Pay</td>
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<td></td>
<td>Engagement of Staff not on the establishment</td>
<td>(a) AO and CFO</td>
<td>Detailed Financial Policies S.3</td>
</tr>
<tr>
<td></td>
<td>(a) Authority to appoint staff to post not on the formal establishment</td>
<td>(b) AO and CFO</td>
<td>For (a) and (b) an Establishment Change Form must be completed.</td>
</tr>
<tr>
<td></td>
<td>(b) Authority to permanently amend the formal establishment</td>
<td>(c) CFO</td>
<td>Utilising Agency Workers Policy</td>
</tr>
<tr>
<td></td>
<td>(c) All Non-Medical Consultancy Staff where aggregate commitment in any one year (or total commitment) is less than £20,000</td>
<td>(d) AO and CFO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(d) Other than (c) where aggregate commitment in any one year (or total commitment) is greater than £20,000</td>
<td>(e) AO or Deputy AO (in conjunction with the CCG’s Lead for Governance)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(e) Engagement of CCG’s solicitors</td>
<td>(f) CCG Director</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(f) Booking of bank staff from approved lists</td>
<td>(g) Hiring of Agency Staff must be within the delegated authority and within the limit of the budget/financed establishment &amp; in line with policy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(g) Booking of agency staff</td>
<td>(h) Budget Holder within overall financial budget</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(h) Authority to fill funded post on the establishment with permanent staff</td>
<td>(i) Budget Holders &amp; Head of Finance within overall financial budgets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Payroll Forms</td>
<td>(j) Line Managers (in line with policy)</td>
<td>Motor Vehicle Travel Expenses Policy for Staff, and, Flexible Working Policy &amp; Procedure</td>
</tr>
<tr>
<td></td>
<td>(i) Authority to complete standing data forms effecting pay, new starters, variations and leavers</td>
<td>(k) Originating Appointing Officer and Head of Finance</td>
<td>Retirement Policy</td>
</tr>
<tr>
<td></td>
<td>(j) Authority to authorise overtime, travel claims and study leave and associated expenses</td>
<td>(l) In line with Policy</td>
<td>Workforce Reduction, Redundancy &amp; Redeployment Policy</td>
</tr>
<tr>
<td></td>
<td>Other Personnel &amp; Pay Issues</td>
<td>(m) In line with Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(l) Staff Retirement</td>
<td>(n) In line with Policy</td>
<td></td>
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<tr>
<td></td>
<td>(m) Redundancy</td>
<td>(o) In line with procedure</td>
<td></td>
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<td></td>
<td>(n) Dismissal</td>
<td>(p) RATs Committee</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(o) Requests for upgrading/re-grading</td>
<td>(q) AO and CFO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(p) Approval of Changes to Allowances paid to Employees(i.e. Not included within &amp; subject to Whitley Council Regulations)</td>
<td></td>
<td>Disciplinary Policy &amp; Procedure</td>
</tr>
<tr>
<td></td>
<td>(q) Removal Expenses, Excess Rent &amp; House Purchases</td>
<td></td>
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</tbody>
</table>

Page 34 of 40 Review – Sept 2015
<table>
<thead>
<tr>
<th>Ref</th>
<th>Matter delegated</th>
<th>Delegated to</th>
<th>Reference Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Agreements/Licenses</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Preparation and signature of tenancy agreements/licenses</td>
<td>CFO (All delegations subject to prior approval by NHSCB/PropCo as required).</td>
<td>Detailed Financial Policies S.3</td>
</tr>
<tr>
<td></td>
<td>Extensions to existing leases</td>
<td></td>
<td>Prime Financial Policies S.12</td>
</tr>
<tr>
<td></td>
<td>Letting of premises to outside organisations</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Approval of rent calculation</td>
<td></td>
<td></td>
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<td>9</td>
<td>Condemning &amp; Disposal</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(a) With current purchase price &lt; £250</td>
<td>(a) Budget Holder</td>
<td>Detailed Financial Policies S.8</td>
</tr>
<tr>
<td></td>
<td>(b) With current purchase new price &lt; £250</td>
<td>(b) Director</td>
<td>Losses &amp; Special Payments Procedure</td>
</tr>
<tr>
<td></td>
<td>(c) Disposal of mechanical and engineering plant</td>
<td>(c) Chief Finance Officer</td>
<td></td>
</tr>
<tr>
<td>Ref</td>
<td>Matter delegated</td>
<td>Delegated to</td>
<td>Reference Documents</td>
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</tr>
<tr>
<td>10</td>
<td>Losses, Write-off &amp; Compensation</td>
<td>(f) AO and CFO (a) to (e) and (g) to (l) CFO or nominated deputy</td>
<td>CCG’s Fraud, Corruption &amp; Bribery Policy Losses and Special Payments Procedure</td>
</tr>
<tr>
<td></td>
<td><strong>Losses</strong></td>
<td>Liaison with the CCG’s Local Counter Fraud Specialist &amp; Police as required and in line with the CCG’s Fraud, Corruption &amp; Bribery Policy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(a) Losses and Cash (due to theft, fraud, overpayments and others)</td>
<td>The CFO to report all categories to the Audit (&amp; Governance) Committee quarterly in arrears for review.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Fruitless Payments (including abandoned Capital Schemes)</td>
<td>The CFO will report any cases they consider to be “novel, contentious or repercussive” to the Chair of the Audit Committee Chair as soon as they become aware of the case.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(c) Bad Debts and Claims Abandoned (Private Patients, Overseas Visitors &amp; Other)</td>
<td>CFO (following recommendations from Audit (&amp; Governance) Committee - “novel, contentious or repercussive” cases or general lessons learnt).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(d) Damage to buildings, loss of equipment and property (culpable causes and other causes)</td>
<td></td>
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<tr>
<td></td>
<td><strong>Special Payments</strong></td>
<td></td>
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<td></td>
<td>(e) Compensation payments made under legal obligations</td>
<td></td>
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<td>(f) Extra Contractual payments to contractors</td>
<td></td>
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<td></td>
<td>(g) Ex-gratia payments:-</td>
<td></td>
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<tr>
<td></td>
<td>To patients and staff for loss of personal effects</td>
<td></td>
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<td></td>
<td>For clinical negligence (negotiated settlements following legal advice) where the guidance relating to such payments has been applied</td>
<td></td>
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<td></td>
<td>For personal injury claims involving negligence where legal advice obtained and relevant guidance has been applied</td>
<td></td>
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<tr>
<td></td>
<td>Other clinical negligence cases and personal injury claims Other, except cases of maladministration where there was no financial loss by the claimant</td>
<td></td>
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<td></td>
<td>Maladministration where there was no financial loss by claimant</td>
<td></td>
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<tr>
<td></td>
<td>(h) Extra statutory and extra regulatory payments</td>
<td></td>
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<tr>
<td></td>
<td>Necessary reporting to the NHS Commissioning Board for “novel, contentious or repercussive” cases or general lessons learnt in line with guidance.</td>
<td></td>
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<tr>
<td>Ref</td>
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</tr>
<tr>
<td>11</td>
<td>Reporting of Incidents to the Police</td>
<td>(a) AO/On Call Manager together (b) In accordance with advice from the CCG’s Local Counter Fraud Specialist</td>
<td>Detailed Financial Policies S.6 CCG’s Fraud, Corruption &amp; Bribery Policy</td>
</tr>
<tr>
<td>12</td>
<td>Petty Cash</td>
<td>Designated budget holder Head of Finance</td>
<td>Budget Managers Manual</td>
</tr>
<tr>
<td>13</td>
<td>Implementation of Internal and External Audit Recommendations</td>
<td>Actioning Officer as identified by Internal Audit and specified in individual audit reports. Overseen by Chief Finance Officer or nominated deputy and reported to the Audit (&amp; Governance) Committee</td>
<td>Audit Committee Terms of Reference</td>
</tr>
<tr>
<td>14</td>
<td>Maintenance &amp; Update of CCG’s Financial Policies and Procedures</td>
<td>Chief Finance Officer</td>
<td>Prime Financial Policies S.1</td>
</tr>
<tr>
<td>Ref</td>
<td>Matter delegated</td>
<td>Delegated to</td>
<td>Reference Documents</td>
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<tr>
<td>15</td>
<td><strong>Insurance Policies and Risk Management</strong>&lt;br&gt;Risk Management&lt;br&gt;Decision on what level of insurance arrangements will be maintained&lt;br&gt;Claims</td>
<td>AO (in conjunction with the CCG’s Lead for Governance)&lt;br&gt;CFO via NHS Litigation Authority&lt;br&gt;AO or CFO</td>
<td>Prime Financial Policies S.15&lt;br&gt;Procedure for the Management of Claims</td>
</tr>
<tr>
<td>16</td>
<td><strong>Medicines Management</strong>&lt;br&gt;Delegated authority to the Nottinghamshire Area Prescribing Committee (APC) for making commissioning decisions on the use of medicines with a financial impact of up to £10K per CCG per annum.</td>
<td>APC</td>
<td>Agreed APC Mandate</td>
</tr>
<tr>
<td>17</td>
<td><strong>Patients &amp; Relatives Complaints</strong>&lt;br&gt;Overall responsibility for ensuring that complaints are dealt with effectively&lt;br&gt;Relationship with Press</td>
<td>AO or nominated deputy (in conjunction with the Director of Quality &amp; Patient Safety)&lt;br&gt;AO or nominated deputy</td>
<td>Guidance for conducting investigations of complaints, incidents and claims</td>
</tr>
<tr>
<td>18</td>
<td><strong>Health and Safety</strong>&lt;br&gt;(a) Review of Fire Precautions&lt;br&gt;(b) Overall responsibility for Health and Safety&lt;br&gt;(c) Establishment and maintenance of effective health and safety policies, procedures and systems</td>
<td>(a) AO or nominated deputy&lt;br&gt;(b) AO&lt;br&gt;(c) Quality &amp; Risk Committee (South)</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td><strong>Review of CCG’s compliance with the Data Protection Act and the establishment/responsibilities of a Senior Information Risk Owner</strong></td>
<td>Director of Outcomes and Information</td>
<td>Confidentiality and Data Protection Policy</td>
</tr>
<tr>
<td>Ref</td>
<td>Matter delegated</td>
<td>Delegated to</td>
<td>Reference Documents</td>
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<tr>
<td>20</td>
<td>Monitor proposals for contractual arrangements between the CCG and outside bodies</td>
<td>AO</td>
<td>MOU – collaborative commissioning arrangements</td>
</tr>
<tr>
<td>21</td>
<td>Review the CCG’s compliance with the Access to Records Act – Caldicott Guardian</td>
<td>Director of Quality &amp; Patient Safety</td>
<td>Subject access request procedure (health records) SAR procedure - non health records</td>
</tr>
<tr>
<td>22</td>
<td>Review of the CCG’s compliance with the Code of Practice for handling confidential information in the contracting environment and the compliance with “safe haven” per EL 92/60</td>
<td>Director of Outcomes and Information</td>
<td>Safe Haven Procedure</td>
</tr>
<tr>
<td>23</td>
<td>Keeping of a Declaration of Interests Register</td>
<td>CCG’s Lead for Governance</td>
<td>Conflicts of interest and declarations of interest policy</td>
</tr>
<tr>
<td>24</td>
<td>Keeping of a Register of Sealings (including Attestation)</td>
<td>CCG’s Lead for Governance</td>
<td>Detailed Financial Policies S. 1</td>
</tr>
<tr>
<td>25</td>
<td>Signing of Documents</td>
<td>Approved and signed by the AO (if absent by the CFO or any other CCG Director not associated with the originating department prior to sealing).</td>
<td>Detailed Financial Policies S. 1</td>
</tr>
<tr>
<td>Ref</td>
<td>Matter delegated</td>
<td>Delegated to</td>
<td>Reference Documents</td>
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</tr>
<tr>
<td>26</td>
<td>Keeping of the Gifts and Hospitality Register</td>
<td>CCG’s Lead for Governance</td>
<td>Gifts &amp; Hospitality Policy</td>
</tr>
<tr>
<td>27</td>
<td>Management of Land, Buildings and other Assets owned or leased by the CCG (in conjunction with PropCo)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maintenance of Asset Register</td>
<td>AO</td>
<td>Prime Financial Policies S.18</td>
</tr>
<tr>
<td></td>
<td>Maintaining legal documents of Title (including Leasehold)</td>
<td>AO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inventory for items less than £5,000</td>
<td>Budget Managers</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Maintenance and Control of Computer Systems and Facilities</td>
<td>CFO</td>
<td>Prime Financial Policies S.9 &amp; S.10</td>
</tr>
<tr>
<td></td>
<td>Financial data and Accounting systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other Computer Systems</td>
<td>Director of Outcomes &amp; Information</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Emergency Planning</td>
<td>The Finance Representative on the incident team during a major incident has delegated authority to incur any necessary expenditure as agreed by the team.</td>
<td>Major Incident Plan</td>
</tr>
<tr>
<td></td>
<td>(The Department of Health defines a major incident as “an event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war or terrorism which threatens serious damage to the security of the UK.”)</td>
<td>The Gold Commander who is on call at the time has delegated authority to make urgent financial decisions relating to both the CCGs within the CCG Cluster and other NHS organisations within the health community as appropriate during a major incident.</td>
<td></td>
</tr>
</tbody>
</table>
**Meeting Title**  
NHS Nottingham West CCG  
**Governing Body**  
**Date:**  
29 September 2016  
**Paper Title**  
Annual Audit Letter 2014-15  
**Agenda Item:**  
NW/GB/16/372  
**Lead Director**  
Report Author  
Jonathan Bemrose, Chief Finance Officer  

<table>
<thead>
<tr>
<th>Purpose (tick one only)</th>
<th>Approval</th>
<th>☐</th>
<th>Acknowledge/ Note</th>
<th>☒</th>
<th>Review</th>
<th>☐</th>
<th>For Information</th>
<th>☐</th>
</tr>
</thead>
</table>

**Executive Summary**  
Annual Audit Letter from KPMG (External Audit) which summarises the 2015/16 audit for NHS Nottingham West CCG. It summarises the key issues arising from the 2015/16 audit at the CCG. The letter is also intended to communicate the issues arising from the audit of the CCG to external stakeholders, such as members of the public. It has therefore been published on the website.

A copy of this Letter will be published on the PSAA’s website at [http://www.psaa.co.uk/audit-reports/annual-audit-letters/](http://www.psaa.co.uk/audit-reports/annual-audit-letters/)

<table>
<thead>
<tr>
<th>Quality Impact Assessment</th>
<th>Yes</th>
<th>☐</th>
<th>No</th>
<th>☐</th>
<th>N/A</th>
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<tr>
<td>Equality Impact Assessment</td>
<td>Yes</td>
<td>☐</td>
<td>No</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Privacy Impact Assessment</td>
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<td>☒</td>
<td>No</td>
<td>☐</td>
<td>N/A</td>
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</table>

**Implications:** (please tick where relevant)

- Integration  
- Reducing inequality  
- Constitution  
- Governance  
- Innovation  
- Learning and Development  
- Quality Impact Assessment  
- Patient Choice  
- Patient & Public Involvement  
- Quality of Services  
- QIPP  
- Research  
- Sustainability  

**Finance checked by:**  
(initials)

**Appendices**

**Report History**

**Recommendation**  
The Governing Body is asked to:  

**NOTE**  
the contents of this letter
This report is addressed to NHS Nottingham West Clinical Commissioning Group (the CCG) and has been prepared for the sole use of the CCG. We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body’s own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

We are committed to providing you with a high quality service. If you have any concerns or are dissatisfied with any part of KPMG’s work, in the first instance you should contact Tony Crawley, the engagement lead to the CCG, who will try to resolve your complaint. If you are dissatisfied with your response please contact the national lead partner for all of KPMG’s work under our contract with Public Sector Audit Appointments Limited, Andrew Sayers (on 0207 6948981, or by email to andrew.sayers@kpmg.co.uk). After this, if you are still dissatisfied with how your complaint has been handled you can access PSAA’s complaints procedure by emailing generalenquiries@psaa.co.uk, by telephoning 020 7072 7445 or by writing to Public Sector Audit Appointments Limited, 3rd Floor, Local Government House, Smith Square, London, SW1P 3HZ.
Introduction
Introduction

Background

This Annual Audit Letter (the letter) summarises the key issues arising from our 2015-16 audit at NHS Nottingham West Clinical Commissioning Group (the CCG). Although this letter is addressed to the Members of the Governing Body of the CCG, it is also intended to communicate these issues to external stakeholders, such as members of the public. It is the responsibility of the CCG to publish this letter on the CCG’s website.

We have reported all the issues in this letter to the CCG during the year and we have provided a list of our reports in Appendix A.

Scope of our audit

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. Our main responsibility is to carry out an audit that meets the requirements of the National Audit Office’s Code of Audit Practice (the Code) which requires us to report on:

<table>
<thead>
<tr>
<th>Financial Statements including the regularity opinion and Annual Governance Statement</th>
<th>We provide an opinion on the CCG’s financial statements. That is whether we believe the financial statements give a true and fair view of the financial affairs of the CCG and of the income and expenditure recorded during the year. We are also required to form a view on the regularity of the CCG’s income and expenditure i.e. that the expenditure and income included in the CCG’s financial statements has been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them. We also confirm whether the CCG has complied with the requirements of the NHS Commissioning Board in the preparation of its Annual Governance Statement (AGS). We also confirm whether the balances you have prepared for consolidation into the Whole of Government Accounts (WGA) are not inconsistent with our other work.</th>
</tr>
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<tbody>
<tr>
<td>Value for Money conclusion</td>
<td>We conclude on the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the CCG’s use of resources.</td>
</tr>
</tbody>
</table>
Adding value from the External Audit service

We have added value to the CCG from our service throughout the year through our:

— Attendance at meetings with members of the Governing Body and Audit Committee to present our audit findings, broaden our knowledge of the CCG and to provide insight from sector developments and examples of best practice;

— Holding an Audit Committee workshop to discuss the new VFM conclusion and best practice we have seen nationally and with other South Nottinghamshire CCGs;

— Providing an independent Director from KPMG to attend an Audit Committee and feedback on the performance of the lay members; and

— A proactive and pragmatic approach to issues arising in the production of the financial statements and new aspects of the accounts such as the Better Care Fund (BCF), including the Annual Governance Statement (AGS), to ensure that our opinion is delivered on time.

Fees

Our initial fee for 2015-16 was £45,000 excluding VAT (2014-15: £60,000). Our fees are set nationally by Public Sector Audit Appointments Ltd (PSAA) and reflect significant 25% reductions made nationally to scale fees. This was in line with the fee agreed at the start of the year with the CCG’s Audit Committee.

Our final expected fee for 2015-16 is £47,300 excluding VAT (2014-15: £60,000) which, as reported in our External Audit Findings 2015-16 report to ‘those charged with governance’ is above the agreed fee at the start of the year because we incurred additional time to complete our work on primary care co-commissioning, and have incurred additional fees of £2,300. The fee variation is subject to final determination by the PSAA and we will continue to discuss the additional fee with the Chief Finance Officer.

We provided non audit services to the CCG by KPMG LLP during 2015/16 – this was for a Director of KPMG to observe an Audit Committee, analyse and assess it against practices elsewhere, and provide a feedback session for Audit Committee members. We charged £2,450 plus VAT for this work.

Acknowledgement

We would like to take this opportunity to thank the officers of the CCG for their continued support throughout the year.
We issued an unqualified opinion on the CCG’s accounts on 27 May 2016. This means that we believe the accounts give a true and fair view of the financial affairs of the CCG and of the income and expenditure recorded during the year.

There were no unadjusted audit differences.

There were no significant matters which we were required to report to those charged with governance.

We are pleased to report that the draft financial statements and working papers were of good quality. Throughout the year, both sides have proactively engaged to ensure potential issues are identified and resolved early, specifically in relation to the Annual Governance Statement, the accounting treatment for the BCF, key accounting policies, and related party transactions.

We issued an unqualified audit opinion on the financial statements following their adoption by the Audit Committee and receipt of the management representations letter.

Our key findings are:
- The remuneration report presented for audit required substantial re-writing with the majority of numbers needing to be restated. Some information has not been included within the final remuneration report due to concerns management have with its accuracy. As this is not consistent with the Department of Health Group Manual for Accounts 2015/16 (MFA) we have referred to this omission in our opinion as an ‘other matter’.
- We agreed a number of minor presentational changes to the accounts with the Finance team, mainly related to compliance with the MFA.
- We read the annual report and have no matters to raise with you.
- We reviewed the AGS and have no matters to raise with you.
- We had no matters to raise with you in relation to the regularity of transactions.

We concluded that the CCG has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. We did not raise any significant risk areas as part of our Audit Plan for 2015-16.
We have formed our regularity opinion on whether, in all material respects, the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. We have also read the content of the Annual Report (including the Remuneration Report) and reviewed the Annual Governance Statement (AGS).

We confirmed that the CCG complied with the NHS Commissioning Board requirements in the preparation of the CCG’s Annual Governance Statement. We raised a medium-level recommendation that the CCG should improve the controls in place governing the preparation of the remuneration report. The CCG has accepted this recommendation. There were two medium recs in relation to the Remuneration Report.

We are pleased to report that there are no high risk recommendations arising from our 2015-16 audit work.

The CCG has fully-implemented agreed audit recommendations from prior years and agreed two medium risk recommendations reported to you as part of our ISA 260 report.

We have a responsibility to consider whether there is a need to issue a public interest report or whether there are any issues which require referral to the Secretary of State. We did not issue a report in the public interest or refer any matters to the Secretary of State in 2015-16.
Appendices
Appendix A

Summary of our reports issued

- **Audit Plan**
  January 2016
  The Audit Plan sets out our approach to the audit of the CCG’s Financial Statements (including the Annual Governance Statement) and our VFM conclusion work.

- **Progress Report**
  April 2016
  The April Progress Report provides a summary of our findings and progress made at our interim visit in February 2016. This progress report also contains technical and sector updates relevant to the CCG.

- **Audit Report**
  May 2016
  The Audit Report provides our audit opinion for the year, the Value for Money conclusion, and our Audit Certificate.

- **External Audit Findings Memorandum**
  May 2016
  The External Audit Findings Memorandum provides details of the results of our audit for 2015-16 including key issues and recommendations raised as a result of our observations. We also provided the mandatory ISA260 declarations as part of this report.

- **Annual Audit Letter**
  July 2016
  This Annual Audit Letter provides a summary of the results of our audit for 2015-16.
<table>
<thead>
<tr>
<th>Meeting Title</th>
<th>NHS Nottingham West CCG Governing Body</th>
<th>Date:</th>
</tr>
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<tbody>
<tr>
<td>Paper Title</td>
<td>Patient Reference Group: Highlight Report of the meeting held on 1 September 2016 and Minutes of the meeting held on 4 August 2016</td>
<td>Agenda Item:</td>
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<tr>
<td></td>
<td>NW/GB/16/373</td>
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<tr>
<td>Lead Director Report Author</td>
<td>Mr Mark Russell, Elected Patient Representative</td>
<td></td>
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<td>Approve ☐ Acknowledge/ Note ☒ Review ☐ For Information ☐</td>
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<tr>
<td>Executive Summary</td>
<td>The highlight report of the Patient Reference Group meeting held on the 1 September 2016 and minutes of the meeting held on 4 August 2016 are presented to the Governing body for information.</td>
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<tr>
<td>Privacy Impact Assessment</td>
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<td>Report History</td>
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<tr>
<td>Recommendation</td>
<td>The Governing Body is asked to:</td>
<td></td>
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<tr>
<td>NOTE</td>
<td>the Patient Reference Group Highlight Report of the meeting held on 1 September 2016 and Minutes of the meeting held on 4 August 2016.</td>
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</table>
Patient Reference Group Highlight Report - September 2016

Matters Arising
The latest update from the CCG’s contracting team on x-ray delays at NUH was shared with the group. NUH had made good progress to clear the backlog of reports, however further issues have had a further impact on MRI reporting. The PRG requested a further update from Vicky Bailey, Chief Officer.

Speaker: Mental Health and Learning disabilities Commissioning Team
Ellen Kinsley and Marie Crowley from Mental Health and Learning Disabilities Commissioning Team were invited to the PRG as part of the group’s annual workplan and priority areas. Queries were answered about group therapy, parity of esteem, suicide prevention and the street triage team. It was also noted that the CCG had been successful in a bid for a new talking therapies service for long-term conditions costing approximately £420k.

The service from Let’s Talk Wellbeing was highly praised by a member of the group. Another member raised the importance of information being accessible about local services, in particular dementia services. Racheal Millband explained that the CCG was revamping its website and there will be dedicated sections for local health services.

Update from Nigel Hallam, Chairman
Nigel Hallam provided an update on key areas of interest to PRG which included:

- CCG financial pressure
- Positive national patient survey results - top 10% - 20% nationally
- BBC East Midlands Today coverage on dementia diagnosis rates
- Annual General Meeting - 29 September, from 6pm at the Haven Centre, Stapleford.

Nigel also acknowledged that the PRG and CCG must move forward following the decision to remove remuneration from patient representative roles from April 2017. Nigel acknowledged the hard work PRG do and the important role they play as one of the ways in which views of the CCG’s 94,000 patients can be captured.

Terms of Reference
A working group was established to update the PRG’s Terms of Reference.

PPG Networking and Celebration Event – 13 October 2016
A South Notts Patient Participation Group (PPG) Networking and Celebration Event would be taking place on Thursday 13 October 2016 at Trent Vineyard. PRG members were encouraged to register their places (two per PPG).
Other meetings attended
John Crouch attended East Midlands Ambulance Service’s patient group. He informed the group the newly recruited senior managers are ensuring changes to the way the service works. EMAS’ own AGM was on Tuesday 6 September and if anyone was interested they have an informative newsletter on their website.

Teresa Burgoyne updated on the success of the NESTA study within Breathe Easy Nottingham West which had begun in 2014. The national study looked at the impact of self-help groups in helping people to become more independent with their lung condition. It found a 42% reduction in unplanned GP visits and a 57% reduction in unplanned hospital admissions.

Any other business
Two volunteers were sought for the next Mystery Shopper exercise. The activity occurred every quarter and required volunteers to contact practices, gathering information on various requirements surgeries should be following to allow patients the ability to book appointments.

A planning group was being organised for the Nottingham West local patient survey in 2017.

John Crouch, Chair ended the meeting on PRG’s Development session in December. He acknowledged there would be more clarity about the Sustainability and Transformation Plan (STP) which the group can discuss.

Date of next meeting
Thursday 6 October, 6.15pm-8.30pm at Rumbletums Café, Kimberley.
Minutes of the Patient Reference Group of NHS Nottingham West Clinical Commissioning Group
Thursday 4 August 2016, 6.15pm-8.30pm at Rumbletums Café

Present:
John Crouch Linden Medical Group (Chair)
Mark Russell West End Surgery (Governing Body patient representative)
Nicolas Harrison West End Surgery
Ali Harvey Chilwell Meadows and Valley Surgeries
Richard Hepple Abbey Medical Centre
Michael Rich Saxon Cross Surgery (CDC patient representative)
Glenda Pitchford Bramcote Surgery
Barbara Brice Manor Surgery
Joan Morley Church Street Medical Centre
Susan McNab Abbey Medical Centre
Tom Turner The Oaks
Shirley Inskip Hama Medical Centre
Glen Swanwick Valley Surgery
Julie Bryant Saxon Cross (HealthWatch Champion)
Adrian Manhire Manor Surgery (Vice-chair & CDC patient representative)
Richard Eade Bramcote Surgery
Teresa Burgoyne Church Street Surgery
Bob Hill Hickings Lane

In Attendance:
Racheal Millband Communications & Engagement Manager
Maria Kennedy PALS & Patient Experience Officer
Tracey Lindley Head of Strategy & Development
Dr Guy Mansford Clinical Lead (item NWPRG/16/69)

Apologies:
Craig Sharples Head of Governance, Quality & Engagement
Jacky Williams County Councillor & Health & Wellbeing Board Member
Peter Pickering Church Walk Surgery
Adam Stockwell Youth Representative
Martin Plackett Hickings Lane
Colin Failes Manor Surgery
Ray Basford Hama Medical Centre

<table>
<thead>
<tr>
<th>Item</th>
<th>Discussion</th>
<th>Lead</th>
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| NWPRG/16/65  | **Welcome, introductions and apologies**
 John Crouch, Chair, welcomed everyone to the meeting. Apologies for absence were noted. |

| NWPRG/16/66  | **Declarations of Interest**
 No declarations of interest were received. |
Minutes of the PRG held on 14 July 2016 & matters arising

It was agreed that the following amendments would be made:

NWPRG/16/57 – NWPRG/16/49 – Update on MCP, STP and Governance: Matters arising (NWPRG/16/49): The first paragraph would be replaced by the following: “Mark Russell explained that a confidential paper had been circulated to Governing Body members on the CCG’s governance arrangements. Mark was unable to share any details due to the confidential nature of the paper but explained he was opposed to the paper. He answered the questions from the group within the rounds of confidentiality”.

NWPRG/16/61 – Update from the Governing Body & Clinical Development Committee: The first paragraph should be changed to read: “A highlight report from the latest Governing Body had not been available due to the meeting being a development session”.

Matters Arising:

NWPRG/16/03 - Warfarin Testing: The decision on anti-coagulation monitoring would be covered later in the agenda.

NWPRG/16/29 – Update from GB & CDC: An update would be chased on the concerns raised at June’s meeting around delays in X-ray results from NUH. Adrian Manhire was aware of a patient complaint that had been made, but they were still waiting for a response some weeks later from the Complaints Team. Tracey Lindley agreed to confirm what issues had been raised at the Finance and Information Group.

NWPRG/16/40 – Other meetings attended: Glenda Pitchford had started work on the booklet of local services and would circulate shortly.

NWPRG/16/51 – Transforming participation in health and care: Racheal Millband shared the following update from Linda Garnett, following her development session:

Linda thought the Newsround demonstrated that some members had a good level of involvement across a wide range of issues and activities, while others are more focused on internal practice issues. She suggested that the high and low impact activity list could help decisions on where to focus energy in the future.

Linda felt strongly that members find it difficult to turn citizens’ initial interest into participation. She felt there were not enough different mechanisms to reflect the fact that not everyone can or wants to attend meetings. She advised that the group spends time thinking about alternative routes to participation, particularly using virtual groups and social media and that these can be single issue rather than practice based.

Mark Russell said he felt development sessions had already been undertaken by the PRG and had no understanding for the reason of June’s meeting. Barbara Brice
proposed a vote of confidence in Mark Russell which was supported by the group.

**NWPRG/16/58 – Patient survey results & mystery shopper:** A response had been received about how many practices were offering text messaging and the data would be shared in the minutes.

**Post-meeting note:** The CCG has funded this service for practices from 1 October 2015. Please note, the following data is a snapshot from back in February 2015 when Rachael Harrold was looking at activity.

<table>
<thead>
<tr>
<th>GP Practice</th>
<th>Number of text messages</th>
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</thead>
<tbody>
<tr>
<td>Church Walk Surgery, Eastwood</td>
<td>4,000 to 8,000 per month</td>
</tr>
<tr>
<td>Hama Medical Centre, Kimberley</td>
<td>3,800 per month</td>
</tr>
<tr>
<td>Church Street Medical Centre, Eastwood</td>
<td>3,000 per month</td>
</tr>
<tr>
<td>Valley &amp; Chilwell Meadows, Chilwell</td>
<td>350 per month</td>
</tr>
<tr>
<td>Bramcote Surgery, Bramcote</td>
<td>500 per month</td>
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<tr>
<td>The Manor Surgery, Beeston</td>
<td>400 per month</td>
</tr>
<tr>
<td>West End Surgery, Beeston</td>
<td>400 per month</td>
</tr>
<tr>
<td>Abbey Medical Centre, Beeston</td>
<td>1,500 per month</td>
</tr>
<tr>
<td>Hickings Lane Medical Centre, Stapleford</td>
<td>400 per month</td>
</tr>
<tr>
<td>The Oaks Surgery, Beeston</td>
<td>400 per month</td>
</tr>
<tr>
<td>Saxon Cross Surgery, Stapleford</td>
<td>1,500 per month</td>
</tr>
<tr>
<td>Linden Medical Group</td>
<td>1,400 per month</td>
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**NWPRG/16/60 – Lifestyle funding health event – Beeston practices:** Rachael Millband would ask Mike Lewis from Chilwell Meadows PPG to contacts PPG members.

**Newsround**

**Abbey:** The PPG and practice were very happy to get a ‘Good’ overall CQC rating with ‘Outstanding’ for care. Thanks to fundraising efforts, a new children’s corner had been set up.

**Church Street:** A new GP had joined the practice along with a new Practice Nurse and Practice Manager. They had just started their electronic prescription service but had faced a few problems.
**Hickings:** Their CQC inspection had taken place. Good progress was being made with the building extension.

**West End:** Major changes had taken place with the management of the surgery. The PPG would be meeting with the practice shortly. Their CQC re-inspection would take place in September.

**Bramcote:** The PPG were pleased that comments from the patient survey had resulted in a new female GP. The PPG were supportive of the merger work and consultation that was being undertaken.

**Saxon:** Their virtual PPG was successfully up and running. Their Practice Manager had produced a useful paper about the Five Year Forward View which listed incentives and schemes for General Practice. Julie Bryant would ask for permission to share the document with the PRG.

**Manor:** The PPG had not met since the last PRG. They were looking for a new GP to replace a female GP with an interest in women’s medicine. Their CQC results were ‘Good’ overall with ‘Outstanding’ for patient care.

**The Oaks:** The mystery shopper and engaged practice scheme had been discussed and they were pleased that the practice was consistently compliant with the requirements. There had been a small review of the phlebotomy service. An extension to the building had been proposed but a decision was still to be made.

**Valley:** A new community pharmacist had joined the practice. Tracey Lindley explained how some practices have newly funded pharmacists in-house and other practices work closely with the CCG’s medicines management team.

**Linden:** The Wollaton closure had taken place. Approximately half of the patients registered with Doctor’s Corner had remained. Problems were being faced with the new call handling telephone system at Stapleford. The practice now had a hearing loop facility.

**Outcome of governance review paper from Governing Body**

Dr Mansford was welcomed to the meeting. He explained at the Governing Body that he had offered to attend the PRG to give an overview of the governance paper. He apologised for how the timings had fell badly between the meeting dates of the PRG and Governing Body.

He gave a detailed overview which included the reasons for the paper, the difference between lay members and patient representatives and the national guidance on conflicts of interest. Dr Mansford explained recommendations 2 – 8, which had been felt to be uncontentious.

Nicholas Harrison queried recommendation 3 and whether there would be any implications for both the PPI lay member and patient representative having a vote on the Governing Body.
Mark Russell said that he saw the role of the lay member as bringing an external viewpoint to the PRG because their role was across patient involvement in the broadest sense, whereas the patient representative role would specifically represent the views of the PRG. It was questioned when Nigel Hallam’s term of office was due to end. The group agreed with Richard Eade’s suggestion that a member of the PRG should be invited to take part in the recruitment for the new PPI lay member.

Dr Mansford explained that within recommendation 1, he strongly supported the view that the patient representative should have a vote on the Governing Body. A lengthy discussion followed about remuneration. Some members felt strongly that the three patient representatives had put in a lot of time and effort into their roles and this should be recognised. The group agreed that Nottingham West was seen as a trailblazer for patient engagement.

Mark Russell proposed a meeting be held to include Mark, Adrian Manhire, Michael Rich and John Crouch to discuss a way forward on remuneration for elected patient representatives.

Dr Mansford summarised that he had a very clear message from group to take back to Governing Body on 25 August 2016.

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The Chair asked Dr Mansford to provide an update on the anti-coagulation paper which went to the Clinical Development Committee (CDC) in July. The briefing paper suggested a substantial saving could be made. Dr Mansford explained that all the practices had unanimously stated that they did not want to take on this in view of the potential undefined safety risk as the CCG currently operated within a very safe system. He accepted that there had been a long delay in providing an answer to the issue.

Adrian Manhire had attended the CDC and shared two observations. Firstly that it had taken the CCG two years to listen to patient views from the PRG. Secondly that it was clear that GPs and practices did not want to take this work on despite the views of the PRG and inconvenience to patients. Some of this was related to training staff which might not be necessary with the introduction of DOACS. In view of the stated hazards of Warfarin (as noted at the CDC), AM asked whether this would justify the earlier introduction of DOACS (direct acting oral anticoagulants) which did not require such close monitoring. Dr Mansford felt that the cost would be prohibitive at the moment but they would be introduced over the next two or three years.

John Crouch thanked Dr Mansford for his time.

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Tracey Lindley provided a summary of the latest national patient survey. Key highlights include:
2nd in the whole country for Receptionists being very helpful
2nd in country for appointments being very convenient
4th in country for overall experience of making an appointment being very good
6th in country for being very easy to get through by phone
6th in country for opening hours being very convenient.

Out of more than 200 CCGs, Nottingham West was in the top 10% for the majority of the results. Tracey offered to share the summary electronically.

Adrian Manhire said these results were due to the successful Engaged Practice Scheme. It had helped to raise the profile of things that are important to patients such as access and receptionists. John Crouch added that the customer care training made a big difference.

Mark Russell explained that the Annual Report is a good document which explains everything the CCG has done over the past year in one place. He had also circulated new NHS England guidance ‘Annual Reporting on the legal duty to involve patients and the public in commissioning’.

It was agreed that it would be an agenda item at the PRG on 1 September to allow members time to read the document. Questions would be collated and considered for submission to the Annual General Meeting on 29 September.

Mark Russell provided a verbal update from the Governing Body. Items included an emotive patient story about end of life care; safeguarding annual report; annual assurance letter and emergency planning. Dr Nicole Atkinson from Church Street had been confirmed as the Clinical Chair from 1 April 2017. Dr Atkinson would attend October’s PRG meeting.

Adrian Manhire prepared a paper from the CDC on 14 July. Items of interest included the national diabetes prevention programme; care homes reorganisation; financial position and a new mental health forum. Adrian added that on the topic of anticoagulation testing, he believed there had been post-decision rationalisation from Dr Mansford who had emphasised different arguments at today’s meeting.

Tracey Lindley explained that several practices offered acupuncture which was not commissioned by the CCG, it was part of the chronic pain pathway. From September 2016, NICE guidance would change to not recommending acupuncture at all. Notice had been served to all providers.

Mark Russell queried whether plans were being made for patient involvement in a review of services at NUH.
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<thead>
<tr>
<th>NWPRG/16/73</th>
<th>Any other business</th>
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<td>Mark Russell wanted to draw attention to the group that his term of office would finish on 31 March 2017. He advised the group to start thinking about the election process.</td>
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<table>
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<th>Date of next meeting &amp; close</th>
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<tr>
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<td>Thursday 1 September, 1.15pm-3.30pm at 74 Middle Street Resource Centre, Beeston, NG9 2AR.</td>
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**Meeting Title:** NHS Nottingham West CCG  
**Governing Body:**  
**Date:** 29 September 2016  
**Paper Title:** Minutes of the Finance and Information Group meeting held on 16 August 2016  
**Agenda Item:** NW/GB/16/374  
**Lead Director Report Author:** Dr Mike O’Neil, Meeting Chair and GP, Saxon Cross Surgery  
Emma Richardson, Data Analyst  

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<th>Acknowledge/ Note</th>
<th>Review</th>
<th>For Information</th>
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**Executive Summary:** The minutes of the Finance and Information Group meeting held on 16 August 2016.

If paper is for approval, have the following impact assessments been completed?

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<th>Quality Impact Assessment</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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**Implications:** (please tick where relevant)

- Integration
- Reducing inequality
- Constitution
- Governance
- Innovation
- Learning and Development

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**Recommendation:** The Governing Body is asked to:

NOTE the minutes of the Finance and Information Group meeting held on 16 August 2016.
Meeting of Nottingham West Clinical Commissioning Finance and Information Group  
Tuesday 16th August 2016  
Stapleford Care Centre, NG9 8DB 
Minutes

Present:
Dr Mike O’Neil (MON) Meeting Chair & GP, Saxon Cross Surgery
Ian Livsey (IL) Deputy Chief Finance Officer (3 South CCG’s)
Tracey Lindley (TL), Head of Strategy and Development (NWCCG)
Debbie Stiles-Powell (DSP) Senior Finance Manager, QIPP/BCF (3 South CCG’s)
Robert Taylor (RT) Head of Outcomes and Information
Leon Blackwell Senior Contract Support Officer (3 South CCG’s)
Sarah Allcock Executive Assistant to Chief Officer and Chairman
Dr U Singh (US) GP partner, Linden Medical Group
Adrian Manhire (AM) Patient Representative
Adrian Taylor (AT) Practice Manager, Manor Surgery
Craig Sharples (CS) Head of Governance, Quality and Engagement (NWCCG)
David Sharpe Interim Prescribing Advisor (NWCCG)
Emma Richardson (ER) Data Analyst (Minutes)

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NW/FIG/16/80 **Apologies for Absence.**  
Apologies were received from Vicky Bailey and Mel Sims; however Leon Blackwell attended on behalf of the contracts team.

NW/FIG/16/81 **Declarations of Interest above those already recorded on the CCG’s Register or as being relevant to this Agenda.**  
No declarations of interest were submitted.

NW/FIG/16/82 **Minutes of the last meeting and Action Log**  
The minutes of the July FIG meeting were discussed. The group then signed off the minutes for the August Nottingham West Governing Body.

**NW/FIG/16/61 LB to raise MRI issue with Maxine Bunn, Director of Commissioning.** This issue has now been raised with the trust. It has been fed-back to the Trust that all changes that affect activity and/or finance should be raised via the regular NUH Activity & Finance Group meetings, which reports back to the Contract Executive Board.  
**Action Closed.**

**NW/FIG/16/72 RT to look into activity and cost variance of HRG ‘HD25A – infections of bones and joints’.** RT stated that this was only a cost pressure for the consortia in M1 and M2. This pressure was equivalent to £8k. The cost pressure has now gone, as activity has aligned with plan in M3.  
**Action Closed.**
### NW/FIG/16/83 Acute Contracts Report/ Monitoring and Variance Report

RT presented the M3 Monitoring and Variance report to the group.

**NUH**

RT presented the newly included points raised from the NUH letter. Due to the implementation of digital health records at NUH coding had been less timely and there has therefore in month 3 there has been an increased number of U codes equivalent to £2.3m of cost across the consortia YTD.

RT also noted that a significant amount of activity was being paid by CCGs whereas it should fall under NHS England specialised commissioning. Analysis has revealed that this was due to newly released 5th Edition of ICD-10 codes (some new codes and some removed) which had not been accounted for in NUH IR. This has now become a cost pressure for the CCGs.

M2 overspend is equivalent to £1.7mil (1.6%) across the consortia YTD. NWCCG M3 variance is equivalent to -£83k under spend (0.7%). As this also takes into consideration issues with the toolkit, true cost are equivalent to £731k (0.7%) across the consortia, and -£106k under spend (0.9%).

RT presented M3 variance at POD level for NUH. For NWCCG NEL is currently over plan in M3 equal to £100k (2.9%) RT stated that this has been affected directly by the toolkit issue. POD OPPROC is also overspent in M3 by £102k (25%). RT stated that this was linked to T&O and Gynaecology at NUH which is currently being monitored by the CCG. POD OTHER has also seen an over spend of £104k (14%) in M3; RT stated that this is due to a case mix change in antenatal.

AM questioned the quality of coding at NUH. RT responded and stated that NUH have very credible and thorough coding, which may include multiple codes per inpatient spell. MON added the all of the codes are audited to check quality and final HRG.

**Circle**

For M3 there is an over spend of £1.1mil (7.4%) across the consortia YTD. Nottingham West variance is £99k (5.1%).

At POD level there is a current cost pressure of £51k from the POD ‘DRUGS’. £30k of this is linked to the drug Cytokine-Gastro and has been formally raised in a contract query. DSP reiterated that this drug is currently being monitored by the CCG High Cost Drugs pharmacist at Circle as a current priority highlighted by CCG COO’s. RT informed the group that POD ‘OTHER’ includes QIPP and is currently over spent by £138k.

### NW/FIG/16/84 Circle High Cost Drugs Pharmacist – Q1 report

LB presented the Q1 report from Circle contract management board regarding the recent placement of the CCG High Cost Drugs Pharmacist. LB stated that this role would look at a number of areas which included:

- Re-categorisation work
- Drugs price planning
- Audit of Cytokine Inhibitors and the criterial changes around this drug
- Home care medicines and clinical governance
- Invoice management pharmacy system
- Working with the CCG prescribing advisors
- Infliximab drugs switch

LB stated that this report will be provided every quarter by Circle contract management board, with any updated being fed back to FIG meetings.

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<thead>
<tr>
<th>NW/FIG/16/85</th>
<th>Finance Cube</th>
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<tbody>
<tr>
<td>RT stated to the group that the final finance cube is nearly complete; therefore an update with the new report will be brought to the September FIG meeting.</td>
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<th>NW Financial Performance &amp; Reserves 2016/17</th>
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<tbody>
<tr>
<td>IL presented the NWCCG Governing Body finance report for M4 to the group, he informed members that the CCG is currently over plan because of a small pressure at Circle and the large tranche of QIPP that hasn’t been transacted in the NUH contract. Continuing Care is currently £427K overspent and is the main focus area for finance. The finance team are working with CHC to carry out an audit of 1-1 spend, looking at all cases and a review of the top 40 care packages.</td>
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<tr>
<td>IL informed the group that a Department of Health review has mandated that Funded Nursing Care should increase from £112 to £156 per patient per week. This will be equivalent to £1M across the three South CCGs and £350K for NWCCG. £598K of reserves has been used to offset the current financial pressures.</td>
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<tr>
<th>NW/FIG/16/87</th>
<th>NW QIPP</th>
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<tr>
<td>DSP discussed QIPP plans for 16/17 with FIG. The QIPP target for NWCCG for 16/17 is £5.1m.</td>
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<tr>
<td>DSP stated that there are current QIPP pressures from the Patella Resurfacing issue which has now been served notice at NUH. Pressures are equivalent to £200k at Nottingham West. DSP also rose that practices need to use the new liver pathway more at Nottingham West. Currently fibro scans at NUH cost £995; however they only cost £50 in primary care. DSP highlighted a huge QIPP saving if more practices refer on ICE for fibro scans. TL stated that all practices should receive this message. MON also requested that this is added to the CDC agenda for September.</td>
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<tr>
<td><strong>Action:</strong> SA to send out Liver Pathway information out to all practice managers. <strong>Action:</strong> ER to request that the Liver Pathway is included on the September 16 QIPP agenda.</td>
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<tr>
<td>DSP also highlighted QIPP savings in prescribing. ‘Category M’ drugs are currently low in cost and this may become a cost pressure later in the year. DS stated that ‘Category M’ drugs are generic drugs widely used such as paracetamol. The price of these drugs increase or decrease every quarter, therefore savings are reliant on the price being low.</td>
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<tr>
<th>NW/FIG/16/88</th>
<th>Financial Pressures</th>
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<tr>
<td>DSP informed the group that NNE CCG Governing Body have been discussing current cost pressures and have decided to compile a list of potential savings that could be made if the financial position deteriorates. Now that the list has been presented to Governing Body DSP provided a further explanation into each area to the group.</td>
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<tr>
<td>Areas that had been proposed for exploration included:</td>
<td></td>
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</table>
- **OP follow up review:**
  An OP follow up cap has been agreed by CG Clinical Leads and COO’s. This has now been served notice to NUH that they will now be paid for the Top quartile or decile of follow ups to align NUH and make them similar to peer groups. AM stated that Circle stated their current frustrations with the difference in payments between Circle and NUH for follow ups, therefore this will create some fairness amongst providers. DSP highlighted that there may be some risks with the change, such as some patients being discharged back into primary care inappropriately, and will ensure NUH prepares for the change. CS highlighted that if there are any changes to the service that patients may have to be consulted. DSP ensured CS that no services changes will happen, this will just been a contractual change.

- **DC to OP procedures**
The CCG have now given 12 months’ notice to state that certain day case procedures will move to be outpatient procedures when appropriate and therefore will be paid a lower price and become a cost saving for CCG’s.

- **Over counter medicines**
The CCG are exploring how the cost of over the counter medicines and current NHS costs can be compared and published on a poster for the public to see. This will hopefully result in increased purchasing of over the counter medicines instead of a prescription from the GP which is a higher cost. AT argued and stated that the patients who used the over the counter medicines were patients with free prescriptions therefore this would be limited potential savings. DSP stated that this campaign was aimed to all patients; therefore there will be a saving. AM questioned why the NHS pay so much more for over the counter medicines. DSP stated that this is directly related to back office functions and the processing of prescriptions.

- **Triage of 2ww referrals**
DSP explained that junior doctors and locums have lower thresholds for referring patients. COOs have actioned that all 2ww referrals are triaged by senior practice managers. AT and MON stated that Nottingham West is also very good at triaging all referrals in weekly and daily practice referral meetings.

- **Prior approval for PLCV**
CCGs will monitor if the essential criteria is being followed correctly by all providers and specialties.

- **Lower back pain**
DSP has stated that due to NICE Guidance CCGs have decommissioned acupuncture. MON stated that next time practices should be made aware well in advance. AT highlighted that prescribing costs may increase ones the service is stopped.

- **Patient Transport**
CCGs are reviewing the criteria for patient transport. At the moment 30-40% of patients can walk and do not need hospital transport.

- **Minuscular tears**
Studies have found that exercise is just as good as therapy. Therefore there are
current plans for group therapy and new pathway.

AM highlighted that these areas need to be sold to patients. Some are the areas are very complex so need to be summarised so any member of the public will understand. CS questioned what the next processes were and whether any consultations need to be planned, if so can a timetable be produced. TL stated that these areas need to be discussed publicly. MON stated that this should be added to the next PCG and CCG agendas.

**Action:** ER to request Financial pressure agenda items are added to CDC and PGC agendas.

DSP stated that all potential savings ideas are all welcomed by the finance team.

<table>
<thead>
<tr>
<th>NW/FIG/16/89</th>
<th><strong>Right Care – Nottingham West Final Summary</strong></th>
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<tr>
<td>ER presented the final summary of the phase 2 ‘what to change’ right care pack to the group. ER gave a brief background of NHS Right care, and Nottingham West CCG Right care peer groups highlighting NNE and Erewash CCG’s included. ER then stated that the potential savings were presented in 5 tables:</td>
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<tr>
<td>- Non Elective</td>
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<td>- Elective</td>
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<tr>
<td>- Procedures</td>
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<td>- Other Secondary Care</td>
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<tr>
<td>- Prescribing</td>
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<td>ER stated that teams at NWCCG had met numerous times to agree the final indicators presented in the report. Each indicator with a potential saving also had a comment of what the CCG could or are already doing to work towards a potential right care saving. TL then suggested that specific members of the CCG teams need to be specified in the comments to ensure there is a lead for each indicator.</td>
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<td>RT highlighted that specifically T&amp;O is where most savings can be made, and highlighted that the new MSK pathway should help achieve the potential savings stated.</td>
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<td>MON stated that this needs to be added onto the agenda of the Practice Commissioning Group to be discussed. MON also stated that practices can work together to start to look at certain areas of potential savings such as hip and knee referrals highlighted as a saving over £1million by Right Care.</td>
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<th>NW/FIG/16/90</th>
<th><strong>MON Update</strong></th>
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<td>MON highlighted to the group that Emma Richardson would be leaving the CCG and thanked her for her contributions. MON also informed the group that 2 new analysts will be starting in the next month to replace Emma and the other vacant analyst post. MON and the group look forward to the new analysts starting.</td>
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<tr>
<th>NW/FIG/16/91</th>
<th><strong>Forward Agenda Items/ AOB</strong></th>
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<td>No other business was declared, along with no further additional agenda items for September FIG.</td>
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**Date of Next Meeting**

**Tuesday 20 September 2016, Saxon Cross meeting Room, Stapleford Care Centre.**
Meeting Title  
NHS Nottingham West CCG 
Governing Body 
Date: 
29 September 2016 
Paper Title  
Clinical Development Committee: 
Minutes of the meeting held on 14 
July 2016 and Highlight Report of the 
meeting held on 8 September 2016 
Agenda Item: 
NW/GB/16/375 
Lead Director 
Report Author  
Dr Guy Mansford, Chief Clinical Officer 
Sarah Allcock, Executive Assistant 
Purpose (tick one 
only)  
Approval ☐ 
Acknowledge/ Note ☒ 
Review ☐ 
For Information ☐ 
Executive 
Summary  
The Highlight Report of the Clinical Development Committee meeting held on the 8 
September 2016 is presented to the Governing Body for information, as are the 
approved minutes of the 14 July 2016 meeting. A number of proposals discussed 
and agreed at the meetings were recorded in the minutes.

If paper is for approval, have the following impact assessments been completed?

Quality Impact Assessment  
Yes ☒ 
No ☐ 
N/A ☐ 
Equality Impact Assessment  
Yes ☒ 
No ☐ 
N/A ☐ 
Privacy Impact Assessment  
Yes ☐ 
No ☐ 
N/A ☒ 
Implications: (please tick where relevant)

Integration ☐ 
Patient Choice ☐ 
Reducing inequality ☐ 
Patient & Public Involvement ☐ 
Constitution ☐ 
Quality of Services ☐ 
Governance ☐ 
QIPP ☐ 
Innovation ☐ 
Research ☐ 
Learning and Development ☐ 
Sustainability ☐ 
Finance checked by:  
(initials)

Appendices

Report History

Recommendation  
The Governing Body is asked to:

NOTE the Highlight Report of the Clinical Development Committee meeting held 
on 8 September 2016 and the ratified minutes of the meeting held on 14 July 2016.
Fast Track CHC Audit Findings

Nichola Bramhall, Director of Nursing and Quality shared findings from the recent Fast Track Continuing Health Care (CHC) audit, which reviewed referrals received by CityCare between 20 June and 8 August 2016 for patients from the three South Nottinghamshire CCGs. The report clearly identifies that a proportion of fast track cases are inappropriate and the quality of referrals is variable. This has both quality and financial implications for the CCGs, the CHC provider and the individuals concerned. Actions have been identified which will improve both the quality of referrals and reduce the associated financial risk.

Mrs Bramhall requested the support of member practices to reduce the activity and spend in this area. A CHC turnaround group has recently been established which meets on a fortnightly basis, Dr O’Neil is a member. A recovery action plan has been developed to explore a number of areas where there is potential to either make savings or halt growth and contain costs.

Enhanced Service – Care Homes Update

The enhanced service has been updated following the care home work that has been carried out at the task and finish group and with regard to registration rationalisation. The amendments aim to improve working relationships with care homes across GP practices and community services. The focus is upon pro-active care to avoid crisis. The remuneration for practices has remained the same.

Concerns were raised by members regarding some of the wording which could suggest that there is an obligation on practices to improve the care a home provides. Dr Mansford agreed to review and consider changing some of the wording to reflect the concerns raised.

Additional QIPP Requirements

A list of potential schemes which had been produced across the South Nottinghamshire CCGs was circulated.

Pain Management Review Proposal

Across Nottingham City, Nottingham West, Nottingham North & East and Rushcliffe CCGs, there are different pain management pathways with a lack of clarity over best practice to
meet population need and elements of existing service provision that are known not to be consistent with evidence of clinically and cost effective care. It is proposed that a review of the pain pathway is undertaken with the following scope:

- A comprehensive review of the current chronic pain management pathway
- Assessment of the population need for the pain management pathway
- Review of the evidence base for pain management
- Proposal for the future commissioning of the pain management pathway based on population need and evidence of good practice.

The Clinical Development Committee recommended APPROVING the proposal for a review of the Pain Management Pathway in Greater Nottingham.

**Reduction of Routine Follow-Ups for the Non-Surgical Management of Ulcerative Colitis**

Ulcerative Colitis and Chron’s Disease are the two most common forms of Inflammatory Bowel Disease; Ulcerative Colitis is a lifelong disease that is associated with significant morbidity. Stephen Andersen, Strategy & Development Manager proposed implementing a new pathway involving the reduction of routine follow up attendances for non-surgical management of ulcerative patients. It is proposed that the pathway be implemented across the four greater Nottingham CCGs starting in October 2016.

The Clinical Development Committee recommended APPROVING the new pathway.

**Community Ophthalmology Proposal**

Analysis of the current Community Ophthalmology pathway suggests that it is costing more than it would to allow all referrals to go direct to secondary care. Whilst the current pathway has enhanced the scope of practice in community optometrists there is a significant amount of management time invested in the management of these contracts and accreditation of providers.

There are other models of community ophthalmology both locally and nationally. The ophthalmology service in NUH is already under pressure and the expectation is that the numbers of patients requiring ophthalmology services will continue to increase.

In order to seek to address these issues, a working group including commissioners, secondary care providers and community optometrists was established to consider what further secondary care activity could be transferred to a community ophthalmology service and how that service should be commissioned.

The proposal involves the:

- Transfer of follow up activity from secondary care to community settings
- Increase the cost effectiveness of the current community ophthalmology service
- Create capacity in secondary care to manage those patients that do require secondary care support

The Clinical Development Committee recommended APPROVING the new pathway.

**Finance Report**

Mr Livsey delivered a presentation on the current financial situation, the key message being that the CCG is in a very difficult financial position and discussions have taken with NHS England (NHSE) around the delivery of the 1% surplus and the possibility that this may not be achieved.

The CCG is forecasting to meet all of its statutory financial duties in 2016/17 however; the level of overspending above budget in acute and Continuing Healthcare (CHC) together with the current shortfall in achievement of savings (QIPP) is posing a significant risk to the delivery of the duty to remain within the revenue resource limit.

QIPP is forecast to achieve plan, however this position is supported by non-recurrent QIPP from reserves. Mr Livsey reported that a PMO Collaborative QIPP Group has been established, they are looking to change the payment mechanism for day cases and follow ups to generate further savings.

**Practice Members Group**

It was agreed to hold the annual Practice Members Group meeting on **Wednesday 19 October, 7pm in the Stapleford Suite, Stapleford Care Centre** to discuss collective general practice and equalising core funding. The Clinical Development Committee scheduled for the 13 October has been **cancelled**.
Nottingham West CCG Clinical Development Committee (CDC)

Thursday 14 July 2016 at 1:30pm
Stapleford Suite, 3rd Floor, Stapleford Care Centre

Present
Dr Guy Mansford                 Meeting Chair
  GP, Chief Clinical Officer - The Oaks Medical Centre
Dr Mike O’Neil                  GP, Finance & IT Lead - Saxon Cross Surgery
Dr John Tomlinson               Deputy Director of Public Health
Mr Adrian Taylor               Practice Business Manager – The Manor Surgery
Ms Andrea Swanson               Practice Business Manager – The Oaks Medical Centre
Dr Katie Rhodes                GP, Chilwell Valley and Meadows Surgeries
Dr Kelvin Lim                   GP, Church Walk Surgery
Dr Andrew Hopwood               GP, Bramcote Surgery
Dr Katie Rhodes                GP, Chilwell Meadows and Valley Surgery
Dr Nicholas Browne             GP, Abbey Medical Centre
Dr Nicole Atkinson             GP, Church Street Surgery
Ms Anita Smith                  Practice Manager, Church Street Surgery
Dr Tariq Hama                  GP, Hama Medical Centre (from 14:10pm)
Dr Syrus Adl                    GP, Linden Medical Group
Dr Baynham                     GP, West End Surgery
Dr Adrian Manhire              Patient Representative
Mrs Sue Turner                 Transformation Manager, Notts County Council
Mr Ian Livsey                   Deputy Director of Finance

In Attendance
Miss Sarah Allcock             Executive Assistant (Minutes)
Mrs Kelly Wallace              Strategy & Development Manager
Mr Nigel Hallam                Chairman
Mr Craig Sharples              Head of Quality, Engagement & Governance
Mr Stephen Andersen            Strategy & Development Manager
Mrs Sue Bishop                 Lay Member with a Lead for Governance
Mr Ashley Davis               Mid and South Notts RDT Mobilisation Lead
Dr Laura Daunt                 Community Geriatrician (for item NWCDC/16/35)
Dr Catherine Gaynor           Community Geriatrician (for item NWCDC/16/35)

Apologies
Dr James Read                   GP, Manor Surgery
Dr Kalindi Tumurugoti          GP, Linden Medical Group
Mrs Tracey Lindley            Head of Strategy & Development

Cumulative record of Clinical Development Committee Members’ Attendance (2016/17)

<table>
<thead>
<tr>
<th>Name</th>
<th>Possible</th>
<th>Actual</th>
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<tbody>
<tr>
<td>The Oaks Medical Centre</td>
<td>3</td>
<td>3</td>
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<tr>
<td>The Manor surgery</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Saxon Cross surgery</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Church Walk surgery</td>
<td>3</td>
<td>3</td>
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<tr>
<td>J. Tomlinson</td>
<td>3</td>
<td>3</td>
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<tr>
<td>T. Lindley</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>S. Turner</td>
<td>3</td>
<td>3</td>
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<tr>
<td>V. Bailey</td>
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<td>1</td>
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Introductions and Apologies for Absence
Dr Mansford welcomed everyone to the meeting and a round of introductions was made.

Declaration of Interest relating to items on this agenda
No additional declaration of interests noted over and above those in the register of interests.

Dr Mansford reminded GP colleagues that they are in attendance in a commissioning capacity and not a provider, as such, to avoid any perceived conflict of interests Mr Hallam will take over the chairing for items NWCDC/16/36 and NWCDC/16/37, where a decision is required.

Minutes of the meeting held on 9 June 2016 and Matters Arising
The minutes of the meeting held on 9 June 2016 were approved as an accurate record, subject to minor typographical amendments.

With regard to Action NWCDC/16/27, Dr O’Neil advised that discussions with CityCare are ongoing and the issue should be resolved within the next month.

Dr Laura Daunt – Community Geriatrician
Dr Laura Daunt and Dr Kay Gaynor, Community Geriatricians for Nottingham West attended the meeting to provide the Clinical Development Committee (CDC) with a presentation on the current provision of community geriatricians across South Nottinghamshire and their thoughts for the future.

Dr Lim commented that the service has been working well and he has found it useful that Laura and Kay link in with the Care Co-ordinators. Dr Mansford commented that Nottingham West really value the service provided by Laura and Kay and would be keen to involve them further in the care home work and develop the relationship with primary care.

Laura and Kay raised an issue concerning access to System One at NUH, Dr O’Neil agreed to look into this and find a solution. **ACTION NWCDC/16/35: Dr O’Neil to look into the access issue at NUH.**

Healthier You: National Diabetes Prevention Programme
Ashley Davis, Mid and South Notts RDT Mobilisation Lead at Ingeus, attended the
meeting to provide a brief overview of the NHS Diabetes Prevention Programme (NDPP) which is being led by NHS England, Public Health England and Diabetes UK and being launched in Nottingham West CCG on the 27 August 2016. The programme focusses on behavioural intervention to reduce the risk of developing Type 2 diabetes through weight loss, improved diet and increased levels of physical activity.

It is proposed that the twelve Nottingham West practices start referring individuals to the programme from the 27 August 2016, the official national start date. It was noted that the trail blazer practices for Nottingham West are the Oaks Medical Centre and Church Street Medical Centre; the practices will work closely with Ingeus to help review and validate the programme and its processes.

The programme will be available to individuals identified as having non-diabetic hyperglycaemic, defined as having an HbA1C reading of 42-47, or a fasting plasma glucose (FPG) of 5.5-6.9mmol/l. For patients referred onto the programme by a GP or via NHS Health Check, an HbA1C or a FPG test must have been undertaken within twelve months prior to referrals.

An information system will need to be embedded into every GP practice, the prime role of the system will be to identify individuals who are suitable to be referred to the NDPP programme, the purchase of CENSURA is recommended for Nottingham West. It was noted that this would be a different system to that purchase by Nottingham North & East and Rushcliffe CCGs.

It is proposed to incentivise practices to provide the requirements; the total payment for the CCG will be £12,000 per annum with each practice being paid a share of the sum split by weighted capitation.

Mr Andersen advised members that the pathway has been agreed with Dr Paul Jacklin. Dr Lim asked about the perceived outcomes of the programme. Mr Davis confirmed that there will be a national evaluation of the programme which will feed into the future development of the programme; he also advised members that pilot sites have been identified but it is still too early to get any meaningful data.

Dr Mansford expressed concern about the lack of backup and suggested that he would like to see availability of evening sessions. Dr Tomlinson stated that he would want clear parameters regarding which service to refer to when there is a crossover of services.

The Clinical Development Committee recommended:

- APPROVING the proposed pathway
- APPROVING the purchase and installation of the CENSURA system
- APPROVING the provision of a fixed incentive scheme for GP practices totalling £12,000
- APPROVING the Oaks Medical Centre and Church Street Medical Centre as trailblazers.
**NWCDC/16/37 Anti-coagulation – Options to Consider**

Stephen Andersen, Strategy & Development Manager presented this paper, which assesses the three possible options to providing the anti-coagulation service and the financial impact of each option. The current service within Nottingham West CCG is a hospital based dosing and testing anti-coagulation service used for managing the full range of cases. Direct Oral Anti-Coagulants (DOACs) are used in all areas but are generally avoided for heart valve and reduced kidney function patients.

Other options proposed included a move to practice based testing and dosing service for warfarin, the basic principles of the practice based model are the same as the existing service, with a blood test, dose calculation and warfarin prescribed. The difference being that all these processes take place during the same patient visit at the GP practice. Practices would be paid for patients to be tested and dosed at £140 per case, including consumables; this figure is based on the rate adopted by Rushcliffe CCG. Another option was a move to a predominant use of DOACs as there is clear evidence that the use of DOACs is increasing, however this would cost the CCG an additional £500K.

Dr Mansford stated that he has real concerns about taking on the risk. Dr Atkinson agreed and suggested that capacity would also be an issue as many practices would not have sufficient capacity to undertake the test.

Dr Manhire advised the Committee that the Patient Reference Group (PRG) has been very keen on this as a quality issue for some time, they see considerable drawbacks for patients using the service at Nottingham University Hospitals and feel the whole process is inconvenient, specifically, not being clear what your dosage is. Dr Mansford stated that he does not get any pressure from his patients to change the current system. It was agreed that the Clinical Development Committee need to formulate a formal response to the PRG regarding this issue. **ACTION NWCDC/16/37: Dr Mansford to formally respond to the PRG regarding the decision taken by the Committee on Anti-Coagulation.**

Mr Hallam summarised that the Clinical Development Committee had a number of concerns with the proposed practice based testing option predominantly regarding safety, and the sustainability of staffing numbers within practices. The Committee therefore recommended retaining the current Nottingham University Hospitals Trust testing and dosing service (Option 1), however they acknowledged that the gradual shift to DOACs will continue and will not be resisted by Nottingham West.

**NWCDC/16/38 Draft Care Home Registration Rationalisation**

Dr Mansford informed the Committee that the aim of the Care Home Task and Finish Group was to simplify the model of care homes attended by practices, make the medical workforce go further and form a two way responsible relationship with care homes which is currently missing.

The first draft of the care home registration rationalisation was circulated to practices and discussed at the Care Home Task and Finish Group on 23 June 2016. Following that discussion the second draft was created. Members discussed the proposed re-assignment; it was proposed to make the following
changes; Falcon House being removed from The Oaks and aligned under The Manor and The Oaks to take on the whole of Beeston Lodge.

Members **ACKNOWLEDGED** the draft care home registration rationalisation and were supportive of the principle; however a number of queries concerning borderline practices will need to be addressed outside of the meeting.

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<tr>
<th>NWCDC/16/39</th>
<th>Establishment of a Mental Health and Learning Disabilities Forum</th>
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<tr>
<td>Mr Andersen presented the proposal to establish a Mental Health and Learning Disabilities Forum, and informed members that he has been working with Dr Read to develop the Terms of Reference.</td>
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<tr>
<td>The Clinical Development Committee <strong>APPROVED</strong> the establishment of a Mental Health and Learning Disabilities Forum which will meet on a quarterly basis and <strong>APPROVED</strong> the draft Terms of Reference.</td>
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<tr>
<th>NWCDC/16/40</th>
<th>SystmOne QRISK2 Calculator</th>
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<tr>
<td>Dr O'Neil reported that Practices using SystmOne as their clinical system will have been made aware of an issue with the QRISK2 tool, which is used to estimate ten-year cardiovascular risk. This issue has now been resolved and the tool has now been re-enabled and is available for use.</td>
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<td>As part of an operation co-ordinated by NHS England, GP Practices have been provided with details of patients registered at their practice that may require a review.</td>
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<tr>
<td>The Clinical Development Committee <strong>NOTED</strong> the report and the requirement for practices to ensure they generate their respective reports and review patients accordingly.</td>
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<tr>
<th>NWCDC/16/41</th>
<th>Social Care Strategy Update</th>
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<tr>
<td>Mrs Turner circulated a situation position for Adult Social Care and outlined key information in relation to Adult Social Care within Nottinghamshire County Council; this included an overview of the Savings and Transformation Programme, Adult Social Care Strategy and Better Care Fund Allocation 2015/16 and 2016/17. Mrs Turner agreed to bring a further update on the allocations after the Better Care Fund Board.</td>
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<tr>
<td>Mrs Turner confirmed that Nottinghamshire County Council will not be using the template letter previously circulated regarding Social Care in Nottinghamshire.</td>
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<tr>
<td>The Clinical Development Committee <strong>ACKNOWLEDGED</strong> the key issues in relation to Adult Social Care within Nottinghamshire County Council.</td>
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<th>NWCDC/16/42</th>
<th>CCG Clinical Chair</th>
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<td>Mr Hallam left the meeting for this item as he will be involved in the interview panel for the Clinical Chair.</td>
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<td>Mr Sharples talked to the Committee about the process to find Dr Mansford’s successor, it was noted that the interviews for the Clinical Chair will be held on 26</td>
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July 2016 and part of the process is for the candidates to get the support of their peers. Dr Nicole Atkinson expressed her interest in the position and talked to the Committee about why she feels she is suitable for the role.

The Clinical Development Committee **ENDORSED** Dr Atkinson’s application.

### NWCDC/16/43 Update from the Chairman

Mr Hallam, Chairman at Nottingham West CCG talked about the ongoing review of Committees and Groups within the CCG, noting that the landscape has changed nationally and locally. He acknowledged that finance will continue to be the biggest challenge the CCG faces this year and beyond.

Mr Hallam provided members with an update on succession planning, noting that the Governing Body is currently looking to recruit a secondary care doctor; and in due course his own role as Chairman will come to an end.

Mr Hallam informed members of the forthcoming Annual General Meeting, taking place on Thursday 29 September 2016 at the Haven Centre, Stapleford, he encouraged members to attend to see some of the initiatives the Nottingham West team are working on.

Dr Mansford thanked Mr Hallam for his update and noted that Nottingham West is very lucky to have someone of Mr Hallam's calibre involved in so many areas.

### NWCDC/16/44 Finance Report

Mr Livsey provided members with a verbal update on the latest financial position; he noted that the CCG is forecasting to use up all of its contingency reserves by year end, the current forecast with pressures at NUH is in the region of £1.5 – 2m, and this puts a risk on the delivery of the planned surplus.

Mr Livsey noted that the finance team will be having conversations with NHS England about non-delivery of 1% surplus.

### NWCDC/16/45 Patient Reference Group

Dr Manhire provided members with an update from the recent Patient Reference Group (PRG). The recent development session focussed on IT development, consent and patient records, there had been some confusion about various patients’ records, however Andy Evans was able to allay many fears around consent.

The Group are concerned around the new Conflicts of Interest guidance, as they feel it has the potential to reduce the influence of the patients on the Governing Body. Mr Sharples clarified that there has never been a recommendation to remove a patient representative from the Governing Body, the new guidance recommends having a minimum of three Lay members on the Governing Body.

Mr Hallam re-iterated that there is no proposal to remove the patient representative from the Governing Body; he stated that the CCG has got to try and cover all Governance issues, whilst also being mindful of financial issues.
Engaged Practice Scheme

Dr Mansford reported that a new specification is being drafted; the mystery shopper exercise went well with eleven out of twelve practices passing. Practice plans are still outstanding for some practices; payment will not be made until the plans are received.

A Clinical Lead nomination for Hama Medical Centre, West End Surgery and Abbey Medical Centre remain outstanding. Post Meeting Note: All practices have now responded.

Health and Wellbeing Board update

Updates were circulated from the Health and Wellbeing Board meetings held in May and June 2016.

Dr Mansford reported that the Board is currently undergoing a major revamp, to enable closer working between City and County Health and Wellbeing Boards.

Any Other Business

- **Phlebotomy**
  Dr O'Neil reported that the allocation of phlebotomy activity is under urgent review, the review will be based on the capitation figures as at the end of June 2016. It is expected that the activity is reviewed against practice list size on an annual basis, those practices that have experienced a sharp rise or fall in their registered population since 31st December 2013 will notice the greatest change. It was noted that the overall contracted activity cannot be changed at this time and therefore we are looking at re-distributing the current activity. Rachael Harrold will circulate the amended activity electronically.

- **Decommissioning of Acupuncture Service**
  Dr Lim expressed his disappointment at the way this service has been decommissioned without any discussion at the Clinical Development Committee about the impact on Nottingham West, and the increase in prescribing and surgical outcomes. It was noted that a decommissioning policy is currently being drafted; this will ensure that there is a more rigorous process in place for the decommissioning of services. Dr Mansford acknowledged that this had been handled badly and suggested that further discussions are required outside of the meeting. Mr Andersen reported that he is looking into the costs associated with the service and suggested bringing a paper to the next meeting for further discussion. ACTION NWCDC/16/48: Mr Andersen to produce a paper for consideration at the next meeting.

Agree action points and feedback

Date of Next Meeting:
- Thursday 8 September 2016, 1:30pm, Stapleford Suite
Executive Summary

The minutes of the Nottinghamshire Safeguarding Childrens Board meeting held on 7 September 2016 are not yet ratified and will therefore follow. Key highlights from the meeting are reported below.

ASSURE

- Nottinghamshire Safeguarding Children Board Annual Report 2015/16 – received and approved by the Board. The report outlines how further improvements to local safeguarding procedures have continued in the last year and how these have been externally validated. Priorities for the coming year are also outlined including continued review of process for case reviews to ensure they are proportionate and effective, implement the changes recommended by the National Review of LSCBs which relate to Child Death Overview Panels and continued learning and development.

- Section 136 Audit Action Plan – multi-agency action plan developed in response to recent audit received showing progress to date and deadlines/ leads for outstanding actions. All are currently on track.

ADVISE

- Triennial Serious Case Review Report ‘Unpredictable but not Unpreventable: A Fresh Approach to Learning from Serious and Fatal Maltreatment’- presentation provided by one of the report authors. Key points included:
  - Need to move from considering incidents as unpredictable and unpreventable to unpredictable but not unpreventable
  - 0f 149 fatal SCRs reviewed 2011-14 only 11% concluded that the death was predictable or preventable
  - Evidence that we can prevent harm even when cause not predictable e.g. Sudden Infant Death Syndrome
  - Need to focus on identifying predisposing vulnerabilities/ risks/ omitting harmful actions and promoting protective actions
  - Need to move away from blame to identifying and sharing learning
  - 293 SCRs reported 2011-14, 197 resulting in death, 96 in serious harm. 175 available for triennial review
  - 78% of children known to social services- of these 14% did not meet the referral threshold
  - Child protection activity continues to rise 90,000 in 2009 to 140,000 in 2014
with no change in number of children suffering death or serious harm

- **Child, parent and family characteristics and vulnerabilities** - presentation received. Noted that deaths across all groups (except adolescent group) reduced. Particular vulnerabilities for disabled children identified as result of over estimation of parents ability to cope, potential signs of abuse/neglect attributed to disability and professionals less able to communicate well with disabled children. Adolescents’ areas of vulnerability self-harm, suicide, MH problems, sexual exploitation, risk taking behaviour, legacy of abuse - particularly noted in Looked After Children. Parental risk factors – trilogy of risk, MH issues, substance misuse and domestic violence and abuse plus prior experience of own abuse. Acrimonious separation, multiple consecutive partners, maternal ambivalence and history of crime. 22% of SCRs have three vulnerabilities.

- **Opportunities for Protection** – presentation received and workshop facilitated to encourage identification of opportunities for learning and improvement in relation to individual case management, working together as professionals and agency structures, processes and cultures.

**ALERT**

- There were no issues to escalate to the Governing Body.

Minutes from the meeting held on are also attached for information (a contemporaneous highlight report has previously been provided to the Governing Body).

If paper is for approval, have the following impact assessments been completed?

<table>
<thead>
<tr>
<th>Quality Impact Assessment</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>Equality Impact Assessment</td>
<td>Yes</td>
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<td>Privacy Impact Assessment</td>
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**Implications:** (please tick where relevant)

- Integration
- Reducing inequality
- Constitution
- Governance
- Innovation
- Learning and Development

- Patient Choice
- Patient & Public Involvement
- Quality of Services
- QIPP
- Research
- Sustainability

**Finance checked by:** N/A

**Appendices**

N/A

**Report History**

A contemporaneous highlight report is received quarterly. Minutes follow once ratified by the NSCB.

**Recommendation**

The Governing Body is asked to:

NOTE the contents of the highlight report.
Minutes of
NSCB Full Board Meeting

Held on
Wednesday 16th March 2016

V.03

Nottinghamshire Safeguarding Children Board
Children, Families and Cultural Services
County Hall
West Bridgford
Nottingham
NG2 7QP
Tel No: 0115 97 73935
<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION</th>
<th>PRESENT</th>
<th>APOLOGIES</th>
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<tr>
<td>Chris Few (Chair)</td>
<td>Independent NSCB Chair</td>
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<tr>
<td>Julie Gardner (Vice Chair)</td>
<td>Associate Director for Safeguarding &amp; Social Care, Nottinghamshire Healthcare NHS Trust</td>
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<tr>
<td>Colin Pettigrew</td>
<td>Corporate Director, Children Families and Cultural Services, Nottinghamshire County Council</td>
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<tr>
<td>Derek Highton</td>
<td>Service Director, Youth Families and Cultural Services, Nottinghamshire County Council</td>
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<tr>
<td>Steve Edwards</td>
<td>Service Director, Children’s Social Care, Nottinghamshire County Council</td>
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<tr>
<td>Marion Clay</td>
<td>Acting Service Director – Education Standards and Inclusion, Children Families and Cultural Services, Nottinghamshire County Council</td>
<td>✓</td>
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<tr>
<td>Laurence Jones</td>
<td>Group Manager, Early Help Services, Nottinghamshire County Council</td>
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<tr>
<td>Pam Rosseter</td>
<td>Group Manager, Safeguarding &amp; Independent Review, Nottinghamshire County Council</td>
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<tr>
<td>Caroline Baria</td>
<td>Service Director, Personal Care and Support, South Nottinghamshire, Nottinghamshire County Council</td>
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<tr>
<td>Kate Allen</td>
<td>Consultant in Public Health, Adult Social Care, Health and Public Protection, Nottinghamshire County Council</td>
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<tr>
<td>Cathy Burke</td>
<td>Nurse Consultant Safeguarding, NHS Bassetlaw Clinical Commissioning Group (CCG)</td>
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<tr>
<td>Val Simnett</td>
<td>Designated Nurse Safeguarding Children, NHS (Nottinghamshire) 5 CCGs</td>
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<tr>
<td>Dr Fiona Straw</td>
<td>Designated Doctor for Safeguarding, NHS (Nottinghamshire) 5 CCGs</td>
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<tr>
<td>Moira Hardy</td>
<td>Deputy Director of Nursing, Midwifery &amp; Quality Doncaster &amp; Bassetlaw Hospitals NHS Foundation Trust</td>
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<tr>
<td>Elaine Moss</td>
<td>Chief Nurse &amp; Director of Quality, NHS Newark/Sherwood and Mansfield/Ashfield</td>
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<tr>
<td>Nichola Bramhall</td>
<td>Director of Nursing and Quality, Nottingham North and East, Nottingham West and Rushcliffe Clinical Commissioning Groups</td>
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<td>Denise Nightingale</td>
<td>Executive Lead: Quality &amp; Patient Safety; Chief Nurse, Bassetlaw Clinical Commissioning Group (CCG)</td>
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<tr>
<td>Dr Stephen Fowlie</td>
<td>Medical Director, Nottingham University Hospitals NHS Trust</td>
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<tr>
<td>Suzanne Banks</td>
<td>Interim Chief Nurse, Sherwood Forest Hospitals NHS Foundation Trust</td>
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<tr>
<td>Caroline Jones,</td>
<td>Head of Safeguarding, Sherwood Forest Hospitals NHS Foundation Trust</td>
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<tr>
<td>Wendy Hazard</td>
<td>Locality Quality Manager, East Midlands Ambulance Service</td>
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<tr>
<td>Bushra Ismaiel</td>
<td>Designated Doctor for Safeguarding, Doncaster &amp; Bassetlaw Hospitals NHS Foundation Trust</td>
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<tr>
<td>Carole Lavelle</td>
<td>Assistant Director of Nursing – NHS England, South Yorkshire &amp; Bassetlaw</td>
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<tr>
<td>Ben Wild</td>
<td>Assistant Chief Executive, Derbyshire, Leicestershire, Nottinghamshire &amp; Rutland Community Rehabilitation Company Ltd</td>
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<td>Nigel Hill</td>
<td>Head of National Probation Service, Nottinghamshire</td>
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<td>Helen Chamberlain</td>
<td>Head of Public Protection, Nottinghamshire Police</td>
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<td>Clare Taylor</td>
<td>Service Manager, Early Intervention Team, Cafcass</td>
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<tr>
<td>Leanne Monger</td>
<td>Newark &amp; Sherwood District Council (District and Borough Council Representative)</td>
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<td>Sue Fenton</td>
<td>Manager, Home Start Nottingham</td>
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<td>Donna Trusler</td>
<td>Principal, The Manor Academy</td>
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<td>Cllr Kate Foale</td>
<td>NCC Lead Member with responsibility for Children’s Social Care</td>
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<td>Victoria Morley</td>
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<td>Peter Wright</td>
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<td>Steve Baumber</td>
<td>NSCB Business Manager</td>
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<td>Hilary Turner</td>
<td>NSCB Business Manager</td>
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<td>Bob Ross</td>
<td>NSCB Development Manager</td>
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<td>Trish Jordan</td>
<td>NSCB Training Coordinator</td>
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<td>Michelle Elliott</td>
<td>NSCB Administrator</td>
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<tr>
<td>Alyson Packham</td>
<td>Deputising for Dr Fowlie</td>
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<td>Cathy Burke</td>
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<td>J. Brady, Associate</td>
<td>Deputising for Val Simnett Designated Nurse Safeguarding Children, NHS Nottinghamshire County CC</td>
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<td>Emma Allickr, Senior Probation Officer</td>
<td>Deputising for Nigel Hill</td>
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<td>DCI Lee Sanders, Nottinghamshire Police</td>
<td>Deputising for Helen Chamberlain</td>
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<td>Agenda Item</td>
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<tr>
<td>Welcome &amp; Apologies</td>
<td>The chair, Chris Few (CF), welcomed everyone to the meeting, introductions were made and apologies were noted. CF informed Board members that HC is unable to attend the meeting today but has sent DCI Lee Sanders to deputise. Appendix H on today’s agenda – Police National Safeguarding Action Plan to be deferred to a further meeting. CF commented that any questions that Board members would like answered be forward to HC.</td>
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<td>Minutes &amp; Matters Arising From 14th December 2015</td>
<td>Minutes of the meeting held on 14th December 2015 were reviewed for accuracy and for matters arising: CF confirmed that actions 01 to 07 identified on the previous minutes have been completed. Action 08 on page 13 will be completed after the Multi-Agency Audit Subgroup meet on the 1st April 2016. NB requested that her job title be corrected on the membership list as follows: Director of Nursing and Quality, Nottingham North and East, Nottingham West and Rushcliffe Clinical Commissioning Groups - Completed. The minutes of the previous meeting were agreed as a true and accurate copy.</td>
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<td>Verbal Item Colin Pettigrew</td>
<td>Historic Abuse Colin Pettigrew (CP) provided a verbal update on Operation Daybreak/Equinox. CP commented that meetings held at County Hall with victims and survivors of Historical Sexual Abuse have been constructive and of value. Goddard National Inquiry CP confirmed that the first hearing was last Wednesday. The Goddard Inquiry have asked for details of children’s homes in existence since the 1940’s, safeguarding procedures, Serious Case Reviews and training plans. The Goddard Inquiry was set up as a 5 year inquiry but expected to last a possible 10 years. A specific Nottinghamshire project team has been set up to respond to the inquiry.</td>
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<td>Appendix B Chris Few</td>
<td>Feedback and next steps from ‘Meeting the challenge’ development event. CF shared the aims and feedback from the “Meeting the challenge” development event which took place on the 10th February 2016. • CF explained that the feedback from the meeting was very positive and there was support for more events like this to</td>
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allow open discussions.

- CF stated that the National Review of LSCB’s should be reporting its findings within the next couple of weeks and will clearly have a significant impact on the work of the Board and future arrangements.
- CF explained that the Business Plan for 2016/18 will be prepared reflecting the feedback/actions identified from the development day. **The Business Plan will go to the next Executive meeting on the 11th May 2016.**
- CF spoke about the Young People’s Plan for 2016/18 which will be consistent with our Business Plan.
- Feedback from Board members has been received around the need to include support for victims of sexual abuse and other forms of abuse, emotional health and wellbeing of children and safeguarding elective home education children.
- CF confirmed that the work with the MASH Team and Early Help Unit has gone from strength to strength.
- CF confirmed that he and the Board officers have spoken about a proposal of Thematic Board meetings on major issues for at least two NSCB meetings within the year.
- Links between City/County/Adults Safeguarding Boards. CF explained that discussions/research had taken place between the Chairs, Group Managers and Board Mangers concerning subgroups working closer together. The conclusion was that all productive opportunities were being taken and this would continue.

SE spoke about the use of agency staff in children’s social care and how it is a challenge - A discussion took place about usage of agency staff within agencies. SB confirmed that reports from Health providers and the Police were presented at an Executive meeting previously. **It was agreed that use of agency staff to be placed on the forward planner for the Executive as an ongoing item.**

DH spoke about Data, Management Information and Performance Information which is shared with the Board around children services to be shared more widely. CF confirmed that this is an area have already been identified on the new Business Plan.

CP mentioned the next Ofsted inspection and how it would be a joint inspection. SB confirmed that the joint inspection arrangements are based on police areas and examine themes which are currently early help, domestic abuse, neglect, FGM and toxic trio and CSE.

**Action 01: Agency staff/work force to be placed on the Exec Planner - a request to go out to provide information on vacancies and agency staffing rates in key safeguarding areas.**
| **Appendix C**  
Jane Brady | **Action 02: Business Plan 2016/18 to be discussed at the next Executive meeting on the 11th May 2016.** |
|---|---|
| **CP-IS: progress report**  
JB shared and highlighted key points in the report. JB confirmed funding for £37,000 had been secured from NHS England North Midlands to support a project manager for 1 year (2 days a week). Recent information from the National Team is that we are further ahead with the project than other parts of the Country. CF enquired if any support was required by the Board. JB confirmed work is positive and in progress with and update expected by the end of the year. AP said that she has links with London Borough of Newham and the North Pennine Trust who have implement the CP-IS and will ask for an update. JB to contact the National Team to enquire if any areas have been identified as good practice. |
| **Action 03: JB to contact the National Team to enquire if any areas have been identified as good practice.** |
| **Appendix D**  
Jane Brady | **Standard domestic abuse risk assessments – actions from JN15**  
CF informed the Board that the next item was for agreement from the Board in relation to a serious case review recommendation about notification of standard risk domestic abuse incidents to health. JB explained that in the JN15 case a domestic abuse incident occurred when the woman was pregnant and was identified during the SCR process. JB mentioned that she has linked in with Claire Dean from the police who identified 420 incidents over the last 3 months where there are children in the household and it had also been requested to look at adults without children. A discussion took place around information sharing, medium and high risk cases and issues in terms of adult consent. LS said that in standard or medium risk incidents, if no consent is given, information will probably not be shared. A further discussion took place around sharing information in cases where victims are pregnant. CD from the police stated that it is hard to extract information on pregnant women. JB mentioned that she has spoken to Moira Cordon, Education Representative at the MASH about standard risk incidents in school aged children and took the view that information sharing would be more appropriate to go to education instead of health. JB confirmed that the issues around adults and consent would be taken forward with the Adult Leads and the NSAB. CF confirmed that further development work needed to be carried |
| **JB**  
**CF** | }
out to identify and put in place notification for pregnant women.

BR drew the Board’s attention to Appendix I in the CQC report about areas of improvement about notifications of standard risk domestic abuse incidents in health.

The Board agreed the recommendations that:

Option 1 was the preferred option in view of the resource implication and risks of breaching data protection laws. And that further intra / inter-agency work be pursued as per Option 3 to complement Option 1 regarding notifications in relation to pregnant women.

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<tr>
<th>Verbal Item Cathy Burke</th>
<th>CDOP-governance issues in health</th>
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<tr>
<td>CB outlined that the Coroner had asked the CDOP to oversee implementation of the recommendations from the health reviews in relation to a child that died from sepsis. The key reason for this was that a number of years previously another child died from sepsis; there was learning for health organisations but it appeared that not all the recommendations were implemented. At the time of both of these sad cases there were organisational changes taking place in health which are thought to have had a bearing on the effectiveness of the implementation of the recommendations. The learning point for all agencies is to be mindful of ongoing developments so that they are not lost when organisations are going through change.</td>
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<td>CF commented that it was an issue when agency and organisational changes had taken place and risk assessments and action plans had not been completed. CF and Board managers to discuss further.</td>
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<td>SB mentioned that not all reviews come to the Board and that it would be hard to identify the ones that needed checking for completion.</td>
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<td>PR commented that there was a different relationship now between the CDOP and coroner’s office and that the governance of CDOP is under review.</td>
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<th>Appendix E Suzie Morris</th>
<th>Electronic communication re: ICPCs</th>
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<td>CF explained that at the Board meeting on 21st September 2015 a report was presented regarding electronic communication. The Board asked SM for an update regarding the on-going work and CF presented SM’s report. PR highlighted that positive progress is being made but further work to encourage agencies to provide the most secure email address is ongoing.</td>
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<td>CF encouraged Board members to go back to their organisations and emphasise the benefits of using secure email addresses and to avoid using the cryptshare fall back.</td>
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JB explained that one of the issues within health was that the Business Support Officers sending out the information were not always clear about what part of health sat where. Further secure email addresses have been provided and a meeting has been arranged for 18th March 2016 to pursue clarity.

SB mentioned that Children Social Care had been involved in a survey of attendees at conferences and feedback was positive around the invitation process and how it was working. PR also commented that service user feedback was also positive in terms of the management of the meetings, and the chair and agencies ability to participate in the meetings. This issue is to be placed on the Executive Forward Planner under Performance Management.

DH asked if there was an option to consider video and telephone conferencing to enable agencies to be represented in the most cost effective way. After a discussion it was agreed to include this in the Business Plan and commission someone to look at opportunities in this area.

LS expressed concerns that the invitations to ICPC need to go to the correct police officer, this not always being the officer attending the incident. PR confirmed that invites are copied to the police in the MASH and requested that the Board Manager be advised of any problems.

**Action 04: Feedback around the electronic communications invitation process and how it is working to be placed on the Executive Forward Planner – under Performance Management.**

**Action 05: Option to consider video and telephone conferencing to be included in the Business Plan.**

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<th>Appendix F</th>
<th>Colin Pettigrew</th>
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<td><strong>Refresh of CYP plan</strong></td>
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<td>CP spoke to the report. After a discussion the following points were raised:</td>
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CF queried the scope of the plan in terms of it not being sufficiently ambitious or aspirational in terms of achievement. This was rebutted by MC who stated the target was very aspirational as attainment is currently very poor for white, working class boys. MC to look at the language to ensure the aspirational nature of the plan comes through.

CP emphasised the need to find ways of influencing and redefining a local democratic processes to hold the Regional Schools Commissioner to account – almost all our secondary schools are Academies and some recently refused to attend a County Scrutiny meeting.

PW queried the measurability of the outcomes. MC and DH provided reassurance that the detail is in the underlying material, which contained data which is monitored by Ofsted. |
CF requested more clarity about what good would look like in the context of the plan.

CF commented that that CYPF plan (2016-2108) will be signed off at the next Children and Young People’s Committee and asked that any further comments of suggested amendments be forwarded to Chris Jones.

**Appendix G**  
**Public Health – the commissioning process**  
KA shared her report and highlighted key points. The Hub is financed from pooled funding. Governance is to the Children’s Trust. A key challenge is under investment. Positive progress is being made but problems in gaining approval through each CCG governance arrangements remain. After a discussion the following points were raised:

- CF asked for confirmation concerning the potential for CCG budgets to be fully integrated to ensure that local population needs across the county were addressed. A discussion took place. KA confirmed that some services might be integrated. Structure changes would have to happen but there was agreement for those in South Nottinghamshire to work together more closely.
- CB spoke about the document concerning building relationships and mapping. CB had attended a Safeguarding conference for Designated and Named Professionals and concerns were expressed about these issues in relation to Primary Care provision.
- NB informed the Board that the integrated commissioning hub have commissioned a different type of contract as from the 1st April. The contract is linked specifically to outcomes and there has been a considerable amount of consultation with children, young people and families. She is happy to share the information quality outcome framework.

**Break/Refreshments**

<table>
<thead>
<tr>
<th>Appendix H</th>
<th>Police National Safeguarding Action Plan</th>
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<tbody>
<tr>
<td>Helen Chamberlain</td>
<td>This Item deferred.</td>
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<table>
<thead>
<tr>
<th>Appendix I</th>
<th>CQC Review of Services for Looked After Children and Safeguarding in Nottinghamshire: October 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicola Bramhall</td>
<td>NB explained that the final report will be published on 31st March 2016. NB gave a verbal update on the draft report and mentioned about how they are going to coordinate the responses and to monitor oversight of the action plan. NB asked to what extent the Board would like to be involved concerning the action plans. PR mentioned that the report was positive.</td>
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</table>

It was noted that responsibility sits with health organisations to respond to the review recommendations | NB |
and it was agreed that a steer would be provided to the Board Managers on which agencies may need to contribute to this.

<table>
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<tr>
<th>Appendix J</th>
<th>Prevent</th>
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<tbody>
<tr>
<td>Anthony Shardlow</td>
<td>CF introduced Anthony Shardlow (TS), circulated an additional handout containing restricted data on individuals being assisted through Channel and shared his report highlighting key points. TS is the coordinator for the Safer Nottinghamshire Board and is responsible for the Prevent agenda across the County. Current Governance of Prevent is through the Safer Nottinghamshire Board and a steering group has coordinated the Action Plan.</td>
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<td></td>
<td>• Reporting mechanism – Safer Nottinghamshire Board receive an update report twice a year. It was agreed to share this report with the NSCB alongside exception reporting.</td>
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<td></td>
<td>• KF asked how far schools are engaging in the Prevent Training. A team training schools is being run by Sara Lee, NCC Achievement and Equality Team working with SE. The training package has been sent out through the Safeguarding Leads in schools and has been rolled out over the County. TS confirmed schools are engaging and that there has been very positive feedback.</td>
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<td></td>
<td>• CB asked how Health access training package. TS confirmed that Health have their own training package which is being led by Caroline Book. TS said if problems were found in booking onto the Health Training he was happy for staff to go on the NCC Training.</td>
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<td></td>
<td>• Concerns were expressed around vulnerable adults/children with mental health issues and links with CAMHS. TS confirmed that work had started to establish appropriate links in this area but was in the early stages. TS confirmed that no one from CAMHS is on the Channel Panel. TS to feed this back and take forward.</td>
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<td>• LM mentioned how well the Zebra red training is going in the District/Borough Councils and had received positive feedback.</td>
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<td>• LM asked queried a statement on page 2 around Prevent and the refugee situation across Europe in relation to a significant increase in visible support for anti-refugee marches and rallies. LM asked how this would feed into the programme/local planning for Syrian Resettlement and Asylum Dispersal in Nottinghamshire. TS to ask Prevent Team in the Police for an update and will share the information.</td>
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<td></td>
<td>• LJ asked for guidance on thresholds which have changed and TS advised that Information is being put together by the Home Office, expected around May.</td>
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</table>
|  | • TS confirmed that referrals come through schools,
colleges, concerned parents or Health. TS said he is happy to supply further information if required.

- SB mentioned about the NSCB Guidance/Procedures presently have generic information and stated it would be helpful when the update guidance from the Home Office is received to forward to SB for inclusion in our guidance / Pathway to Provision / e-learning package.
- PR requested a list of colleagues who sit on the Channel Panel to be sent out with the minutes.
- PR asked about mentors; how they are selected and if they have safeguarding training? Mentors are provided by an independent providers. No further detail was available at the meeting.

**Action 06:** Safer Nottinghamshire Board receive an update report twice a year. It was agreed to share this report with the NSCB alongside exception reporting.

**Action 07:** TS to forward a list to ME of colleagues who sit on the Channel Panel – to be circulated with the minutes.

CF thanked TS for a very informative and useful report.

<table>
<thead>
<tr>
<th>Action 06</th>
<th>Safer Nottinghamshire Board receive an update report twice a year. It was agreed to share this report with the NSCB alongside exception reporting.</th>
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<tbody>
<tr>
<td>TS/ME</td>
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<tr>
<td>Action 07</td>
<td>TS to forward a list to ME of colleagues who sit on the Channel Panel – to be circulated with the minutes.</td>
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<tr>
<td>ME</td>
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**AOB**

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<tr>
<th>Information items</th>
<th>CF drew members’ attention to Appendices K to M which were circulated for Board members’ information.</th>
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</table>

**Meeting ended at 4.30 pm**

**Next Meeting**

- Wednesday 1st June 2016, John Fretwell Centre, Sookholme Road, Mansfield, Nottinghamshire, NG19 8LL
Minutes of the Nottinghamshire Safeguarding Adults Board Meeting

Held on 14th January 2016

Nottinghamshire Safeguarding Adults Board
C/o Safeguarding Adults Strategic Team
County Hall
West Bridgford
Nottingham
NG2 7QP
Tel No: 0115 977 3911
<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION</th>
<th>PRESENT</th>
<th>APOLOGIES</th>
<th>ABSENT</th>
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<tbody>
<tr>
<td>Allan Breeton</td>
<td>Chair</td>
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<td>Amanda Sullivan</td>
<td>Vice Chair</td>
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<td>Bernadette Carter</td>
<td>Senior Solicitor (Litigation), Safeguarding and Social Care, Legal Services, Nottinghamshire County Council</td>
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<td>Caroline Baria</td>
<td>Board Member</td>
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<td>Claire Bearder</td>
<td>Board Member</td>
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<td>David Pearson</td>
<td>Board Member</td>
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<td>Deborah Kitson</td>
<td>Associate Member</td>
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<td>Denise Nightingale</td>
<td>Board Member</td>
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<td>Elaine Moss</td>
<td>Board Member</td>
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<td>Helen Chamberlain</td>
<td>Board Member</td>
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<td>Julie Cuthbert</td>
<td>Board Member</td>
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<td>Julie Gardner</td>
<td>Board Member</td>
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<td>Karmon Hawley</td>
<td>Board Member</td>
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<td>Moira Hardy</td>
<td>Board Member</td>
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<tr>
<td>Name</td>
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<tr>
<td>Nichola Bramhall</td>
<td>Deputy Board Member</td>
<td>Director of Nursing and Quality, Nottingham North and East, Nottingham West and Rushcliffe Clinical Commissioning Groups</td>
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<tr>
<td>Gail Colley-Bontoff – Deputy for Nichola Bramhall</td>
<td>Head of Quality and Adult Safeguarding, South Nottinghamshire Clinical Commissioning Groups</td>
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<tr>
<td>Nicola Ryan Board Member</td>
<td>Deputy Chief Nurse, NHS Bassetlaw Clinical Commissioning Group</td>
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<tr>
<td>Nigel Hill Board Member</td>
<td>Head of Nottinghamshire National Probation Service</td>
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<tr>
<td>Richard Cropley Board Member</td>
<td>Persons at Risk Team Manager, Nottinghamshire Fire and Rescue Service</td>
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<tr>
<td>Rob Morris (Dr) Board Member</td>
<td>Consultant Physician, Nottingham University Hospitals NHS Trust</td>
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<tr>
<td>Ruth Hyde Board Member</td>
<td>Chief Executive Officer, Broxtowe Borough Council</td>
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<tr>
<td>Sarah Banks Associate Member</td>
<td>Advanced Legal Practitioner, Legal Services, Nottinghamshire County Council</td>
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<tr>
<td>Steve Edwards Board Member</td>
<td>Service Director, Children’s Social Care, Nottinghamshire County Council</td>
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<tr>
<td>Stuart Sale Board Member</td>
<td>Nottinghamshire Safeguarding Adults Board Manager, Safeguarding Adults Strategic Team, Nottinghamshire County Council</td>
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<tr>
<td>Sue Bowler Board Member</td>
<td>Director of Nursing, Sherwood Forest Hospitals Trust</td>
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<tr>
<td>Sue Matthews Associate Member</td>
<td>Crown Advocate, Crown Prosecution Service</td>
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<tr>
<td>Wendy Hazard Board Member</td>
<td>Locality Quality Manager – Nottinghamshire, North Division East Midlands Ambulance Service</td>
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<tr>
<td>Anna Jakeman – Minute Taker</td>
<td>Business Support, Safeguarding Adults Strategic Team, Nottinghamshire County Council</td>
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<tr>
<td>Colin Pettigrew – Guest</td>
<td>Corporate Director for Children, Families and Cultural Services</td>
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<tr>
<td>Tina Nock – Guest</td>
<td>Deputy Mental Health, POC and High Secure Lead, Specialised Commissioning, NHS England (Midlands and East Region)</td>
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<tr>
<td>Agenda Item</td>
<td>Discussion</td>
<td>Action by</td>
<td>By date</td>
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</tr>
<tr>
<td>1.</td>
<td>Welcome, Introductions and Apologies</td>
<td>Allan Breeton</td>
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<td>2.</td>
<td>Minutes of the Board Meeting held on 8th October 2015</td>
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<td></td>
<td>Points of Accuracy</td>
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<tr>
<td>2.1</td>
<td>Action: Anna Jakeman is to amend the minutes of the meeting on 8th October 2015 to reflect Nicola Ryan's correct job title.</td>
<td>Anna Jakeman</td>
<td>15.01.16</td>
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<td></td>
<td>Update: the minutes have been updated.</td>
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<td>There were no other points of accuracy raised, and the minutes were agreed to be a true and accurate record of the meeting.</td>
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<td></td>
<td>Matters Arising</td>
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<td></td>
<td>Action 2.1 – Allan Breeton is to update the Board at the January meeting on the briefing given to the Chief Officers’ Forum on 13th November 2015: Allan confirmed that he and Caroline Baria had presented to the Chief Officers’ Forum, and they were happy with the update given.</td>
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<td>Action 2.2 – Claire Bearder is to provide an update on the work being done by Becky Sampson in looking at the requirement for organisations to carry out reviews of internal policies and procedures in order that assurance can be provided that safeguarding arrangements are in place and any lessons from the Savile case are explored in social care: Claire distributed a paper written by Becky Sampson on the work to be undertaken within Nottinghamshire County Council further to the Jimmy Savile investigations.</td>
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<td>Action 2.3 – Allan Breeton is to provide an update in relation to the meeting which is scheduled to take place on 27th October 2015 to discuss the issues facing the Board in relation to NHS England’s involvement and engagement with Board business: Allan confirmed that further to the meeting in October, Tina Nock was in attendance at this meeting, and would be liaising with the Board going forward.</td>
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<td>Action 2.4 – Allan Breeton is to organise a meeting in relation to the possible funding for safeguarding boards, and provide an update to the NSAB at the January meeting: This action is to be carried forward to the next meeting in April.</td>
<td>Allan Breeton</td>
<td>14.04.16</td>
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<td></td>
<td>Action 2.5 – Allan Breeton and Julie Cuthbert are to meet to review the films</td>
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L:\Adult Protection\Team\Safeguarding Adults\Functions, Activities, Work\NSAB Committee\3. Minutes\2016\20160114 - Development Day\NSAB Minutes 20160114 - FINAL.doc

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obtained from Unchosen, and provide an update to the Board at the next meeting as to how they will be utilised:
Julie Cuthbert stated that, having reviewed the films, she felt they would be useful for the Training Sub-Group to utilise.

### 2.3 Action: Stuart Sale is to discuss with the Training Sub-Group how the NSAB can best utilise the films obtained from the charity, Unchosen.

**Action 2.6 – Allan Breeton is to provide a further update on the chairing of the sub-groups at the January Board meeting:**
This had been discussed at the Board’s Development Session on the morning of 14th January, and the structure of the sub-groups is to be reviewed with input from chairs, the Nottinghamshire Safeguarding Children Board, and the Children’s and Adults’ Safeguarding Board in Nottingham City.

### 2.4 Action: Allan Breeton is to provide an update on the review of the structure of the sub-groups at the April Board meeting.

**Action 2.7 – Ruth Hyde is to provide an update on the work of the Prevent Steering Group:**
Ruth Hyde confirmed that the Steering Group is currently drafting an action plan document. Funding is being pooled and there is evidence of good joint working between agencies. She confirmed that she would be able to circulate the action plan once finalised, and commented that the role of the Board will be to raise awareness of the work or the Prevent Steering Group in accordance with the plan, although added that this can be reviewed once the plan has been circulated.

### 2.5 Action: Ruth Hyde is to send the Prevent Steering Group’s Action Plan to Anna Jakeman for circulation to the Board once it is finalised.

**Action 3.1 – Anna Jakeman is to circulate a copy of the Think Family presentation to Board members after the meeting:**
This action is completed.

**Action 4.1 – Anna Jakeman is to distribute the Restructure of Adult Mental Health Beds paper and appendices to the Board members:**
This action is completed.

**Action 4.2 – All Board members are to consider the report on the Restructure of Adult Mental Health Beds and its appendices and email Julie Gardner with any feedback by 31st October 2015:**
This action is completed.

**Action 4.3 – Julie Gardner is to update the report further to any feedback received, and include a response in relation to services available for dementia patients:**
Julie confirmed that the situation in relation to the Adult Mental Health Beds has stabilised, and mitigations put in place are evidencing that the risk is being alleviated and the number of available beds has improved. However, she asked that if any member of the Board believed the risk to be escalating at any time, they advise Julie as soon as possible.

**Action 5.1 – Claire Bearder is to arrange for the wording on page 4 of the Strategic Plan under the heading “Transitions” to be changed to reflect the membership of the task and finish group being from across health organisations, not just social care:**
This action is completed.

**Action 7.1 – Nichola Bramhall is to email the pathway which is being...**
developed by the Strategic Management Group to Anna Jakeman:

**Action 7.2** – Anna Jakeman is to circulate the pathway document to Board members:

**Action 7.3** – Nichola Bramhall is to ask Elaine Moss to provide an update to the Board on the Strategic Management Group at the January Board meeting:

These actions were to be covered by agenda item number 3 on Historical Abuse, and would be discussed later in the meeting.

**Action 8.1** – Allan Breeton is to invite the CQC to attend the January Board meeting to present the Statement on Adult Safeguarding:

The CQC was not in attendance and the action is therefore carried forward to the April Board meeting:

**2.6 Action:** Allan Breeton is to invite the CQC to attend the April Board meeting to present the Statement on Adult Safeguarding.

**Action 9.1** – Allan Breeton asked all Board members to consider the draft Annual Report and email any comments or feedback to the Safeguarding Adults Strategic Team by 23rd October 2015:

This action is completed, and the Annual Report was launched at the Partnership Event which took place on 24th November 2015.

**Action 10.1** – Allan Breeton is to arrange for the East Midlands Regional Safeguarding Board Business Plan and Mental Health Concordat to be circulated to Board members:

The documents were circulated with the papers for this meeting, and the action is therefore completed.

**Action 11.1.1** – Julie Cuthbert is to send a copy of the Board presentation to Anna Jakeman for circulation once it has been finalised with the video incorporated:

The presentation was circulated to Board members with the papers for this meeting, and the action is therefore completed.

**Action 11.1.2** – All Board members are to provide Julie Cuthbert with their organisations’ contacts for the Communications Sub-Group by email to julie.cuthbert@nottscc.gov.uk:

This action is completed.

**Action 11.2.1** – Caroline Baria and Claire Bearder are to meet to discuss the clarity of the information contained within the suite of data being presented to the Board:

Claire confirmed that work has been undertaken to look at the timeliness of assessments, and work is ongoing to ensure good outcomes in a timely manner, rather than in set timescales.

**Action 11.2.2** – The QA Sub-Group is to break down the information into the broad themes of referrals that do not go on to a Section 42 Enquiry, and provide further information in the suite of data to be presented to the Board:

Claire confirmed that this action would be covered under the QA Sub-Group Update later in the meeting.

**Action 11.2.3** – Claire Bearder and the QA Sub-Group are to look at the scope of the work required to consider repeat referrals, and provide an update at the January Board meeting:

Claire confirmed that this action would be covered under the QA Sub-Group Update later in the meeting.

**Action 11.2.4** – Claire Bearder is to add the Restructure of Adult Mental Health Beds to the Risk Register:
2.7 **Action:** All Board members are to advise the Safeguarding Adults Strategic Team by email (safeguarding1.adults@nottscc.gov.uk) of any new risks which they feel should be added to the Risk Register.

*Action 11.2.6 – Caroline Baria and Claire Bearder are to consider Recommendation 3 of the QA Sub-Group report, and provide a further update at the January Board meeting:* Claire confirmed that this had been covered under action 11.2.1, and would also be covered under the QA Sub-Group Update later in the meeting.

*Action 11.3.1 – Allan Breeton is to speak to health, Police and Social Care partners with regard to the chairing of all Sub-Groups, and update the Board at the next meeting:* Further to discussions at the Board’s Development Session on the morning of 14th January, it was agreed that the structure of the sub-groups is to undergo a review, and further updates would be provided at the Board meeting in April, as per Action 2.4 above.

### 3. Historical Abuse Update

Allan welcomed Colin Pettigrew, the Corporate Director for Children, Families and Cultural Services at Nottinghamshire County Council, to the meeting.

Colin had arranged for a report and appendices regarding Investigations into Allegations of Historical Abuse to be distributed to the Board prior to the meeting.

Colin outlined the report, and informed the Board that there is a well-developed process for reporting allegations of abuse. Hundreds of alleged victims have come forward. However, it is notoriously difficult to prosecute cases due to the time since the alleged abuse took place and, as such, the number of arrests and successful prosecutions is considerably less than the number of allegations. There is also the issue that some of the incidents, such as caning, which today are considered “abusive” were at the time legal.

There was a discussion between Colin and Amanda regarding the involvement of Health in the Strategic Management Group, which was described in the report distributed. It was agreed that Amanda and Colin would have further discussions away from the Board meeting.

Colin then gave a presentation to the Board with an update on the Independent Inquiry into Child Sexual Abuse, which has not been detailed in these minutes.

Allan thanked Colin for the information provided and invited comments and questions from the Board.

Helen Chamberlain informed the Board that there have been some positive outcomes, with some guilty pleas showing the level of compelling evidence for example.
Allan noted that an interim report into the Goddard Inquiry is not due for another couple of years, and queried how the Board keeps track of learning in the meantime. Colin confirmed that he would be able to report to the Board on an ad hoc basis, or ask Steve Edwards to on his behalf, adding that significant changes have taken place over the years and continue to do so, giving an example of some children’s homes now which house four or five children with staff, whereas traditionally they may have homed up to forty or even fifty children.

Helen stated that the types of allegations being received are approximately 50% sexual abuse allegations, and approximately 50% allegations of physical assault and chastisement, but that is not always clear from media coverage.

Steve described the media approach for front-line staff, and confirmed that they are aware that they should report any approach from the media to himself and the Communications team.

Caroline Baria stated that, from an Adult Social Care point of view, there is a responsibility to ensure that there is a process for reporting allegations of historical abuse and to ensure that the right levels of support are in place for individuals. She added that there is counselling provision in the County which is funded by the CCGs, and work is underway to review this. Julie Gardner stated that victims often feel that they have not accessed or received sufficient services and support, and there is a need to consider what is in place for the future should incidents occur in the present time. Further discussion took place regarding access into services and the role of GPs in referring individuals. Amanda commented that there is no “one size fits all” service and it may be that specific bespoke assessments are required to establish what support an individual needs. If it is established that there is a gap in services for an individual, it may be that further commissioning is required. Nicola added that because of some individuals’ age and health needs they may be in need of care home support. Allan suggested that the Strategic Management Group which has been set up was the correct forum for further discussion in this regard, and asked that these topics were discussed there, with updates to be provided to the Board if necessary.

The recommendation in the report provided by Colin “that the two Safeguarding Adult Boards seek assurance that systems are in place to assess the needs of those victims/survivors who are identified as vulnerable and that appropriate provision is accessible to address the assessed needs” was approved by the Board, and it was noted that Caroline Baria, Julie Gardner and Elaine Moss are all members of the Strategic Management Group and would therefore be in a position to provide updates to the NSAB.

3.1 **Action:** Colin Pettigrew and Steve Edwards are to provide updates to the Board in relation to learning points and progress on the Goddard Inquiry as they become available.

3.2 **Action:** Caroline Baria, Julie Gardner and Elaine Moss are to provide updates from the Strategic Management Group to the Board as they become available.

4. **Pathway to Provision**

A link to the new Pathway to Provision had been distributed prior to the meeting, and Steve Edwards presented the document to the Board, explaining that it had been updated in November 2015 and was now a shorter version of the original.

**Colin Pettigrew / Steve Edwards**

**Caroline Baria / Julie Gardner / Elaine Moss**

**Ongoing**

**Ongoing**
Ruth felt that it was a very useful document, and commented that a similar document covering low to high level need in relation to adult safeguarding would be helpful, as she did not feel that it was always clear from a “local point of view” what options are available. Caroline responded that there are safeguarding pathways, but these do not include information on the provision of services.

Julie Cuthbert signposted the Board to the Nottinghamshire Help Yourself website, and Stuart added that the website is aimed at the public but may also be useful for staff, as it directs people to the available services. Caroline commented that District Councils need to ensure that they are contributing to and utilising the website.

### 5. Investigations into Southern Health NHS Foundation Trust

Amanda Sullivan informed the Board that the investigations into Southern Health NHS Foundation Trust had commenced following the death of a young man with learning disabilities who also suffered seizures. While a patient, a decision had been taken that he could bathe alone despite the risks, but he had a fit while in the bath and drowned.

NHS England commissioned an independent report into the deaths of people with learning disabilities or mental health illnesses at the Trust, looking at the period from March 2011 to September 2015. The investigation considered amongst other things which unexpected deaths were investigated, the reporting of unexpected deaths, and engagement with families and carers. It was found that a significant number of unexpected deaths were not reviewed sufficiently or at all. A number of recommendations were made, including recommendations about reporting and timeliness.

Allan noted that Jane Cummings, Chief Nursing Officer at NHS England, is due to produce some guidance.

There was a discussion regarding the implications for Nottinghamshire of the investigations into Southern Health – for example, which cases are investigated, what death certificates state, and where Nottinghamshire is in relation to the recommendations in the report. Julie Gardner confirmed that all “serious incidents” are reported within Nottinghamshire Healthcare NHS Trust, but she was not sure which are investigated. Tina Nock explained that there is a framework for reporting serious incidents, which is likely to be updated in line with the recommendations made in the report on Southern Healthcare.

Amanda confirmed she would ask Elaine Moss to produce a report for the Board which would consider Nottinghamshire’s current position on reporting and investigating unexpected deaths, and provide assurance to the Board on the work being done in order to avoid the type of situation which has arisen in Southern Health NHS Foundation Trust.

### 5.1 Action: Amanda Sullivan is to ask Elaine Moss to produce a report from the CCG regarding Nottinghamshire’s position against the recommendations made in the NHS England Report into Southern Health NHS Foundation Trust.

6. **Sub-Group Updates**

6.1 **Communications Sub-Group Update**

Julie Cuthbert informed the Board that there had been recent newspaper
articles on winter warmth, keeping the elderly safe, and cold weather situations. She also confirmed that the next round of the Safeguarding Awareness Survey would commence in April 2016.

Julie also asked that if agencies want to raise any issues, they contact Julie Cuthbert so that it can be considered. Allan added that if there was a top-level concern it should go directly to him, but other issues or articles of interest for the Board should go via Julie. Stuart commented that this should include “good news stories” and articles on how safeguarding is making a difference.

6.2 Quality Assurance Sub-Group Update

A report which explained the data contained in a number of graphs had been distributed to the Board prior to the meeting.

After Claire had outlined the report and data, Stuart commented that of particular note was the fact that if an individual was asked what their desired outcome was the risk reduced was of a significantly higher percentage that if an individual was not asked about their desired outcome. Allan added that making safeguarding personal is a Board priority and all individuals should be asked.

David stated that the data needs to be fed back to practitioners to ensure good practice, but Caroline also queried whether there is a recording issue or whether individuals are genuinely not being asked the question. Stuart responded that all questions on the system are mandatory, but one issue for consideration is that people are not understanding the questions being asked.

David queried what happens if an individual lacks capacity, and Claire responded that it is still possible to establish what outcome that individual wants. Claire added that the sub-group can drill down into data to establish if capacity is an issue.

Ruth noted that while questions may be mandatory on the local authority’s systems, they may not be on the systems of other agencies. She suggested a prompt sheet might be a useful tool to remind people to obtain information prior to making a referral. Allan asked Claire and the sub-group to look into this as an option.

6.2.1 Action: Claire Bearder is to ask the Quality Assurance Sub-Group to look into the creation of a prompt sheet to remind people to obtain information prior to making a referral, and provide an update at the next Board meeting.

There were two recommendations in the report on the QA Sub-Group. The first, that the NSAB approves a proposal to focus the next data analysis on the care home sector, was agreed. The second, that the NSAB considers whether mitigating factors presented in the Nottinghamshire Healthcare Trust report offers assurance to enable risk number 5 relating to the restructure of adult mental health beds to be removed from the Register, was not agreed. Instead, as discussed earlier in the meeting, it was agreed that the risk would remain on the Register in order to ensure it is kept under review.

6.3 Training Sub-Group Update

Stuart confirmed that the Learning Pathway has now been agreed and it will be implemented during the course of the next year.
Stuart also confirmed that the Making Safeguarding Personal Making Effective Referrals training has now commenced, and further courses are planned during January and February 2016.

6.4 Safeguarding Adults Reviews Sub-Group Update

Amanda outlined the update report which had been distributed prior to the meeting. She gave an update on the SAR G15, confirming that the Overview Report had been signed off at the Extraordinary Board meeting in December subject to some agreed amendments being made.

Amanda also provided an update on the SF/SD case, confirming that all three perpetrators in the case have been convicted. The review is currently underway, led by the City’s Safeguarding Board and supported by the NSAB.

User guidance has now been produced in relation to reviews, which gives more flexibility as to the type of review which can be commissioned.

7. Any Other Business and Closing Remarks

David asked that his thanks be noted to Allan for his continued leadership, and to members for their continuing commitment to the Board, adding that this was his first meeting since returning to his role at the Council after his time at ADASS.

David also confirmed that a paper had been presented to the Health and Wellbeing Board in relation to safeguarding.

He also informed the Board that Nottinghamshire County Council’s budget proposal consultation is underway. He asked that Board members familiarise themselves with the proposals relating to Adult Social Care and asked that they respond to the consultation.

8. Close

There being no further business, Allan thanked the Board members for their attendance and input at both the morning and afternoon sessions and closed the meeting.

9. Future Meeting Dates

NSAB Meetings:

- 14th April 2016
  2:00pm to 5:00pm
  Nottingham Fire & Rescue Service, Bestwood Lodge, Arnold, Nottingham, NG5 8PD

- 14th July 2016
  2:00pm to 5:00pm
  Nottingham Fire & Rescue Service, Bestwood Lodge, Arnold, Nottingham, NG5 8PD

- 13th October 2016
  2:00pm to 5:00pm
  Nottingham Fire & Rescue Service, Bestwood Lodge, Arnold, Nottingham, NG5 8PD
### NSAB Partnership Events:

- **17th May 2016**  
  9:00am (for a 9:30am start) to 12:30pm  
  The Towers, Botany Avenue, Mansfield, NG18 5NG

- **22nd November 2016**  
  9:00am (for a 9:30am start) to 12:30pm  
  The Talbot Suite, Rufford Mill, NG22 9DG
Minutes of the Nottinghamshire Safeguarding Adults Board Meeting

Held on 14th April 2016
### Attendance List for the NSAB Meeting

**14th April 2016**

<table>
<thead>
<tr>
<th>NAME</th>
<th>ORGANISATION</th>
<th>PRESENT</th>
<th>APOLOGIES</th>
<th>ABSENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allan Breeton Chair</td>
<td>Independent Chair, Nottinghamshire Safeguarding Adults Board</td>
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<tr>
<td>Amanda Sullivan Vice Chair</td>
<td>Chief Operating Officer, Newark and Sherwood Clinical Commissioning Group</td>
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<tr>
<td>Amanda Marsden Deputy for Richard Cropley</td>
<td>Adult Safeguarding Lead, Persons at Risk Team, Nottinghamshire Fire and Rescue Service</td>
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<tr>
<td>Bella Dorman Deputy for Rob Morris</td>
<td>Designated Nurse Safeguarding Adults and Consent, Nottingham University Hospitals NHS Trust</td>
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<tr>
<td>Bernadette Carter Associate Board Member</td>
<td>Senior Solicitor (Litigation), Safeguarding and Social Care, Legal Services, Nottinghamshire County Council</td>
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<tr>
<td>Caroline Baria Board Member</td>
<td>Service Director, Strategic Commissioning, Access and Safeguarding, Nottinghamshire County Council</td>
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<tr>
<td>Caroline Jones Board Member</td>
<td>Interim Head of Safeguarding, Sherwood Forest Hospitals NHS Foundation Trust</td>
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<tr>
<td>Claire Bearder Board Member</td>
<td>Group Manager, Access and Safeguarding, Nottinghamshire County Council</td>
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<tr>
<td>David Pearson Board Member</td>
<td>Corporate Director, Adult Social Care, Health and Public Protection, Nottinghamshire County Council</td>
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<tr>
<td>Deborah Kitson Associate Member</td>
<td>Chief Executive Officer, Ann Craft Trust</td>
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<td>Denise Nightingale Board Member</td>
<td>Chief Nurse and Executive Lead for Quality and Safety, NHS Bassetlaw Clinical Commissioning Group</td>
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<td>Elaine Moss Board Member</td>
<td>Director of Quality and Governance, Newark and Sherwood Clinical Commissioning Group</td>
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<td>Helen Chamberlain Board Member</td>
<td>Superintendent, Nottinghamshire Police</td>
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<td>James Povey Guest</td>
<td>Nottingham University Hospitals NHS Trust</td>
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<td>Name</td>
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<tr>
<td>Julie Cuthbert</td>
<td>Board Member, Senior Communications Business Partner, Nottinghamshire County Council</td>
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<tr>
<td>Julie Gardner</td>
<td>Board Member, Associate Director, Safeguarding and Social Care, Nottinghamshire Healthcare NHS Trust</td>
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<tr>
<td>Karmon Hawley</td>
<td>Board Member, Inspection Manager, Adult Social Care Inspection Directorate, Care Quality Commission</td>
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<tr>
<td>Leigh Sanders</td>
<td>Deputy for Helen Chamberlain, Deputy Chief Inspector, Nottinghamshire Police</td>
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<td>Matthew Tedstone</td>
<td>Guest, Inspection Manager, Care Quality Commission</td>
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<tr>
<td>Moira Hardy</td>
<td>Board Member, Deputy Director of Nursing, Midwifery and Quality, Doncaster &amp; Bassetlaw Hospitals NHS Foundation Trust</td>
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<tr>
<td>Nichola Bramhall</td>
<td>Deputy Board Member, Director of Nursing and Quality, Nottingham North and East, Nottingham West and Rushcliffe Clinical Commissioning Groups</td>
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<tr>
<td>Nicola Ryan</td>
<td>Board Member, Deputy Chief Nurse, NHS Bassetlaw Clinical Commissioning Group</td>
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<tr>
<td>Nigel Hill</td>
<td>Board Member, Head of Nottinghamshire National Probation Service</td>
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<tr>
<td>Paul McKay</td>
<td>Deputy for David Pearson, Service Director, South Nottinghamshire and Public Protection, Nottinghamshire County Council</td>
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<tr>
<td>Richard Cropley</td>
<td>Board Member, Persons at Risk Team Manager, Nottinghamshire Fire and Rescue Service</td>
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<td>Rob Morris (Dr)</td>
<td>Board Member, Consultant Physician, Nottingham University Hospitals NHS Trust</td>
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<tr>
<td>Ruth Hyde</td>
<td>Board Member, Chief Executive Officer, Broxtowe Borough Council</td>
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<tr>
<td>Sarah Banks</td>
<td>Associate Member, Advanced Legal Practitioner, Legal Services, Nottinghamshire County Council</td>
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<td>Steve Edwards</td>
<td>Board Member, Service Director, Children’s Social Care, Nottinghamshire County Council</td>
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<td>Name</td>
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<tr>
<td>Stuart Sale</td>
<td>Board Member, Nottinghamshire Safeguarding Adults Board Manager</td>
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<tr>
<td>Sue Matthews</td>
<td>Associate Member, Crown Advocate, Crown Prosecution Service</td>
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<tr>
<td>Suzanne Banks</td>
<td>Board Member, Interim Chief Nurse, Sherwood Forest Hospitals NHS Foundation Trust</td>
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<tr>
<td>Wendy Hazard</td>
<td>Board Member, Locality Quality Manager – Nottinghamshire, North Division East Midlands Ambulance Service</td>
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<tr>
<td>Anna Jakeman – Minute Taker</td>
<td>Nottinghamshire Safeguarding Adults Board Officer, Safeguarding Adults Strategic Team</td>
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**Minutes of the NSAB Meeting**  
**14th April 2016**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Discussion</th>
<th>Action by</th>
<th>By date</th>
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<tbody>
<tr>
<td>1.</td>
<td>Welcome, Introductions and Apologies</td>
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<td></td>
<td>Allan Breeton welcomed all to the meeting, apologies were given as detailed above, and introductions were made.</td>
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<td>2.</td>
<td>Minutes of the Board Meeting held on 14th January 2016</td>
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<td></td>
<td>Points of Accuracy</td>
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<tr>
<td></td>
<td>There were no points of accuracy raised, and the minutes were agreed to be a true and accurate record of the meeting.</td>
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<td></td>
<td>Matters Arising</td>
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<td>The actions from the meeting held in January are detailed on the attached Action Log.</td>
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<td>3.</td>
<td>Sub-Group Updates</td>
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<td>3.1</td>
<td>Communications Sub-Group Update</td>
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<td>Julie Cuthbert confirmed that the latest safeguarding awareness survey is now live, and asked that all Board Members establish if the survey is available on their individual agency's website and raise awareness of it among colleagues and customers. The closing date for the survey is 11th May 2016.</td>
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<tr>
<td>3.1.1</td>
<td>Action: All Board members are to establish if the new Safeguarding Awareness Survey is available on their agency's website, and raise awareness of it among colleagues and customers.</td>
<td>All</td>
<td>11.05.16</td>
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<td></td>
<td>Julie also stated that an audit and update of publicity materials is due to commence, and she is working with Stuart Sale in this regard. Possible options for publicity material include a leaflet for the public, a fact sheet, and an info graphic poster.</td>
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<td>The Elder Abuse Awareness Day will take place on 15th June 2016. Julie is due to meet with Jane Locke, a Senior Practitioner in the Older Adults Team at the County Council, to review case studies, and she requested that Board Members also forward to her, via the Safeguarding Team's email address (<a href="mailto:safeguarding1.adults@nottscc.gov.uk">safeguarding1.adults@nottscc.gov.uk</a>) any case studies which could be utilised, adding that ideally they should be cases which have not yet been covered in the press.</td>
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<tr>
<td>3.1.2</td>
<td>Action: All Board members are to advise Julie Cuthbert via the Safeguarding Adults Team email address of any case studies which could be utilised for Elder Abuse Awareness Day.</td>
<td>All</td>
<td>31.05.16</td>
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</tbody>
</table>
### 3.2 Learning and Development Sub-Group Update

Stuart Sale presented an update report to the Board, a copy of which had been distributed prior to the meeting and is therefore not detailed within these minutes.

There were two recommendations contained within the report:

**Recommendation 1:** that the NSAB agrees to add to the scope of the safeguarding competency framework and pathway framework to include competencies relating to the mental capacity act.

Stuart stated that the framework has been developed and updated based on the Bournemouth National Capability Framework. The Sub-Group has formed a small group which is looking at updating the document further to include mental capacity act competencies. He acknowledged that there has also been a further document, "Safeguarding Adults: Roles and competences for health care staff – Intercollegiate Document", which has been produced by NHS England. Further information is being sought by the Sub-Group in relation to this document and once clarification on various points has been received the document and its impact will be considered by the Sub-Group.

The Board agreed Recommendation 1.

**Recommendation 2:** that the NSAB notes the content of this report and the work of the Learning and Development Sub-Group.

The Board agreed Recommendation 2.

### 3.3 Quality Assurance Sub-Group Update

Claire Bearder presented a report to the Board with the latest data, a copy of which had been distributed prior to the meeting and is therefore not detailed within these minutes.

**Board Data**

Claire detailed the figures shown in the report and attached Board Data Analysis, after which the Board was invited to make any comments.

Julie Gardner queried whether, in relation to the figures around individuals who are not being asked of desired outcomes, there is confidence that the referrers are asking those individuals prior to making a safeguarding referral. Claire responded that the Local Authority has oversight and is able to look into this further.

**Action:** Claire Bearder and the QA Sub-Group are to look into whether those making a safeguarding referral have made enquiries as to what outcome the individual concerned requires.

Deborah Kitson queried whether any details are available with regard to what question is asked about desired outcomes, and also how the question is asked. Claire responded that the question will be asked in a multitude of ways, although the data is collected through a tick-box system.

Allan noted the decrease in the percentage of individuals being asked desired outcomes. There was a discussion around improvements within the Local Authority in this regard.
<table>
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<tr>
<th>Risk Register</th>
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<tr>
<td>Claire detailed the updated position as set out in the report in relation to the Risk Register. Further to discussion, the Board agreed with the recommendation that it would assume ownership of the Register, whilst the risk owner would retain responsibility for taking any mitigating actions and the QA Sub-Group would continue to monitor progress.</td>
</tr>
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In relation to Risk 2, Elaine Moss confirmed that she is due to meet with the Deputy Nurse for Nottinghamshire, and would raise the risk around communication with NHS England. Elaine added that she meets with the Deputy Nurse regularly, and would therefore be in a position to raise any other issues which may arise involving NHS England.

**3.3.2 Action:** Elaine Moss is to liaise with the Deputy Nurse for Nottinghamshire in relation to the engagement of NHS England (Risk 2 on the Risk Register) and provide an update to the QA Sub-Group via Claire Bearder.

Nicola Ryan stated that the Bassetlaw area has connections with a different sector of NHS England, and confirmed that she would raise the risk with Denise Nightingale and request that she liaises with Margaret Kitchen at NHS England.

**3.3.3 Action:** Nicola Ryan is to liaise with Denise Nightingale in relation to the engagement of NHS England in order that Denise can feedback/liaise with Margaret Kitchen of NHS England in the Bassetlaw area.

Claire commented that Karon Glynn had been undertaking work in relation to Risk 2, and Elaine responded that Karon’s post is now being recruited to and will be filled by an individual who has the responsibility of working across various areas and forming links.

In respect of the second recommendation that the Board reviews the risk levels for risks 3, 4 and 5 this was done and the levels for risks 3 and 4 remained as they are.

Julie Gardner then informed the Board that Risk 5 is also on the City’s Safeguarding Adults Board Risk Register and Malcolm Dillon, the Chair, has asked for a meeting to consider the risk rating and any mitigating actions. It was agreed that a partnership approach across both the City and County was required in order to look at how to progress the issues around mental health beds.

Elaine suggested a meeting of Health colleagues was required, as the risk is very broad with a number of issues, in order to breakdown who/which agency owns different parts of the risk. It was agreed that Elaine would organise a meeting and provide an update and revised wording for the Risk Register to the QA Sub-Group via Claire Bearder.

**3.3.4 Action:** In relation to the restructure of mental health beds (Risk 5 on the Risk Register), Elaine Moss is to arrange the organisation of a meeting of Health colleagues, and provide an update and revised wording to the QA Sub-Group via Claire Bearder.

**3.3.5 Action:** Julie Gardner is to liaise with Malcolm Dillon, the Independent Chair of the Nottingham City Safeguarding Adults Board, regarding the joint approach across the City and County to the restructure of mental health beds.
There then followed a discussion as to whether or not an additional risk regarding the number of referrals received not leading to a Section 42 Enquiry should be added to the Risk Register. As detailed in the report provided to the Board, targeted work is being undertaken in order to address the issues, and it was agreed that an additional risk was not currently required, but that the QA Sub-Group should continue to monitor and if the risk is increasing the situation can be re-assessed.

3.4 Safeguarding Adults Review Sub-Group

Stuart Sale presented an update report to the Board, a copy of which had been distributed prior to the meeting and is therefore not detailed within these minutes. However, additional information was provided to the Board, including confirmation that the author of SAR G15 has agreed to facilitate to learning events which will take place in June 2016, and work is now underway to analyse the impact of previous serious case reviews and will focus on the themes which have arisen. Allan also added that the East Midlands Regional Safeguarding Board had requested information in relation to recent serious case reviews / safeguarding adults reviews. Claire commented that the rationale behind the work is that if the themes which consistently arise can be addressed it may help to prevent similar cases in the future.

4. Care Quality Commission Statement on Safeguarding

Karmon Hawley presented on behalf of the CQC, providing information to the Board regarding the role and approach of the CQC in relation to safeguarding. A copy of the presentation is to be circulated, and is not therefore detailed within these minutes.

4.1 Action: Anna Jakeman is to arrange for the CQC Presentation to be distributed to Board members with the minutes of the meeting.

Following Karmon's presentation, Allan thanked her for the information and invited the Board to make any comments or ask any questions.

Further to a question from Julie Gardner regarding what “good” looks like in terms of a provider, Karmon confirmed that a provider handbook is available on the CQC’s website which details exactly what the CQC requires.

Claire Bearder asked Karmon to clarify the CQC’s role in terms of safeguarding adults reviews, and Karmon confirmed that the CQC will produce reports and attend panel meetings where possible when required. She added that there may be occasions when it is not possible to provide information. Requests will be distributed to team members to review and write a report.

There was a discussion regarding the links formed by the CQC, and Karmon stated that it does not consistently link in but if, for example, there is a death in a care or residential home the CQC will liaise with the Coroner who in turn links to other organisations.

Deborah Kitson queried Karmon’s thoughts on the thresholds for safeguarding, and Karmon confirmed that she did not think individuals were always aware of them. However, people do tend to err on the side of caution and refer “too much” rather than not enough. Nicola Ryan commented that places which do not refer any cases are more concerning that those who
4.2  Action: Karmon Hawley is to arrange for information regarding location managers and a named contact for the Board at the CQC to be distributed to Board members via Anna Jakeman.

**Elaine Moss**

14.07.16

<table>
<thead>
<tr>
<th>Southern Health NHS Foundation Trust Report – Nottinghamshire’s Position</th>
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<tr>
<td>Elaine Moss stated that a report had been published in December 2015 regarding mental health and learning disability deaths in the Southern Health area, with significant issues being highlighted. Elaine had been tasked with carrying out a review of the position in Nottinghamshire in relation to those issues, and she confirmed that a request has been sent out for assurance and evidence that work is being done. Once responses are received, she will complete a report for the Board.</td>
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<tr>
<td>Some of the main issues which have been highlighted include the involvement of families, reporting, and communication, all of which have arisen before now. Elaine confirmed that the review which is now underway will not just relate to patients with mental health or learning disabilities, but all people who pass through the health system. Most health service commissioner run quality monitoring and visits at least monthly. In Nottinghamshire, some organisations are in special measures and the CQC is already providing reports on those.</td>
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<td>Elaine confirmed that the assurance so far is that although not everything is perfect in provider agencies, work is being undertaken. She added that her report will be circulated as soon as it is complete.</td>
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<tr>
<td><strong>5.1</strong>  Action: Elaine Moss is to arrange for the circulation of the report into Nottinghamshire’s position in relation to the Southern Health NHS Foundation Trust report as soon as it is complete.</td>
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<tr>
<td>Elaine Moss</td>
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<td>14.07.16</td>
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Nicola Ryan agreed with Elaine that evidence of work should be requested, not just assurance. She added that processes have been in place for some time, and are not new as a result of the Southern Health situation.

6. Goddard and Local Inquiries

Julie Gardner informed the Board that she sits on the Strategic Management Group. The Group has not met since the Board’s last meeting in January 2016. However, it is due to meet during the week commencing 18th April, at which time it will be considering topics including the Goddard Inquiry, a risk register, and victim support.

Julie also stated that there is now a survivors meeting, and she outlined the priorities and confirmed that Colin Pettigrew, Corporate Director for Children’s Services at Nottinghamshire County Council, is drafting terms of reference. The survivors group will meet approximately every two months.

Claire informed the Board that a good practice guide for responding to historic abuse allegations may be incorporated into the Policies and Procedures which are already in place.

Leigh Sanders confirmed that the first perpetrator from the Beechdale Children’s Home has now been convicted.

7. Review of Board and Sub-Group Structures

Stuart Sale confirmed that, following a review of the Board and its sub-groups’ structures further to discussions held at the Board’s Development Day in January, there would be no combined sub-groups going forward, but that further work is undertaken to review where cross-authority working in Adult Safeguarding can be continued and developed. Details of the review were presented an update report to the Board, a copy of which had been distributed prior to the meeting and is therefore not detailed within these minutes.

Paul McKay noted that the Board does link into Community Safety and Safer Nottinghamshire work, but added that there is a considerable amount of work which the Board is not privy to and he felt that a review in this regard would also be of benefit.

Allan suggested that a meeting between himself and the leads of the statutory agencies, together with Ruth Hyde as the representative for the districts would be of benefit in order to discuss how cross-authority multi-agency working can be taken forward further to the review of the Board and its sub-groups’ structures.

7.1 Action: Anna Jakeman is to arrange a meeting between Allan Breton, the Police, Health and Local Authority leads, and Ruth Hyde to discuss the work which has taken place to review sub-group structures and how this can now be taken forward.
8. **Chair’s Report**

<table>
<thead>
<tr>
<th>Action Log</th>
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<tbody>
<tr>
<td>Allan proposed that an action log, a version of which had been distributed to the Board prior to the meeting was utilised going forward and which would be attached as an annex to the minutes. This was agreed by the Board.</td>
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<thead>
<tr>
<th>Board Report Template</th>
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<tbody>
<tr>
<td>Allan proposed using the draft Board Report template, a copy of which had been distributed prior to the meeting, for any reports to be presented at the Board meetings in order to ensure some consistency. He added that the Children’s Safeguarding Board already uses a template. This was agreed by the Board.</td>
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<thead>
<tr>
<th>Annual Report</th>
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<tbody>
<tr>
<td>Allan informed the Board that the Care Act specifies that members need to provide information as to how their organisations contribute. A template has been developed by Stuart, question 1 of which is mandatory.</td>
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</tbody>
</table>

| 8.1 Action: Stuart Sale and Anna Jakeman are to arrange for the letter and template requesting information from Board Members regarding agency contributions for the NSAB Annual Report to be circulated. |
|------------------|------------------|
| Stuart Sale / Anna Jakeman | 22.04.16 |

| 8.2 Action: All Board Members are to ensure that they return the information regarding agency contributions for the Annual Report by 20th May 2016. |
|------------------|------------------|
| All | 20.05.16 |

<table>
<thead>
<tr>
<th>New Care Act Guidance</th>
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<tbody>
<tr>
<td>Allan informed the Board that the updated Care Act Guidance has been issued, and there are a number of changes relating to Safeguarding. A list of the main changes had been provided prior to the meeting.</td>
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<tr>
<th>Process for Initial Information Requests Relating to Possible Safeguarding Adults Reviews</th>
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<tbody>
<tr>
<td>Allan stated that Board Members need to take ownership of information being returned to the Safeguarding Adults Team. Anna Jakeman confirmed that the information request template has been updated to include Board Member information, and this will be utilised going forward.</td>
</tr>
</tbody>
</table>

9. **Organisational Update**

| Leigh Sanders confirmed that the position of Assistant Chief Constable is due to become vacant. Helen Chamberlain is also moving away from Public Protection, and the new Board Member will be Detective Superintendent Robert Griffin. Leigh will remain as the Board Member’s Deputy for now. The changes are due to be in place from 3rd May 2016. Allan confirmed that he is due to meet with Chief Constable Chris Eyre, so will discuss the changes with him. Allan asked that his thanks to Helen Chamberlain for her work and contribution to the Board be noted. |

| Allan asked if there were any other changes taking place, and Caroline Jones confirmed that for Sherwood Forest Hospitals she would be the Board Member going forward, and Suzanne Banks will be her deputy. |
10. **Any Other Business**

   No further business was raised at the meeting.

11. **Close**

   There being no further business, Allan thanked the Board members for their attendance and input and closed the meeting.

12. **Future Meeting Dates**

   **NSAB Meetings:**
   - 14\textsuperscript{th} July 2016  
     2:00pm to 5:00pm  
     Nottingham Fire & Rescue Service, Bestwood Lodge, Arnold, Nottingham, NG5 8PD
   - 13\textsuperscript{th} October 2016  
     2:00pm to 5:00pm  
     Nottingham Fire & Rescue Service, Bestwood Lodge, Arnold, Nottingham, NG5 8PD

   **NSAB Partnership Events:**
   - 17\textsuperscript{th} May 2016  
     9:00am (for a 9:30am start) to 12:30pm  
     The Towers, Botany Avenue, Mansfield, NG18 5NG
   - 22\textsuperscript{nd} November 2016  
     9:00am (for a 9:30am start) to 12:30pm  
     The Talbot Suite, Rufford Mill, NG22 9DG